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# A Whole Woman Strategy and Action Plan to Raise National Awareness About Osteoporosis

Lenard W. Kaye

*University of Maine*, [len.kaye@maine.edu](mailto:len.kaye@maine.edu)

Majorie A. Harris

*University of Maine*

Clifford Rosen

*Maine Center for Osteoporosis Research and Education*

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# A Whole Woman Strategy and Action Plan to Raise National Awareness About Osteoporosis

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## **Final Report**

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Lenard W. Kaye, D.S.W.  
Co-Principal Investigator

Marjorie A. Harris, L.C.S.W.  
Project Director

Center on Aging  
University of Maine  
5723 Donald P. Corbett Business Building  
Orono, Maine 04469

Clifford Rosen, M.D.  
Co-Principal Investigator

Maine Center for Osteoporosis Research and Education  
900 Broadway  
Bangor, Maine 04401

## Executive Summary

The University of Maine Center on Aging, in partnership with the Maine Center for Osteoporosis Research and Education, was one of three grantees taking part in a U.S. Administration on Aging-funded project to develop a national osteoporosis awareness and action plan targeting postmenopausal women. While proceeding with the Center's segment of the project, we collaborated regularly with the other two grantees, the National Osteoporosis Foundation (NOF) and the Foundation for Osteoporosis Research and Education (FORE).

### *Methodology*

The University of Maine Center on Aging's portion of the research entailed several phases of activity. Initially, focus groups were conducted with 147 ethnically and racially diverse older women around the country (Maine, New York, Pennsylvania, California, and Kansas) to determine where older women obtain their health information, what they consider reliable and unreliable informational sources, and where they've gotten information in the past that has resulted in changes in their health behavior.

The second phase focused on researching existing osteoporosis education programs and previous or ongoing campaigns to ascertain what programmatic elements have been most and least effective. Sixteen telephone and three in-person interviews were conducted with professionals throughout the United States having special expertise in the field of osteoporosis education, and working with aging and underserved populations. In addition, informal discussions were held with a large number of other individuals while in attendance at the two FORE Summits and through e-mail.

Phase three entailed obtaining feedback from 13 focus groups with 122 ethnically and racially diverse older women around the country (California, Illinois, Georgia, Maine, and New York), concerning mock brochures, graphics, and messages for the campaign as well as ideas about spokespeople and promotional items. The mock brochures and graphics were developed in consultation with marketing and design consultants. Additionally, we worked with local and national marketing consultants to develop theoretical and conceptual foundations for framing and informing the campaign.

Throughout the research project we received feedback and recommendations from two national expert blue ribbon panels in the areas of osteoporosis education and research and aging, women, and minority populations. In addition, we met with our local advisory board of experts periodically.

It should be noted that while recommendations offered have considerable value in informing a campaign that reaches specialized segments of the older female population, the limited number of key informants interviewed, focus groups conducted, and older female study participants recruited, requires caution in terms of application. Ongoing inquiry is essential to continually refine campaign recommendations as they apply to special subgroups of ethnically, racially, and functionally diverse elder women populations.

## *Project Findings*

### **Phase I**

Findings from this phase of the project are broken down by study question area with the results briefly summarized.

#### *Sources of Health Information*

Although elder women get their health information from a variety of sources, some sources emerged from the focus groups as being particularly important. Results were consistent among groups, with the only major exception of print media not being as important to the women with visual impairments. The most frequently cited sources are as follows:

- Health providers
  - Physicians
  - Pharmacists
  - Nutritionists
  - Nurses, Nurse Practitioners
- Publications
  - Newsletters-both health and general with health articles
  - Magazines - “Prevention” and “Modern Maturity” most mentioned
  - Pamphlets from doctors’ offices, health fairs, mail
  - Books
  - Newspapers
- Broadcast media
  - Television – particularly health segments on newscasts
  - Radio-particularly important in rural Midwest
- Formal health lectures
- Family
- Internet
- Telephone information lines

#### *Sources Considered Reliable*

Sources cited as reliable were generally the same as above. Those most often cited as reliable are as follows:

- Health providers
  - Physicians
  - Pharmacists
  - Nurses

- Internet
- Publications
  - Books
  - Magazines - particularly “Prevention”
  - Newspapers
  - Newsletters - particularly insurance company generated
- Family
- Formal health lectures - particularly hospital-based
- Television - particularly newscast health segments
- Radio

#### *Sources Considered Unreliable*

The majority of focus group participants were unable to identify unreliable resources with one woman even stating that she had never thought about health information being anything but reliable. Among those who did question a source’s reliability, the following were most frequently identified as unreliable:

- Ads, commercials, infomercials
- Some friends, family, neighbors
- Some newspaper articles, magazines and tabloids
- Anything published by pharmaceutical companies

#### *Sources of Information Resulting in Changed Health Behavior*

Women gave the following responses, in decreasing frequency, when asked where they had received health information in the past that resulted in their changing their behavior:

- Health professionals
  - Self-initiative
- Media
  - Family/Friends
  - Health lectures

#### *Past or Current Behavior to Reduce Impact of Osteoporosis*

Many participants were already doing something to prevent or treat osteoporosis.

The most common responses were as follows, again in descending order of frequency:

- Followed physician’s recommendations
- Had bone density testing

- Take calcium supplements
- Exercise regularly
- Try to practice good nutrition
- Take hormone replacements
- Attend health fair screenings
- Listen to own body

### *Motivation*

While motivators of change in behavior were not solicited separately, probes were employed to get at this issue. The following is a list of factors identified by participants in descending order of frequency:

- Fear
- Desire to be healthier and feel better in general
- Family
- Self-efficacy
- Desire to support spouse's personal health care plan
- Simplicity and cost of recommended treatment
- Vanity

### *Conclusion*

Despite the diversity of the participants, their responses were remarkably similar. Although many of the participants in this phase of the project were from underserved groups (ethnic, socioeconomic, inner city, rural), the focus groups were organized through Area Agencies on Aging or senior citizen centers. The participants were therefore, all, at the very least, connected with one of these community agencies. Their views may not represent those subgroup members totally disconnected from such resources.

## **Phase II**

From December, 2002 until May, 2003, a total of 16 telephone and 3 in-person interviews were conducted with authorities in the fields of osteoporosis and aging. Through the use of the internet, referrals from other professionals, the U.S. Surgeon General's Report, and the National Osteoporosis Foundation literature search, professionals were identified in the fields of multicultural health and women's issues. Two categories of interview questions were asked depending upon the interviewee's area of professional expertise. One set was for those individuals involved with existing campaigns or educational programs and the other for experts in specific related fields, as delineated above.

The interviews confirmed much of the information gathered during our first round of focus groups concerning where and how elder women obtain health information. Clearly, health care professionals and various media venues are the most important sources outside family. The interviewees’ strong recommendation to keep messages simple and to the point while adapting slightly for different subgroups is reiterated by many participants in our Phase III focus groups.

Although osteoporosis educational information and programs are plentiful, it is clear there are a significant number of elder women who have not had access to such material and programming for various reasons. To reach these women, our interviewees made a strong recommendation to take the message to them in their communities. This might be through mobile screening machines, exercise classes held in housing projects or senior centers, or calcium education in grocery stores. Interviewees provided many creative recommendations to accomplish this goal.

The importance of using a wide variety of venues and channels for communicating our message is evident from the interviews, and a vast array of possibilities exists. Making use of elder women themselves to help reach their peers emerged as an inexpensive and potentially highly effective model. Because far too few health care professionals understand the importance of bone density screening for this age group, targeting this group for education must be a part of an effective campaign as well. Potential national professional organizations and associations were identified for collaboration. Partnering with existing social service and ethnic networks will help to reach diverse groups of women.

Interviewees’ experiences, both effective and ineffective, reaching underserved populations provided a wealth of information to improve chances for an ultimately successful campaign. Clearly, it is imperative that individual communities guide the campaigns for their particular represented groups.

Universally, these professionals welcomed the prospect of a national osteoporosis education and prevention campaign for postmenopausal women. They are eager to be involved and to be kept up-to-date on the progress. There is much to be learned from existing programs and campaigns as we move forward

**Phase III**

The responses from participants in this round of focus groups are summarized by the question asked.

***Mock Brochures***

The majority of participants chose one of two brochures, both of which were the bold blue with yellow writing. In each case, the message (“Bone Up on Bone Loss” and “Tone Your Bones! Battle Bone Loss with Exercise”) was most often identified as what caught participants’ attention. The majority of respondents stated they made their brochure selection based on the message rather than the graphic. Color was a factor frequently, though less often than the message. Very few respondents reported making the choice based on the graphic alone.

***Graphics***

The design concept featured skeleton x-rays performing various activities. This was an attempt to use a graphic idea that would be different from the vast majority of material currently available to consumers

about osteoporosis. In addition, it was theorized that skeletons were relevant for a bone disease and would also catch the attention of the consumer. The four pictures tested appeared on the mock brochures. Major findings were as follows:

- The two full skeleton pictures were preferred over the partial skeleton ones.
- The whimsical nature of the preferred graphics appealed to many, but other women found them silly or inappropriate for this kind of campaign.
- The full skeleton graphics, for the most part, did catch participants' attention.

### *Messages*

Participants were shown four messages individually and asked several questions about their reactions to the phrases. The messages generally represented plays on words, again in an attempt to attract a woman's attention. Significant findings are as follows:

- These messages elicited a wide variety of reactions from laughter to confusion to, in two cases, irritation.
- "Tone Your Bones" and "Bone Up on Bone Loss" were the most popular, and many felt they conveyed a positive self-efficacy message.
- Most participants felt messages should be concise and to the point. This was felt to be particularly true for women with English as a second language.

### *Spokespersons*

Participants were asked questions about categories of potential spokespersons for a national campaign. Although individual suggestions were offered by those taking part, the goal was to ascertain what type of person would be most effective. The major findings are as follows:

- Females were overwhelmingly preferred over males.
- Participants preferred someone their general age.
- Of the five choices for spokesperson category, "physician" was most popular and "politician" least.
- There was a strong feeling that a spokesperson should be one with personal experience with osteoporosis or decreasing bone density.
- Many participants preferred an "ordinary woman" over a celebrity as their choice of spokesperson.



### ***Promotional Items***

Women were asked to discuss promotional items they had received in the past with emphasis on those they looked at several times a week. Key findings are as follows:

- Participants had received many promotional items, but most of them were unable to remember what message was associated with any particular item.
- Very few reported looking at the message several times a week.
- Magnets were most frequently identified as promotional items women liked to receive followed by pens, pill boxes, notepads, and key chains.

### **Development Strategies**

The following recommendations are based on our research as well as our collaboration with FORE. Each recommendation is described in detail in the formal grant report. What follows are short summaries of the salient points.

#### ***Advisory Board***

To assure the campaign's broad reach, we strongly recommend the formation of a multidisciplinary advisory board. The Board's duties will be to monitor the campaign, periodically evaluate its effectiveness, and make recommendations for changes to enable the momentum to be sustained. As baby boomers become elder women over the course of the campaign, strategies will need to change to reach this group with markedly different characteristics than their elders.

#### ***Spokespeople***

Having a celebrity spokesperson with which elder women can identify will give credibility to the campaign as well as add media interest. Oprah Winfrey was identified by participants in our Phase III focus groups as well as by some of those who attended the second FORE Summit. She seems to be someone whose popularity crosses racial and ethnic lines. In addition, she recently, very publicly, reached a pivotal age for bone loss concerns. Regardless of the choice, it is clear elder women want a spokesperson that has a personal interest in osteoporosis.

In addition to a national celebrity spokesperson, our research points to the benefits of using one or more "ordinary" women to serve as campaign figures. We suggest using a group of ethnically diverse women who engage in a variety of activities related to the overall messages of the campaign.

#### ***Dissemination of the Message***

It is critical for the campaign's success to have messages disseminated by many groups in as wide a variety of venues as possible. Women need to keep "running into" these messages. For economy and efficiency, existing channels should be used whenever possible. Some of these channels are listed below.

### Health Care Providers

Although our research did not focus on this group, FORE considered how to educate and change the behavior of health care providers around telling women about osteoporosis and ordering bone density exams. We encourage the collaboration with selected professional organizations to further this goal.

### Non-Profit Organizations and Public Agencies

There are numerous non-profit organizations and federal departments that have local distribution channels throughout the country. While the Area Agencies on Aging network is the most obvious, there are many others as well. Some of these, such as Senior Corps, already have a network of volunteers in place. By using as wide a variety as possible, the campaign is assured the farthest reach. We particularly encourage consideration be given to forming alliances with organizations that represent the underserved.

### For-Profit Channels

Although a potential source for partnering, these organizations can play an important role in disseminating the message as well. In particular, businesses that serve a disproportionate number of lower socioeconomic women have the potential to reach these women who have traditionally been overlooked by health care messages.

## ***Special Events***

To attract media attention, we suggest the campaign kickoff be “splashy” and coincide with a high visibility event. The spokesperson(s) should be introduced and the multiethnic nature of the campaign be demonstrated.

## ***Marketing***

It is imperative that our target population continually come into contact with messages about osteoporosis. To achieve this, a large variety of venues should be utilized for marketing the campaign. The following components should be considered:

### Media

Our research indicated that elder women receive a significant amount of health care information from various media venues. These include print as well as broadcast media sources. Magazines and health newsletters from a variety of sources were identified frequently as was television. In isolated rural areas, radio is a vital resource.

### Internet

Although currently used by a minority of elder women, this will become an increasingly more important source of message dissemination in the years to come. A campaign website will not only be valuable for those elder women who do use computers but will also be a resource for adult children looking for information for their mother. Targeting adult children with the campaign message is a vital conduit to elder women.

### Toll-free Telephone Number

If available in several languages, a toll-free information line could serve as an entry point in particular for women having no regular health care provider. Consideration could be given to tying into an existing information line, like Medicare or the National Osteoporosis Foundation.

### Identity Program

It is imperative that this campaign have an identity that is recognizable wherever and whenever the consumer crosses its path. Although it is also essential that the campaign be adapted by individual communities, a constant logo or graphic will assure the campaign has a national identity. The most successful national health campaigns have utilized a unifying theme.

The development of materials must conform to recommendations for age-related visual changes as well as the literacy level of consumers. As much as possible, materials should be able to be read by all groups to necessitate as little adaptation as possible. The shorter the messages, the less the adaptation and translation needed.

A “Bone Building Kit”, should be developed to distribute to women. Included in this should be promotional items that stand out from the many elder women encounter.

### Volunteers

Frequently in our research, we heard about the effectiveness of using elder women to deliver health messages to their peers. Though functioning primarily at a local level, it would be important to make these women feel part of a national group with a name like “Bone Brigade”. Local volunteers could be given awards on a national level. There are many functions volunteers could serve.

## **Local Implementation**

Repeatedly in our research, we heard the message that no national campaign would be successful in changing women’s health behavior without involving local communities. This is particularly true of most ethnic communities. Past campaigns have failed when organizers assumed they knew what a community needed. The level of awareness about osteoporosis varies dramatically among locales, and this factor alone necessitates different strategies and messages locally. What follows are some recommendations for the local level of the osteoporosis awareness campaign.

### ***Spokesperson***

Although it is hoped that the chosen national spokesperson would appeal across ethnic lines, in some cases a local spokesperson with credibility to a particular target group should be considered.

### ***Dissemination***

Well chosen national channels will facilitate the dissemination of osteoporosis information at the local level. In addition, strategic locations in a given community for posting campaign information will need

to be identified. Again, the goal is to use as many different venues as possible to insure that women continually cross paths with the message.

### ***Marketing***

In addition to local broadcast and print media, other excellent venues for marketing on a local level include health fairs, cultural celebrations, grocery stores, and faith-based organizations.

### **Partnering and Joint Ventures**

Successful national health campaigns have generally had a strategic partnership to help secure the campaign funding, increased visibility and even credibility. Some suggestions for partners for this campaign are pharmaceutical companies (possible the Alliance for Better Bone Health, an existing partnership between Aventis and Proctor and Gamble), a food corporation manufacturing high calcium products, and geriatric education academic programs.

### **Message Development**

It is clear from our expert interviews that the overall campaign message should be that osteoporosis is a preventable and treatable disease that can rob a woman of her independence. Emphasis needs to focus on the fact that it is never too late to take action. Repeatedly, it has been emphasized that the message should be simple, direct, and tell a woman what to do. While the message should be positive, the consequences of not acting need to be emphasized as well.

Although there are a variety of risk factors relevant to the development of osteoporosis, our experts agreed that three main messages should be emphasized. They are: 1) to get a bone density test of some sort; 2) to increase calcium intake; and 3) to engage in weight-bearing activity.

In addition to the message testing reported above, we participated in the FORE Summit at which a major activity was the development of campaign messages. Those recommendations are included in the FORE report.

### **Strategies to Reach Minority and Lower Economic Populations**

It is clear that previous campaigns have failed to adequately reach minority and lower economic elder women. It is imperative that this campaign direct particular attention to strategies geared towards educating these underserved populations and, more importantly, to motivating them to change health behavior. Recommendations that follow are based on feedback from both key informant and elder female focus group participants representative of such populations. Caution is urged against overgeneralization given the necessarily limited number of study participants and the changing profiles of these special population groups.

- An overall campaign cannot reach all ethnic subgroups of women without adaptation by individual communities to the specific needs of their residents. It is vital that local leaders be identified who can take the lead in translating materials and/or making them culturally relevant and appropriate. Some of these groups historically have mistrusted the majority health care system and need to hear the message from members of their own community. It is critical to remember that even within some ethnic sub-

groups (such as Latino, Native American, and Asian/Pacific Islander), there are many different cultures and, in some cases, languages spoken.

- Elder members of particular ethnic subgroups may not speak English and may not be oriented towards preventative care. Messages have to be in their language and speak to their values.
- Because family has major importance to many of these groups, family members should be targeted and urged to get their relatives tested. Women can also be urged to take the suggested steps in order to remain healthy for and available to their grandchildren.
- Faith-based affiliations may assume more importance with selected subgroups than with the elder population in general. This may be particularly true in African American communities. It could be advantageous to work through these organizations to reach the target population.
- Photonovelas (stories told through pictures) and telenovelas (Spanish soap operas) have been found to be effective ways to get messages across for segments of the Spanish-speaking population.
- Although perhaps the most difficult subgroup to reach, it is essential that strategies be employed to successfully educate low income older women. The attention of these women may be more focused on getting their basic needs met, and preventative health care may consequently be of relatively lower priority.

We must take our message to women in housing projects, via food stamp mailings, in discount stores, Meals on Wheels trays, etc. and convince them that their lives will be impacted positively as a result of adhering to campaign recommendations.

Piggybacking onto other messages received is recommended for this group.

Whenever possible, providing free gifts such as food, coupons, promotional items, etc. will help attract women to health talks and other campaign-related events. Campaign activities, including exercise classes, should be free of charge if at all possible.

Television may be an excellent venue for getting the message across to this group.

## **Conclusion**

University of Maine Center on Aging staff investigated where elder women obtain health information as well as when and why they make changes in health behavior and life style. By talking with older women themselves and interviewing experts around the country, we sought to determine what information and education strategies are and are not working in existing programs as well as to learn those approaches for reaching underserved populations of elder women. Working with marketing experts, we developed foundations upon which a national osteoporosis campaign could be built. Lastly, we tested selected materials to elicit feedback on preferences of elder

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women concerning graphics, messages, spokespeople, and promotional items. The latter stages of the research were partially guided and informed by the FORE Summits and the professional contacts forged there.

It is clear that with a large cohort of baby-boomers poised to enter their elder years and with the momentum growing to educate people about osteoporosis, the time for a national awareness and action campaign for elder women is now. We have attempted to lay out our study-based recommendations for making this campaign a success. It is our hope that our findings, together with those of the National Osteoporosis Foundation and the Foundation for Osteoporosis Research and Education, will become the guide for this very important campaign.

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# Chapter I

## Phase I Focus Group Report

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For the initial phase of its portion of the AoA osteoporosis awareness initiative, the Center on Aging (CoA) used focus groups to gain insight into older women's beliefs and perceptions about health information. In order to reflect the diversity of women in the United States, focus groups were held with a variety of populations in a number of locations around the country.

### Focus Group Development

Since the CoA is located in Maine, the five state Area Agencies on Aging (AAA's) were used as special resources for the recruitment of women within their individual regions. In addition, the National Council on Aging (NCOA) office in Maine was asked to organize a group composed of working older women. The seventh Maine focus group was organized by the Director of Human Services for Indian Island, the Penobscot Nation reservation. Additionally, collaborators in geriatric human services organized groups representing women from other backgrounds elsewhere in the country. The project director for the CoA's grant facilitated all the Maine groups.

Focus group materials were developed with group questions focusing on how women obtain health information, what they consider reliable and unreliable sources, and their experiences securing health information, both in general and specifically regarding osteoporosis (refer to Appendix A). All focus groups were held during the two month period of January and February, 2003. Groups lasted 90 minutes and women were paid a modest stipend for their participation. All groups were audio taped. Ten to fifteen women were recruited for each group, and the actual groups ranged in size from nine to fifteen participants. In addition to Maine, groups were convened in New York, Pennsylvania, and California (refer to Appendix B).

In response to a recommendation at the first National Osteoporosis Awareness Project Summit in Oakland, California that middle-American older women be included in the focus group process, a group in Manhattan, Kansas was facilitated in April 2003. This focus group was eventually supplemented by telephone interviews with professionals working with older Midwestern women. The results of those interviews are reported on elsewhere in this report.

### Demographics of Participants

Overall, 147 older women participated in the initial round of focus groups. Since the project's goal is to develop a strategy and action plan that will be effective for diverse sub-populations of elder women in the U.S., we attempted to recruit focus group participants who would be reflective of this diversity. There were six ethnic-specific groups. These were African American, (2) Native American, Asian/Pacific Islander, Latino, and Franco-American. In addition, one group was composed of all visually impaired women. To fur-

ther represent the different backgrounds nationally, groups were facilitated in urban (large and small) and rural areas. Income levels varied as well. Education levels of participants ranged from no formal education to graduate school. The mean age of the participants was 71 years with 15% being under 65 and 13% over 80. The majority (56%) lived alone. (refer to Appendix A for demographic charts). Although most women were retired, many still reported at least part-time employment.

## Discussion of Findings

Findings are broken down by focus group question. In order to demonstrate the wide variety of answers received, each discussion is preceded by a list of responses with the frequency indicated. Sources of information, such as newsletters and magazines, are identified by the title given by one or more participants. In certain cases, responses may not clearly correspond to a recognized publication or other source or may not reflect the precise title or name of the source.

### Question 1

**“Let’s start by talking about health in general, not just osteoporosis. We all get health information from many different people and places. We learn about health in many different ways. I’d like to hear about the ways you get your health information.”**

Note: Answers in italics are the most frequent and listed by frequency of response. Those listed in non-italics are responses given one-two times only.

### Health providers

- *Doctor*
- *Pharmacist*
- *Nutritionist*
- *Nurse practitioner, Nurse*
- *Chiropractor*
- Family members who are health care professionals

### Publications

- Local health newsletters
  - *Hospital’s*
  - Chiropractor’s
  - Health food store’s
- National health newsletters
  - *Harvard’s Women’s Health Watch*
  - *Dr. Andrew Weil’s Self Healing*
  - *Mayo Clinic’s Checkup Newsletter*
  - *UC Berkeley’s Wellness Letter*
  - *Sloan Kettering’s newsletter*
  - Dr. Julian Whitaker’s Health & Healing
  - Johns Hopkins’ Health After 50
  - Tufts’ Health & Nutrition Letter
- Newsletters with health articles
  - *AARP*
  - *Senior center’s*

- Community fliers
- College/University newsletters
- Magazines: health exclusively
  - *Prevention*
- Magazines: some health articles only
  - *AARP's magazine*
  - Ladies Home Journal
  - Reader's Digest
  - Kaiser Monthly
  - Women's Day
  - Family Circle
  - Consumer Reports (where to get care and cost)
  - Time
- Pamphlets/printouts
  - *From doctor's office/health center*
  - *Arrive in mail*
  - *Health fairs*
  - Pfizer (through mail)
  - Senior agency/center
  - "Native American clinic"
  - Found "lying around places"
  - County Extension
  - Kansas Dept. on Aging
- Books
  - "Ones that look good at bookstore"
  - The Pill Book
  - Reviewed or advertised in *Prevention*
  - Browse at library
  - "Medical books," medical encyclopedia
  - The Arthritis Cure
  - Natural healing books ordered through mail
  - Local medical school and its library
- Newspaper
  - Dr. Donahue's syndicated column
  - "Senior press service that screens for articles"

### **Broadcast media**

- Television
  - *Health segments on newscasts*
    - "Special health channel"
    - TLC
    - CNN
    - Discovery Channel
    - Talk Shows (one participant specified "Oprah")
    - Documentaries

- “Today Show”
- PBS
- “Good Morning America”
- “Noon health spot”
- Commercials
- “Diane Sawyer’s”
- University health channel broadcast from Mexico
- Sutter Health programs
- Radio
  - Formal health programs
    - Local hospital
    - Speakers at health fair
    - Senior center
    - “Women’s Health Center”
    - “Healthy Aging Program”
    - YMCA luncheon speaker
    - Senior College
    - Horizon 55 Program
    - HealthNet Insurance
    - Arthritis Association health seminars
    - 7th grade class on Health and Achievement
    - High school classes
    - Maine Municipal health seminars for employees
    - County Extension presentations
- Internet
  - *AOL Keyword “health”*
  - *Search under “health” or specific condition*
  - *Homepage health topic*
  - *Children use it for them*
- Non-medical people
  - *Family*
  - *Other elders*
  - *Friends*
  - Tai Chi group
  - Church’s Health and Temperance leader
  - Jane Brody
- Telephone information lines
  - *AARP*
  - Health insurance provider
- Other
  - *Listen to “my own body”*

- Computer in grocery store where one can look up health information
- Health food store
- Church
- Local health dept.

## Discussion

### Health Providers

With the exception of the three California groups (Asian American, African American, and Latino), “personal physicians” was the most frequent reply for source of health care information. Members of the Latino group responded that information sheets from their doctor were an important source. Members of the other two California groups, however, voiced feelings that their doctors did not spend enough time with them to answer questions. A member of the Asian American group stated that she had to pay for an additional 15 minute appointment if she wanted many questions answered. Personal physicians were not mentioned by any member of these two groups as a source of health information. One might speculate that the heavy presence of HMOs in the region may be a factor in this noticeable difference, but clearly regional differences in health care delivery seem to have influenced responses.

Other health care professionals were frequently cited sources of health information with pharmacists mentioned the most followed by nutritionists. The group of Native American women has a health clinic on their reservation, and the “health clinic” in general was a major source of information. Chiropractors were mentioned by participants in three different states. Although mentioned infrequently in other groups, nurses were second only to doctors in importance to members of the Kansas group.

Family members who were health professionals, most often nurses, were frequently mentioned.

### Publications

Health newsletters were seen as a major source of health information by all groups except the Chester, PA group. Someone in this group, however, referred to “things that come in the mail,” which could have been a reference to newsletters. Newsletters from a local hospital, natural food store, or care provider were mentioned, but by far the most frequently noted newsletters were national in scope. Various health newsletters published by Harvard (with the most common being the Women’s Health Letter) were the most often mentioned, and Dr. Andrew Weil’s Self Healing was the next most commonly stated. General newsletters with some health articles were only occasionally mentioned.

Magazines were frequently mentioned in all except the Latino and the Chester, PA groups. One member of the visually impaired group who still was able to read found magazines a useful source of health information. Prevention was widely read with the next most frequently mentioned being the AARP magazine. Most of the others were noted by name only once.

Pamphlets or printouts were a frequently mentioned source of health information with the exception of the group of visually impaired women. Participants most often received these from their doctors’ offices or health centers as well as from their pharmacists. Some were non-specific as to the source, saying only that they “came through the mail.”

With the exception of the Asian American group members and possibly the Chester, PA group (who listed “reading” without elaborating), all groups had some ardent book readers who obtained a lot of health information from this source. The Pill Book was mentioned most frequently followed by books published by Prevention. A number of people reported browsing in bookstores or libraries for books that interested them about health.

With the exception of the Wilton group, all groups in Maine, the Asian American, and the Latino groups identified the newspaper as a source of information. Many of the Maine groups mentioned the syndicated medical article by Dr. Donahue as the specific newspaper source.

### **Broadcast Media**

Television as a source of health information was identified by at least one person in every group. Specifically, health segments of regular newscasts were mentioned most often. Some participants referred to a “special health channel” though didn’t identify it beyond that. Talk shows were mentioned, with the Today Show being the only specific show identified more than once. A variety of other shows or stations were cited with the cable TLC channel being the one mentioned most. Many people identified “television” with no specifics, but given the number of participants referring to television commercials and infomercials in later questions, some of these persons may have been referring to commercials rather than specific shows. A member of the Latino group identified a university health channel broadcast from Mexico. Someone from the California African American group stated she got health information from Sutter Health (network of MD’s and non-profit hospitals serving 100+ northern California communities) television programs. These are obviously sources specific to the regions.

Radio was rarely mentioned as a source except, again not surprisingly, by members of the visually impaired group and also the Kansas group.

### **Internet**

Clearly, the internet is widely used by some women but not by the majority. This source was not mentioned at all in the Latino group or in the Chester, PA group but was the first source mentioned in the group of Native Americans. The groups in central and northern Maine (more rural in general) identified the internet as being more important than those in southern Maine and California. The visually impaired women in NYC did not make use of this source either except through family. Many women in other groups also had family members access the internet for them rather than doing it themselves. Rather than using specific sites, participants stated they searched, particularly using AOL keyword “health.”

### **Formal Health Programs**

Lectures or classes were an important source of information identified by all groups. Local hospitals and senior centers were the two most cited locations for such talks or seminars. The Native American group members seemed to exclusively attend programs at the health center on the reservation or those sponsored by it. Although members of the most rural group mentioned such talks and seminars more than participants in other groups, this source of information seems well utilized in general.



## Non-Medical Persons

Family seemed to be by far the most common source of medical information from non-medical individuals in participants' lives. Of those, daughters were most frequently identified. Members of the visually impaired group, not surprisingly, seemed, in particular, to use family and friends for information. A Tai Chi group as a source was identified only in the Asian American group. A woman in the Chester, PA group stated that she received information from the designated "health and temperance" leader at her church, and both "parish nurse" and "spiritual director" were identified in the Kansas group. A rural Maine member's Seventh Day Adventist church was a source of information. Although these religious sources were cited in only three groups, the groups were rural as well as urban and Caucasian as well as African American.

## Other

Toll free health information telephone lines were mentioned by a member in each of the Bangor, Maine groups.

## Summary

With the exception of the physician as a source of health information, there were no major differences in responses among the 13 focus groups with regard to this question. The group of members with visual impairments gave responses composed primarily of sources that didn't require reading, but they also relied on sighted people to give them information from visual sources. Although there were selected answers related to particular cultural resources, the responses across cultural groups in general were very similar.

## Question 2

### **"Where do you usually get the best and most reliable information?"**

Note: Items highlighted in italics are in order of frequency and represent two or more answers. All other answers were given only once.

### **Health Provider**

- MD (This was mentioned first in nine groups)
  - Personal physician
  - Dr. Andrew Weil
- *Pharmacist*
- *Nurse*
- Nutritionist

### **Internet**

- *Non-specific sites*
- WebMD
- Web TV
- Sites recommended by her MD, like "Harvard Health"

### **Publications**

- Books
  - written or recommended by MD or with medical school affiliation

- The Pill Book
- Books published by Prevention
- Medical reference books ordered by mail from Merck
- “Medical books”
- PDR (Physician’s Desk Reference)
  
- Magazines
  - Prevention
  - AARP magazine
  - Time
  - Newsweek
  - Medical journals like New England Journal of Medicine
  - Psychology Today
  
- Newspapers
  - New York Times
  
- National Health Newsletters
  - *Insurance company /HMO newsletter*
  - Hospital’s “Seniority” organization
  - Tufts Medical School
  - Harvard’s Women’s Health Letter
  - Mayo Clinic’s Checkup Newsletter
  - Dr. Andrew Weil’s Self Healing
  - Women’s health (non-specified)
  - “Through e-mail”
  
- Newsletter sources with health articles
  - Senior Center
  - College
  
- Pamphlets in MD’s office
  
- Various materials in library (particularly medical school library)

## **Family**

- Daughter
- Chiropractor nephew
- “Trusted family member”
- Brother
- Sister-in-law who is “avid reader”

## **Formal Health Programs**

- *Hospital health lectures*
- Senior College courses

- Senior center speakers
- University/college classes
- HMO seminars

### **Broadcast Media**

- Television
  - *Newscasts' health segments*
  - “Your Health” program
  - Dr. Dina Dell and Dr. Steiner
  - “Oprah”
  - Commercials (considered reliable if MD approves)
  - PBS
  - Health channels
- Radio (mentioned only by Lighthouse group members)

### **Other**

- Support groups for specific concerns
- Cooperative Extension
- “Anything that has Harvard attached to it”
- “Listen to my own body”
- “If something makes a lot of sense, no matter what the source is...”
- Gather information from lots of sources and then cross-reference to see what checks out
- Through trial and error, see what works

### **Discussion**

#### **Health Care Providers**

The first response to this question in 9 of the 13 groups was “doctors” or “my doctor.” In the Chester, PA group, the only response given to this question was “doctor.” Although doctors were given as a response in the California African American group, two members voiced trusting only female doctors. In the visually impaired (Lighthouse) group, Dr. Andrew Weil’s name was given in addition to the generic term “physician.” In the northern-most Maine group, doctors were not mentioned specifically in response to this question. However, “healthcare provider” was, and it can be speculated that physician was included in this response since doctors were mentioned positively in answer to the first question. Although physicians were discussed in positive terms in response to many other questions in one of the other Maine groups, there was no reference to them under “most reliable.”

It should be noted that even though overall among the 147 focus group participants “doctor” was given most often in response to this question, there were a number of negative feelings expressed towards these professionals. A member of the Latino group stated that her doctor should be who she gets the most information from, but he/she isn’t. She added that “you have to pay extra for more time with the doctor” if you want to ask many questions. A member of the Asian American group expressed similar feelings, saying “It should be the doctor, but we get more from magazines and the

paper.” She attributed this to the limited time doctors spend with their patients. This perception of time limited visits and paying for extra time with the doctor was not brought up in any of the other groups in response to this question. However, since it was brought up in response to the first question by someone in the only other California group, one would have to speculate that this may be a difference in health care delivery patterns in the San Francisco area. In the other groups, personal physicians were viewed anywhere from the absolute authority to, as one member put it, “Doctors aren’t geniuses or clairvoyants, but for the most part, they do their best.”

Pharmacists were mentioned as highly reliable sources of information about medication in six groups. In most of the other six groups, pharmacists were mentioned in response to the first question, and we would suggest that this resource was seen as a highly reliable one. Nurses were much more of an important source to members of the Kansas group than to any other. In general, these professionals were seen as having the time and interest to answer questions.

### **Internet**

The internet was identified in response to this question in almost half the groups. Those women who did offer it were generally non-specific about sites. One said she used America Online’s “WebMD.” The vast majority of participants did not use the internet, but those who did, seemed to see it as a reliable source of health information. There was some acknowledgement that only certain sites should be considered reliable, but there seemed to be limited understanding regarding this.

### **Publications**

Publications of various sorts seem to be considered a major source of reliable health information by members in most of the groups. Except for the Chester, PA group, which gave no answer except “MD’s,” the only group in which no publications were mentioned was the visually impaired (Lighthouse) group of women. Newsletters were frequently mentioned with those published by an insurance company or HMO being the most often noted. One woman, however, suggested these might be biased. These women in general seemed to read a lot and seek out written information about health topics.

### **Family**

Only five responses involved family members as reliable sources of information, and each of these answers referred to a specific person rather than family in general.

### **Formal Health Programs**

Lectures and seminars were mentioned frequently by the northern-most Maine group and the group of Asian Americans. While some others gave this as an answer, these two groups were striking in the frequency with which they took advantage especially of their local medical centers’ presentations. Availability and cost of these in different areas might presumably be a factor in use and importance.

### **Broadcast Media**

Various forms of mass media were not mentioned as often as in the previous question, but health segments on newscasts were frequently cited. A few specific shows were named by individuals, and one member said she found commercials helpful for giving her information about what to ask her doctor.

## Other

A variety of other answers were given once at one of the 13 groups with one woman stating “Anything with Harvard attached to it.” Another participant was open to all sources and said, “If something makes a lot of sense, no matter what the source is” she listens to it and then checks it out further. Another woman felt her own body was the most reliable source of information for her about her health.

Interestingly, members of the Native American group seemed to strongly feel that any information coming from their health care center, whatever the source, was reliable. The health center is on their reservation and free of charge to them. From their reports, the center sponsored a wide variety of programs, health fairs, and speakers.

## Summary

Although clearly physicians were mentioned most often in response to this question, there was a wide variety of answers. This would seem to imply that senior women consider many different sources of health care information to be reliable. In addition to physicians, the main sources involved various kinds of publications, pharmacists, nurses, lectures at health care facilities, and television newscasts. Although a small percentage of the participants used the internet, it was an important source of reliable information for those who did.

It should also be noted that in all the groups, participants generally seemed to answer the first question by giving sources about which they felt positive. It is therefore very likely that some of the responses to the first question not appearing in the above list are also considered reliable by these women.

## Question 3

**“Now that you’ve told me sources of good health information, I’d like to talk about sources you don’t trust. What are ways you’ve gotten health information that were NOT reliable?”**

Note: The responses are in order of frequency. Those in italics were given by four or more participants. Responses underlined represent answers cited from two to three times.

- *Ads, commercials, infomercials*
- *Some friends, family, neighbors*
- *Some newspaper articles, magazines and tabloids*
- *Anything published by drug companies*
- Any source but their doctor
- Some sites on the internet
- Herbal medicines, “natural healing books,” and homeopathic cures
- MD - on occasion
- Gossip, word of mouth
- Television shows with conflicting opinions
- Television show “ER”

- Junk mail
- “Ignore most everything”
- “Some professional people”
- “Need to check it out yourself” to see if it’s right or wrong
- “Disagreement among MDs”
- Chiropractors
- “Just because someone else does it.”

## Discussion

In general, members had more difficulty identifying unreliable sources than reliable ones. By far, the most frequently mentioned source involved advertisements. These included regular television ads as well as longer infomercials and printed advertising. These were identified in every group but the Chester, PA one. One woman stated, “The more they advertise, the less I want it.” One participant, however, did acknowledge that she might think the ad was reliable if she knew someone who had been helped by the product being advertised. Wonder diets plugged on television were specifically noted as not to be believed.

The next most frequently mentioned source of unreliable information consisted of friends, family members and neighbors. On one occasion, this included a family member who was a health care professional. Publications including newspaper articles, magazines and tabloids were cited often as well.

Throughout the focus groups, drug companies were frequently mentioned as sources of health care information. Almost always, they were seen as totally motivated by profit and viewed disparagingly. In answer to this question, there were a number of responses such as “anything published by a drug company.” Pamphlets were viewed as unreliable if published by a pharmaceutical company, for example. One woman even questioned her doctor’s ability to impartially prescribe medications because she had “sat in the waiting room and watched all those presents the drug representatives bring in.”

Three members expressed the belief that no source but their doctor was totally reliable. On the other hand, two members of the Chester group stated doubts about their physicians’ reliability. One felt he didn’t know that much about sample medicines given out, and the another woman said she questioned her doctor at times. This seems surprising since this same group had no responses other than “physician” to the “most reliable” question. A member of the Lighthouse group commented that conflicting opinions among doctors was troubling for her and made her not know what was reliable. This seemed to be true particularly in the case of hormone replacement therapy. Two Kansas participants mentioned times their doctors had given them incorrect information.

Though not able to give specifics, three members felt there were sites on the internet that couldn’t be trusted as reliable. In general, however, this did not seem to be a concern among those that used it.

Although some members expressed positive feelings about herbal medicine in response to other questions, two women thought “natural healing books” and homeopathic medicine cures were not always reliable.

Television shows with conflicting opinions and specifically the show “ER” were mentioned on two occasions.

Finally, one woman felt that ultimately, “you need to check it out yourself” to see if information is right or wrong, and another stated, “I ignore most everything.” Another responded that despite the source, “If it sounds too good to be true, it probably is.”

### Summary

In general, members seemed to find this to be a difficult question to answer. There is no clear explanation for this, though one could speculate. Interestingly, a member of the Kansas group asked why we were asking this question and stated, “I never thought I shouldn’t trust information I hear.” Regardless, the responses would indicate that a message delivered by a person or company that stands to make money from a particular health care choice is not viewed as impartial and, therefore, the message isn’t assumed to be reliable. In addition, not all participants considered information reliable simply because it came from a health care professional.

Clearly, there are some sources that would not be effective to use for disseminating information to this population.

### Question 4

**“Sometimes we get health information, but we don’t change our habits or behaviors. Other times, receiving health information causes us to change in some way...we decide to seek medical care or take medications...we may change our habits to stay healthier...or we may change our behavior in other ways. Have any of you ever done something different as a result of getting health information?”**

Note: Responses are listed in descending frequency.

- Health professional gave information and advised changing behavior
- Self-imposed (to get off high blood pressure meds; healthy lifestyle whole life; stopped running after deciding it wasn’t good for her at her age; after deciding she had problem described on TV, asked her MD)
- Media reports scared participants and resulted in their changing behavior (stopping hormone replacement, stopping smoking)
- Advice from family/friends (eating more healthily, friend who is a “health freak,” relative encouraged cure-all bitter melon, smoking buddy stopped and wouldn’t allow smoking in her house.)
- Changed behavior after seeing ad on TV or in magazine (wonder drug ad, self-diagnosed after seeing ad about particular health problem, looks for ads for medicine to help particular problem and then orders it)
- Changed behavior to feel better (decrease pain, breathe better)
- Changed behavior after personal or family member’s health scare (broken bones, heart attack, husband’s stroke, gall bladder surgery)
- Attended lecture or class which made her want to change because of speaker or content

- Read information in book or magazine which made sense (garlic pills as cure-all)
- Influenced by family member or friend indirectly (senile mother's comment that daughter would be just like her; had knee replacement after friend's worked; health information following husband's stroke; stopped smoking when daughter developed asthma)
- Buddy system with friend for support to change (walking partner, weight loss)
- Other influences (beautician recommended vitamin for thicker hair)

### **Discussion**

Group members readily talked about their own experiences with health problems and what they did about them. For the most part, the responses provided more information about questions asked at other points in the focus group. Sources of health information mentioned included broadcast media, health professionals, lectures, and written sources such as books or magazines. One woman described attending a talk given by a female about hormone replacement therapy. The participant related deciding to take hormones strictly because the speaker was a woman and therefore "should know about the topic." Family and friends were mentioned as sources of information as well.

One woman reported getting information about hair loss treatment from her beautician, and this was a source of information not previously mentioned in response to other questions.

A number of participants talked of making changes in their health practices on their own or taking the initiative to check with their doctor about something they had heard or read about.

The importance of having someone to make a healthy lifestyle change with you was mentioned in various ways during some of the focus groups. It came up in three groups around this question in terms of such things as exercising, weight loss, and smoking cessation. Members in general seem to think a "buddy system" would be an important component of any prevention program. One woman reported walking daily until her walking companion stopped. It was also felt that this would be helpful in getting more isolated seniors to stick with a health improvement or prevention program.

Interestingly, the members of the Asian American group focused a lot on what foods were supposedly good for their health, in what order foods should be eaten, etc. The facilitator frequently attempted to refocus the discussion back to the question, but the group would revert to talking about foods. In the Latino group, the discussion focused primarily on nutritional issues as well. Changing eating habits as a way of becoming healthier seemed to have cultural implications to this group. One member stated, "In my country, we eat things that are very fatty." If one speculates that the focus on food in the Asian American group also related to cultural factors, these would be significant observations to keep in mind when planning an awareness and prevention program for this population.

### **Summary**

The primary influences leading to change for these women seem to be the advice of professionals, their self-initiative, the media, and family and/or friends.

It was clear in all groups that these women welcomed a chance to talk about health conditions and were interested in hearing each other's experiences. Important to note is the relative lack of differences in answers among the thirteen groups.



### **Question 5**

**“Now let’s talk specifically about osteoporosis. If any of you have done anything to reduce your risk or the impact of osteoporosis on you, I’d like to hear what you did and what motivated you to do this.”**

Note: Responses are listed in descending order of frequency.

- Following recommendation of physician for prevention or treatment
- Had bone density tests at their own request or doctor’s suggestion; seeing changes in bones made them want to follow treatment suggestions
- Taking calcium supplement (sometimes at doctor’s recommendation, some just heard it was good to do from other sources)
- Exercise regularly (most seem to have started it because they’d heard from a variety of places that it was good for bone health and health in general)
- Started to do more to prevent osteoporosis after breaking bones
- Trying to have good nutrition (general sense, not from one source)
- Mothers told them that milk and calcium were important for strong bones and have followed this advice since childhood
- Taking hormone replacement therapy
- Attended clinic/hospital/health fair osteoporosis screening
- Listens to own body
- Had chiropractic adjustments to strengthen bones
- Received information from daughter regarding “herbology” instead of hormones
- Didn’t think osteoporosis could affect her since it didn’t run in her family

### **Discussion**

Women attending the focus groups seemed, to a large extent, to already be fairly knowledgeable about osteoporosis and were taking part in at least minimal preventative behavior or, in the case of those already diagnosed with osteoporosis or osteopenia, measures to treat the disease. They also appeared eager to talk about the disease and what they knew about it. In addition, some had many questions about the condition. It should be noted that members mentioned osteoporosis and their preventative or treatment behavior frequently during the course of the focus groups in answer to other questions. The responses discussed here were given in answer to this specific question only.

Most participants reported taking some preventative measures or treatment at their doctors’ recommendations. Women in every group reported taking calcium supplements, though many were not specific about who told them to do so. In every group except the California African American group, some women had had bone density tests prescribed by their doctors. At least two women in the California African American group reported being told by their doctor that they did not need testing because their race put them at low risk. Interestingly, no one in the other African American group in Chester, PA reported hearing this from her doctor. In fact, two said they had undergone bone density tests and others reported doing things to prevent osteoporosis. Again, one could speculate that the heavy HMO presence in the San Francisco area is a factor in this difference. Low risk women may not be offered the same tests as those at higher risk.

In each group, at least one member mentioned starting preventative/therapeutic measures after breaking a bone or having changes reported on a bone density test. Although a number of women reported knowing calcium and exercise were important for strong bones, the motivation to follow recommendations in this area most often came from a change in health or test result.

Exercise was frequently mentioned by women. Participants in seven of the groups talked about exercise in answer to this question, but it was mentioned at some point in all the groups as an important part of prevention. Forms of exercise varied from walking to exercise clubs to weight lifting. A member of the Latino group reported dancing an hour a day to Latin music as her exercise.

Two women mentioned nutrition in general as important in the prevention of osteoporosis, but otherwise it was mentioned in terms of eating foods high in calcium.

Since the groups were run within six months of the latest report questioning the safety of hormone replacement therapy, not surprisingly this topic was raised throughout, particularly by the Maine focus groups. In response to this last question, however, only four women raised the topic of hormone replacement. One of those had taken herself off hormones in favor of soy products, and another did not follow her physician's recommendation to take hormones in the first place because she felt "if my body stopped producing them, then it was meant to be."

Members in the group composed of Franco American women offered suggestions for obstacles to getting senior women in general to follow through with osteoporosis prevention and treatment. Those were as follows: cost of testing and medicines to treat, side effects of some treatments, person being "too set in her ways" to change, and lack of transportation. Someone also suggested that the fear of learning they have the disease might keep some women from getting a bone density test.

## **Summary**

Although the responses to this question focused primarily on what women were doing to prevent or treat osteoporosis rather than where they got the information and what made them follow through with the recommendations, it seems clear there is a strong interest among these senior women in learning more about the disease and in doing what they can to prevent it or keep it from getting worse. Most of them had heard something about osteoporosis, and the source was generally their doctor in one way or another. Although the sophistication level of the participants varied among the groups and among members within each group, at least some participants in each were doing things to prevent or control the disease.

## **Motivation**

While motivation was not explored by way of a separate question, probes were used to get at this issue within the fourth and fifth questions. The following is a list of the factors identified by participants in descending order of frequency.

- Fear
- To be healthier and feel better in general
- To keep from being diagnosed with a family member or friend's condition (family history putting at risk)

- Family and desire to live longer for their sake (not be a burden; be able to care for family members)
- To prevent health problems
- Always conscious of maintaining good health/have to want to help yourself
- To keep from getting worse
- Relieve suffering and lessen pain
- “Being older makes health problems more real”
- Peer or family pressure
- Not wanting to look like someone they’d seen
- To support spouse’s health care efforts (changing diet or stopping smoking)
- Simplicity and cost of recommended treatment
- Vanity (to look better)
- Respected health care professional’s advice
- Seeing good result when neighbor had treatment
- “Joy of moving”
- Visual reminder of negative effects of not changing
- To be more flexible
- To get off medicine for identified problem
- Needs to see results to keep following health prevention behaviors
- “If it’s not broken, don’t fix it.”
- “Concern, not fear”
- “Don’t have any choice”
- “I’m pretty lazy. It would have to be pretty scary to make me change.”
- “Knowing that I would have done everything I could have to prevent it if I did get something.”
- Saving money
- “Respect for my own person and body.”

### **Discussion**

It is very clear that fear is the most important motivating factor in why these women act on the health information they receive. In every group but Kansas, the words “fear” or “scared” were used frequently. There was disagreement, however, about fear being used to motivate women into acting on health information. While many felt it was the only way to make an impression on people who weren’t already following prevention behavior, others disagreed. One group member who spent a lot of time serving isolated seniors who are primarily housebound voiced her feeling that these people are “already scared” enough about life. There is likely a degree to which fear can serve as a motivating force, but fear in excess of a threshold level may well discourage, rather than encourage, positive action.

Closely behind fear as a motivating factor was the desire to be healthier and feel better in general. A few stated a similar motive of not wanting a health condition they already had to get worse. These factors seemed to relate to improving the quality of one’s life.

Family seems to play a major role in motivating many of the members of the various groups, and this was the most frequently mentioned motivator in the Kansas group. The general desire to live longer for their families' sakes was stated frequently as a motivating factor. Other specific factors involved not wanting to be a burden to their families or, in one case, wanting to be healthy to take care of an ailing parent. Pressure to follow health care recommendations from family was noted as the desire to avoid ending up in a family member's debilitated condition. In addition, a number of women identified their motivation coming from the desire to support a spouse's health care plan by following the plan themselves.

Prevention was identified a number of times as a motivating factor, though this could be related to most of the above as well.

A number of women described a lifelong consciousness of maintaining a healthy lifestyle and felt this was their primary motivation still. As one woman stated, "I take full responsibility for my own health." Several women stated strongly that one has to want to help oneself or nothing will be motivating.

It was a common feeling that being a senior has increased motivation to care for one's health. "Being older makes health problems more real," as one member stated. Another said, "When you're younger, you never thought about worrying about... [your] weight or how [you] feel or anything like that. [You] just slept it off."

When asked directly, many women felt seeing someone who was suffering the effects of a disease, whether known to them or not, was a strong motivating factor. In the case of osteoporosis, they also thought being shown x-rays of healthy and diseased bones would be a helpful motivational tool.

Simplicity of the proposed behavior change and cost did seem to be a factor in motivating a few women. Several other women suggested cost needed to be a consideration in developing a program to reach as many women as possible.

Although health care professionals are a major source of health information for these women, only a couple of women identified the advice alone from the professional as being the motivating factor for change.

The remainder of the items were mentioned only once by a participant. One woman was particularly frank, saying "I'm pretty lazy. It would have to be pretty scary to make me change."

## **Summary**

Clearly, there are many different reasons senior women follow health care advice, but fear was most important to these groups. How to use this to motivate and not chase away is the challenge. It is also apparent that the influence of family in one way or another is key for many women. For this age group of women, concern about their health is prevalent and thus seems to make them eager for information by virtue of that alone. They are interested in preventing problems and resolving current health care concerns.

## Chapter II

### Expert Interview Report

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In this phase of the project, interviews were conducted with experts representing a variety of programs and organizations to obtain information to help further guide a national campaign (refer to Appendix D for list of experts). In order to determine what components of existing osteoporosis education programs and campaigns have been successful to date, professionals involved with such initiatives were identified, and telephone interviews were subsequently conducted. This was accomplished in a variety of ways. Clifford Rosen MD, Co-Principal Investigator of the project, made recommendations of osteoporosis health care professionals currently operating successful programs around the country. Other resources were identified via internet search, the Surgeon General’s Workshop on Osteoporosis and Bone Health Report Draft, and National Osteoporosis Foundation (NOF) literature review references. In addition, interviewees referred research project staff to other programs and professionals. Contacts were made through the March, 2003 FORE Osteoporosis Summit, and Blue Ribbon Panel experts were asked for referrals as well. An attempt was made to realize geographic and racial diversity as well as program or campaign variety. No compensation was made to interviewees. Interviewees varied from directors of current or past state osteoporosis campaigns to professionals from osteoporosis centers, to those responsible for exercise or balance programs for elders. These represented large and small programs.

Through the use of the internet, referrals from other professionals, the Surgeon General’s Report, and NOF literature search, professionals were identified in fields representative of multicultural health and women’s issues. These interviews elicited recommendations for key issues to keep in mind when developing the campaign in order to reach women from minority cultures. These interviewees were involved with programs that educated people on multicultural health issues, provided services to ethnic-specific elders, or represented state offices charged with dealing with women’s issues.

From December, 2002 until May, 2003, a total of 16 telephone and 3 in-person interviews were conducted by the project director. Two categories of interview questions were asked depending upon the interviewee’s professional expertise. One set was geared to those individuals involved with existing campaigns or educational programs and the other for experts in specific related fields, as delineated above. Interviews lasted 10-45 minutes and were generally scheduled in advance.

The interviews provided a wealth of information, much of which has been incorporated into our final recommendations. Some of the experts’ responses to specific questions follow. Answers to the questionnaire for those not involved with existing programs or campaigns have been incorporated into the appropriate questions response categories below.

#### **Question 1**

**Where do you think this population gets their health information primarily?  
Are there differences among ethnic/socioeconomic groups?**

Most experts were in agreement that health care providers are the major source of this information. Parish nurses and nurse practitioners are particularly important in rural areas. Higher socioeconomic groups seem to get information more from family, the internet or reading as compared to relying on health professionals.

Printed material and television are a major source as well for most women, although some ethnic groups value written material less than others. In rural areas, particularly in the Midwest, radio plays an important role.

Although nutritionists were identified frequently as important sources of information by members of our focus group, expert interviewees felt most women do not have free access to nutritionists. The exceptions would be those women with diabetes and women who receive care at multidisciplinary health clinics.

The importance of the internet is debatable with use clearly varying among different subgroups of women. The two experts working with Native Americans in the Midwest and West find internet use to be very low. In general, the younger older women tend to use it more than the older. Spanish speaking newspapers and television are important sources for Latino women as is Spanish speaking radio.

## **Question 2**

### **What do you think they find most reliable? Differences among different groups?**

There was agreement that physicians and nurse practitioners are viewed as most reliable.

## **Question 3**

### **What sources do they not consider reliable? Again, differences among groups?**

Consensus was that elder women don't question the reliability of information enough. Higher level of education does seem to be associated with more questioning of reliability.

## **Question 4**

### **What types of messages do you think work to get women's attention?**

Experts emphasize the importance of personalizing the messages for particular groups. It is critical that one be responsive to a woman's current lifestyle and concentrate on wellness and health at the same time that the consequences of the disease are made known. All agreed that scare tactics do not work. Rather, programs should emphasize that osteoporosis is a preventable and treatable disease. Women should be told what they can do about it. The volume of information needs to be small, and simple non-technical language should be used. Keep messages concrete and to the point. The cost on a national basis of the disease and similar such statistics are not of interest to the average individual. It is important to let older women know that Medicare covers screening, but it is unethical to recommend procedures or treatment they cannot afford. Any goals that are endorsed must be attainable.

## **Question 5**

### **Suggestions for reaching specific segments (e.g., low income, inner city, ethnic or racial minority)?**

In general, messages must be culturally appropriate for each group.

Latinos: Translate materials into Spanish. Most first generation Latino elders do not speak English. It is important to remember that this group has strong mistrust of the health care system. Familiarity is important in the way the message is conveyed. Make women feel it is relevant to their lives. The materials must address osteoporosis within the context of their personal lifestyle. These women are family-focused. The role of mother is very important but women tend to think of their family before their own health. Have the message speak to the benefits for family of what you're recommending. Keep messages simple and focus on the positives. Repeat these throughout campaign. Have messages centered around human interactions. Different communities may need different messages. For brochures, most women have a preference for colorful, illustrated materials with catchy titles. Humor is appreciated.

Native Americans: Written messages will not be as effective with many Native women. Information needs to be basic and has to relate to the particular Native community. Let these women know they ARE important. It is crucial to work through leaders in the community and let them adapt messages for their people. Do not "tell" community leaders or residents what to do. Obviously, there's an historic mistrust of the U.S. government in such communities. Keep in mind that, in general, there is a lack of orientation toward prevention. Use messages that evoke the integrity of the generations. Let these women know that what you're recommending will help them maintain a presence longer within the family. Messages should be hopeful. Consider using humor.

African Americans: Because they are not in the high risk category, these women generally do not believe osteoporosis will affect them. It is important to emphasize that they do need to be concerned. It was recommended that since many of the underserved women in this group don't have resources to support them, it is important to emphasize how recommendations will enable them to remain independent. Convey that getting older and ill do not have to go hand in hand. Use inter-generational images in your materials, and send messages that are positive. Keep messages simple, positive, and concrete.

Asian Americans/ Pacific Islanders: These women need general information on what osteoporosis is and why they should care. Use visuals to convey your message. Keep in mind that prevention is not necessarily part of their thinking, especially among first generation elders. Messages might be more effective if they focus on family benefits. Materials must be translated into each community's language. Emphasize that fall prevention through Tai Chi is a sign of strength.

Low Income: Since this population has many other priorities, consider piggybacking the message onto something else. Make messages simple and direct and give reasons why these women should bother with recommendations given their concern over getting basic needs met. Consider giving low income older women something as part of the message in order to get their attention. Make sure your recommendations are affordable. HUD can be a helpful partner to get messages spread for this group.

### **Question 6**

**What does your program do for marketing? Are there informal networks you've found particularly effective?**

All experts agreed that to reach specific segments, it is vital to find people in the individual communities with whom to work. Have them guide the marketing campaign for that community. Relationship building is key in general. Public service announcements (PSA's) are effective as is having literature and screening services at health fairs. In addition, materials should be provided in those establishments that women commonly frequent such as laundromats, hair salons, and senior centers. A toll free information line has been well used by one program. Involve churches in marketing. Partner with organizations such as women's groups, AAA's, and health professional organizations to get the message across.

### **Question 7**

**In your experience, what brings people to your program? Which groups have been the most difficult to get engaged? Why do you think this is?**

Food is important part of coming together, especially in some cultures. People need to get their needs met. When planning a campaign, listen carefully to what they say they need. Free screening locally attracts large numbers of women. Whenever possible, tie your program into a cultural festival or health fair which women are already attending. People definitely like to be given gifts and other incentive items like magnets, pens, or key chains.

Poor women and members of specific ethnic groups have been the most difficult to engage. Programs have generally failed to make their campaigns relevant to poor women's lives and have not made programmatic services accessible enough. Too often, programs are taken to ethnic communities and implemented by strangers rather than having members of a particular community involved in the development and implementation process. Do not assume you know how to best mount a campaign in individual communities.

### **Question 8**

**In your experience, what seems to be the most frequent motivation for women following through with your program?**

All interviewees agreed that fear and family are the two greatest motivators for this population of women. When women start experiencing one health concern, they begin to think more about other health issues in general.

### **Question 9**

**What sorts of educational outreach programs do you have and what ideas do you have for some that would be helpful if you had the funding?**

There was a general sense that having a mobile full bone density testing machine available to take to local communities would be ideal. Many professionals are already taking heel units to health fairs, onto reservations, etc.

Exercise classes taught by and for seniors have been very successful. Participants progress using increasingly heavy weights as able. Classes are free and provide important opportunities for socializa-



tion. One program sponsored a fashion show that featured fashions designed to mask the effects of osteoporosis and handbags that were easy on bones. Another program distributed eye-catching cards with simple messages placed on Meals on Wheels trays. Free monthly bone health seminars provided in local communities, senior centers, and elsewhere have been well-attended.

In addition to doing screening, interviewees frequently use health fairs as a venue for teaching about calcium rich foods and giving “one minute risk tests” to interested women. Another campaign provided supermarket tours to point out high calcium foods.

One state campaign organized a celebrity appearance to promote bone health during a state house osteoporosis week celebration.

**Question 10**

**How does your patient support component work? Do you have thoughts on how else to utilize a buddy system approach to reach elder women?**

Osteoporosis education and support groups have been very successful at a number of programs. They seem to focus on both the support and education. In one program, a Buddy-to-Buddy system encourages women to pick a friend to encourage to get tested. Another center had a “telebone” program that was similar but involved more information giving by lay women. This was felt to be less successful.

Many interviewees felt using elder volunteers in a campaign to help reach other women could be very effective.

**Question 11**

**What components of your program have you tried and found not to work in educating and motivating women to change their behavior? Why do you think these weren’t effective?**

There were very few responses to this question. One interviewee cautioned against taking standard workshops into ethnic communities rather than first finding out from community members what they need. Another professional cautioned about the importance of adapting nutritional messages for individual groups. Considerations include the availability of fresh produce, how prevalent lactose intolerance is among some ethnic groups, and whether the target group cooks for themselves. Nutritional messages must be culturally sensitive. In the Massachusetts state campaign, messages are posted in subways and busses, but the director questions whether this was an effective place to do so.

In general, those involved with existing programs that made specific attempts to reach women from other cultures felt their attempts were minimally successful.

**Question 12**

**What have been the most successful parts of your program? Why do you think these have worked so well?**

As stated above, exercise programs by and for seniors have been very effective. Groups provide socialization as well as bone benefit. These are different from other exercise programs because they focus on exercises that increase bone density and because they are taught by a peer rather than a younger span-dex-dressed woman.

A program in Florida was very successful reaching middle class women by partnering with state women's clubs to get invited to local groups where osteoporosis education was then provided. The goal was to get women to ask their doctors for bone density screening, and the number doing this rose dramatically as a result.

It was emphasized that long term campaigns are effective only if they are regularly evaluated and refocused or revised.

### **Question 13**

**What are the most important issues you feel should be kept in mind when we formulate the final awareness campaign?**

The following verbatim responses are illustrative:

“It is much easier to change the environment than the individual.”

“When it comes to health prevention, not everyone believes it.”

“Many women do not realize the impact of menopause on bone health.”

“Organize an advisory committee to help guide the campaign. Include representatives from a wide variety of sectors.”

“Work with large health care organizations and include them in the campaign.”

“Remember that churches are the primary social contact for many women in this age group. Use them as a way to get the message across. Meal sites are another important venue.”

“Consider partnering with the Medicare Education and Advocacy Programs in each state.”

“Women need to keep bumping into the word osteoporosis in many different contexts.”

“Any national campaign needs to focus on educating health professionals about recommendations for osteoporosis screening as well as educating women to ask their health care provider for testing. Both are vital.”

### **Summary**

The interviews confirmed much of the information gathered during our first round of focus groups concerning where and how elder women get health information. Clearly, health care professionals and various media venues are the most important source outside family. The interviewees' strong recommendation to keep messages simple and to the point while adapting slightly for different subgroups is a message reiterated by many participants in our second round of focus groups.

Although educational information and programs are plentiful, it is clear there are a significant number of elder women who have not had access to this for whatever reasons. To reach these women, our interviewees made a strong recommendation to take the message to them in their communities. This might be through mobile screening machines, exercise classes held in housing projects or senior centers, or calcium education in grocery stores. Interviewees provided many creative ideas to accomplish this goal.

The importance of using a wide variety of venues and channels for communicating our message is evident from the interviews, and a vast array of possibilities exists. Making use of elder women to help reach their peers emerged as an inexpensive and potentially highly effective model. Since far too few health care professionals understand the importance of bone density screening for this age group, targeting this group for education must be a part of an effective campaign as well. Potential national organizations were identified. Partnering with existing social service and ethnic networks will help to reach diverse groups of women.

Interviewees' experiences, both effective and ineffective, reaching underserved populations provided a wealth of information to improve chances for an ultimately successful campaign. Clearly, it is imperative that individual communities guide the campaigns for their particular groups.

Universally, these professionals welcomed the prospect of a national osteoporosis education and prevention campaign for postmenopausal women. They are eager to be involved and to be kept up to date on the progress. There is much to be learned from existing programs and campaigns as we move forward.



## Chapter III

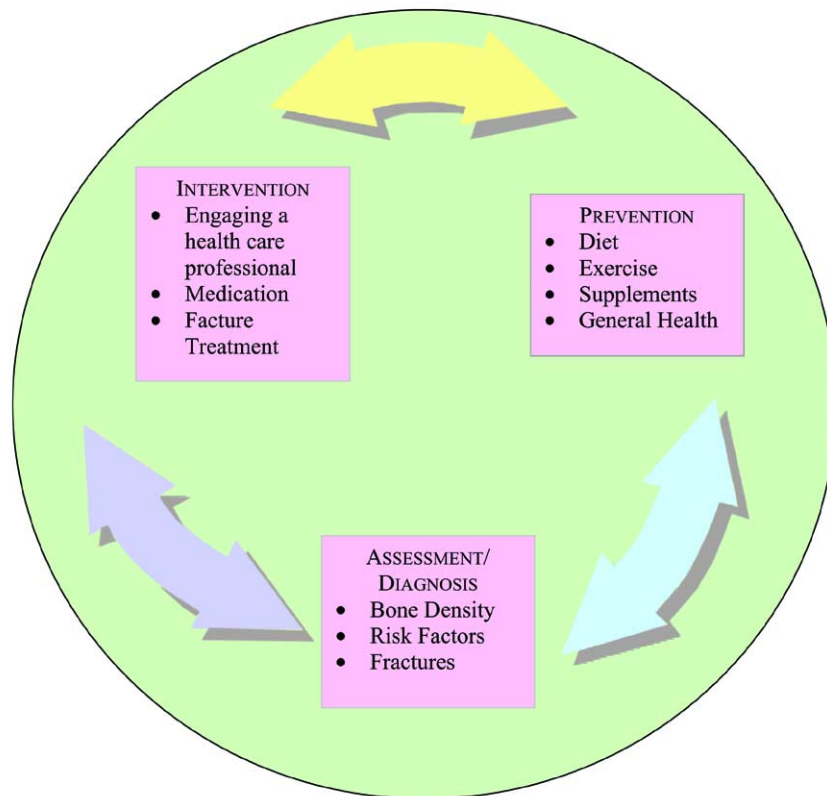
### Theoretical Marketing Foundations

During the summer and fall of 2003, project staff consulted with marketing consultants, both on a local and national level, to develop theoretical foundations for the osteoporosis campaign. There are many initiatives already in place experiencing varied success. The key goal in this campaign is to move women beyond awareness and knowledge into action. With this in mind, the following framework provides a foundation for meeting this goal.

#### OVERVIEW OF THE CAMPAIGN’S OBJECTIVES

This is a model of three stages in the consumer’s approach to osteoporosis. A consumer could cycle through this model in either direction – for example, starting with prevention measures and moving to diagnostic procedures, or undergoing diagnosis and then undertaking preventative and maintenance activities. In general, intervention in the case where there is a fracture, or in other cases where the consumer gets into the cycle at the direction of a health care professional due to an “incident” are considered short-term critical incidents outside the purview of this project.

**Chart III-1: Stages in Consumer Approaches to Osteoporosis**



## Objectives

Our main objective is to encourage consumers over 60 years of age to enter the cycle at the Assessment stage, and specifically to get a bone density scan. Our secondary objective is to encourage consumers to incorporate prevention measures into their daily routines. The three primary actions we want consumers to take are:

1. Bone density scanning
2. Dietary changes
3. Weight-bearing exercise

## UNDERSTANDING OUR CONSUMER GROUPS

Consumer characteristics and needs were analyzed in two ways. Basic cohort analysis, which examines the characteristics of distinct generational groups linked by common outlook and values was undertaken using published sources such as Meredith, Schewe, and Karlovich's *Defining Markets, Defining Moments* (2002). This analysis added to the information generated by the Phase I focus groups with consumers.

### Cohort Information<sup>1</sup>

The following information on cohort characteristics emphasizes, to a great degree, the commonalities among the three primary target markets for this plan. This approach is taken with the intention of managing costs as much as possible through the use of consistent messages and programs that will tap the widest possible audience, while still remaining sensitive to variations in age, ethnic, racial, and socioeconomic groups. In essence, it allows the creation of a larger target market for the purposes of disseminating the key messages regarding osteoporosis.

#### The Postwar Cohort –Our Primary Target Market

Born Between	1928-1945
Age in 2003	58-75
Population	47 million, 21%

This group came of age right after World War II. They defined the suburban lifestyle, moving out of the cities in droves. They are believers – in family, the American Dream, and conformity. Their key concerns are enjoying life, family, and fitting in. As grandparents, this group wants to be less authoritarian and desires a “fun seeking” role with their grandchildren. They are very much into an active lifestyle, and like most groups who have reached or are soon to reach retirement, they generally are seeking activities to fill rather than to save time.

Health attitudes focus on feeling good rather than looking good, and they are interested in health activities designed to extend their longevity. Values important to this cohort include conformity and institutional stability. Members of this group are active grandparents, and even those who are retired may be caregivers for their own parents, for children or grandchildren, and others. A number of them also pursue part-time employment. This group should be depicted having fun and living life to the fullest.

<sup>1</sup> From Meredith, Schewe and Karlovich (2002) *Defining Markets, Defining Moments*

### **The World War II Cohort – Our Secondary Target Market**

Born Between	1922-1927
Age in 2003	76-81
Population	17 million, 8%

This group came of age during World War II and they fought “the good fight.” Indeed, a slogan such as “Food Is a Weapon” might appeal to this group, since that was a theme used to promote rationing and gardening during the war. This group is heavy on nostalgia and patriotism. Their key values include self-reliance and respect for authority, and they exhibit a “can do” attitude reminiscent of the “Rosie the Riveter” campaign. Maintaining independence and self-reliance is important for this group.

This cohort is very group oriented, as they found great meaning in pulling together to win the war. They also enjoy interacting with younger people, and dislike being portrayed as old, infirm, and isolated. Along with their gritty determination, they have a strong sense of romance that can be tapped using nostalgic themes.

### **The Depression Cohort – Our Tertiary Target Market**

Born Between	1912-1921
Age in 2003	82-91
Population	13 million, 6%

The members of this cohort came of age during the Great Depression and they carry a sense of anxiety and risk aversion with them to this day. They are used to being self-sufficient, often in very hard times, and themes that stress not being a burden to loved ones resonate well with this group. They are very practical and down-to-earth and enjoy the simple pleasures of family, friends, and community. Social connection and companionship are important to this group that also had to pull together to make it through tough times, albeit different times than the WWII cohort.

Hard work, safety, and security are important for this group. They want to maintain as much independence and activity as possible for as long as possible. Activity should include as much time with family and friends as possible, and grandchildren are very important social connections for this group. Like the other post-retirement cohorts, this group is looking for ways to fill time rather than save it. Their health orientation also revolves around feeling good rather than looking good. Like the Postwar Cohort, this group tends to be joiners.

Chart III-2 presents a comparative summary of the key characteristics of these three groups.

**Chart III-2 Key Cohort Characteristics – Commonalities and Differences**

Cohort	Family	American Dream/ Conformity/Patriotism	Enjoying Life/Fun/Active Lifestyle	Joining Groups/Social Connection	Responsibility/ Gritness/Self- Reliance/Independence	Institutional Stability/Respect for Authority	Romance	Nostalgia	Anxiety/Risk Aversion/Security	Practical/Simple Pleasures	Extending Longevity	Feeling Good
Postwar	✓	✓	✓			✓		✓			✓	✓
WWII	✓	✓		✓	✓	✓	✓	✓				
Depression	✓			✓	✓			✓	✓	✓		✓

Note that family is important to all three groups. Nostalgia also works, but the three tend to be nostalgic for slightly different cultural icons, so this is a difficult hook to utilize in this case. Themes that work for at least two of the three groups include:

- Patriotic/American Dream/Fitting In, Joining Groups/Social Connection
- Responsibility/Independence/Self-Reliance, Trust in Institutions/Authority, and
- Feeling Good Rather Than Looking Good.

There are many possibilities for incorporating cohort values into marketing materials. One might use, for example, a faded picture of a scene from years ago as the background for a campaign message. The concept of turning back time is appropriate to osteoporosis and the message to build up the lost bone density. With family important to all cohorts, the value of targeting some messages to adult children is significant. Children can be an effective impetus for women getting tested and changing behavior.

**Ethnic Market Analysis**

Schewe and Meredith’s work focuses on age cohorts without regard to ethnic and racial diversity and thus represents the majority viewpoint. Of course, the experiences of women from diverse groups will not necessarily be those of Caucasian, middle class women. For those women who came of age in the United States, defining moments vary from culture to culture. A significant number of women immigrated to this country after young adulthood, and defining moments for them differ from women with the same ethnicity who came of age in the United States.

The cohort model, while representing the majority viewpoint, is an attempt to define the market we have targeted at a level that may have more likelihood of motivating women to change. Some of the values identified, such as family, social connection, and nostalgia, have frequently been identified as important to elder women from most ethnic groups.



Some other themes that emerged during the Phase I Focus Groups as well as statements made by experts from organizations advocating for minority groups are summarized in the following sections. These characteristics and needs may help guide marketing and implementation for each group referenced. It is important to remember, however, that there is always some degree of danger in generalizing about specific groups of people. The following observations represent viewpoints of the consumers participating in our focus groups and those experts interviewed during Phase II of this project.

Latinos: Latinos generally share a strong family orientation that fits in well with each of the age cohorts already described. However, the way to tap into this concern may vary, with some Latinos, for example, best reached through husbands or brothers who may still make many of the decisions within the family. Themes of caring for the family or being around the family for as long as possible should resonate with this group, though. The role of the mother is very important and should be recognized in communications.

There are some characteristics of messages that must be adapted for Latino consumers and, of course, one of them is language. Spanish-language communications must be considered, and these must not be merely translated but must be sensitive to the cultural nuances of the group being targeted (Cuban versus Mexican, for example). Food is usually very important in Latino culture, and given the issues of diet related to osteoporosis, food issues must be addressed in a culturally-sensitive manner.

In addition, there are variations among Latino groups, such as Mexican Americans in general being less likely than Cubans or Puerto Ricans to seek medical care. Immigration status can be an issue, especially among groups who are later immigrants to the US, and fears of jeopardizing immigration status because of having a disease must be taken into account.

Some other factors that may impact the tone or effectiveness of communications include characteristics of the messenger. Among some groups, a warm, friendly, personalized interaction will increase the influence of the information tremendously. The interpersonal style of the health care provider is an extremely strong determinant, in some communities, of whether information will be heard and acted upon. In addition, some Latino communities are a bit more prone to revere doctors and may not question them, so the information must be given as it may not be asked for. The awareness level may be lower in these groups where there can be some ignorance of chronic diseases, so awareness education is critical here as well as education oriented toward immediate action.

On the other hand, there may be some resistance to health care messages in general, and a “here and now” orientation coupled with a fatalistic approach may add up to a feeling that disease or deterioration is inevitable and nothing can be done about it. Modesty or general anxiety about health might be additional barriers to Latinos actually acting on the health messages they receive. Due to past histories, many older Latinos have a mistrust of the health care system which must also be overcome.

With regard to media preferences, many Latinos prefer printed materials that are colorful, nicely illustrated and with catchy titles. Photonovelas (stories told through pictures) could be an effective tool since graphics seem to generally be appreciated more than detailed writing. On television, espe-

cially Spanish-language television, the *telenovela* (soap opera) is very important to many older women from this culture. Getting osteoporosis awareness information into this format could be a potent way to tap this audience. For Public Service Announcements (PSA's), consider using an elderly Latino woman to speak to women in a familiar way.

African Americans: Extended family and interdependent kinship ties are generally extremely important to this group. Health care is often viewed as a family responsibility, not just the individual's, and daughters or sisters could therefore be helpful in spreading the word to other women. Many older African American women, and frequently their health care providers, have a sense that they are at low risk for osteoporosis, especially compared to their other medical problems. Although they are not in a high risk group, African American women still lose mass with age. In addition to those aimed at action, messages must educate about risk and emphasize the consequences of not preventing bone loss.

Lack of resources is an issue for many in this group. It may be fruitful to emphasize the importance of staying independent, since many of these women do not have many resources to fall back on. In addition, some have limited formal education, so it may be hard for them to articulate questions for health care providers. Give them questions to ask, and put them on a card for reference. Many of the underserved in this population have a low literacy level.

Church and faith are very important to most African American women. Members of the clergy can be quite influential in these women's decision making, and they can override the propensity for some of these elders to view illness as "testing one's faith in God." Using the church as a location for health education would be effective in reaching many women. In addition to trusting their clergy, this group may trust community health care workers the most.

Media should be adapted for this group as well. Feasting and cooking are frequently an important component of African American communities, and therefore dietary prescriptions should be sensitive to cultural norms. Many older women in this population tend to rely on pamphlets and television rather than books and reference materials, and the depictions in those media should focus on real life situations rather than statistics and long narratives. Older African American women may also appreciate images of female doctors and intergenerational groups (as do the dominant age cohorts, as discussed above). In general, these consumers do not seem to use toll free numbers, computers, and the internet as much as Caucasians.

Native Americans: One of the most important considerations in reaching Native Americans seems to be integrating information into the tribal community. Peer advocates have been successful with these groups, and in general, information should relate to their native community. Wherever possible, build alliances with tribal agencies and put materials on local letterhead and work through local partners. Oral dissemination of information is very important, as some groups place a low value on printed information. The pace on many reservations is much slower than in non-Native communities. One must take time to visit with women and get to know them before they will listen to the health care messages. This is very much in tune with a strong relationship marketing orientation.

In many cases, Native American women will need basic information. Their level of awareness and interest in osteoporosis may be lower than in the general population. Orientation to prevention is

lacking in many communities. Consider combining the message with other health information. Lots of women do not put their own health first. It is important to let them know they are important. Use family to reach elder women. A message like “Stay alive longer for your grandchildren” would resonate. There is a strong commitment to future generations.

Food has major significance in this culture beyond nourishment. Life events are often celebrated with food, and it can be the center of dances and many religious and healing celebrations. Dietary messages should be adapted for this group of women who have a high incidence of lactose intolerance.

Asian Americans: Like some of the other groups already mentioned, family images and concerns resonate with most Asian Americans. Many elder women have been socialized to define themselves according to their role within the family, resulting in their ignoring their health needs for the family. Focus on the benefits to their family (such as being able to help take care of their grandchildren) of their taking action.

Many elder Asian women have a distrust of Western medicine and will be more likely to accept an illness rather than to seek treatment. There can be a cultural lack of orientation towards preventative care with the belief being that illness is a normal part of life over which they have no control.

Due to their cultural backgrounds, issues of food must be handled in sensitive, culturally-appropriate ways. Many Asian women are lactose intolerant. Like Latinos, Asian Americans come from a variety of national backgrounds which are all somewhat different culturally. Unlike Latinos, Asian Americans are difficult to target with in-language programming because of the diversity of languages involved. Therefore, adaptation involving visual images, food, etc. is often undertaken before language adaptation. Because of this language barrier, a national mass media campaign will probably not reach this group of women. Local media campaigns in the community’s language must be used.

The exercise component of the message may be effectively marketed through dance or Tai Chi classes. Adapt the implementation for the specific community.

Franco Americans: The Franco-American population is of particular interest in Maine as well as in a few other selected parts of the country. While this sub-group is generally more assimilated into the general population than other elder groups, language-appropriate messages are an important consideration, especially for older consumers. There are also some cultural food preferences that can be tapped into when making dietary recommendations. Members of the community should be consulted for further information on what would be culturally appropriate, as in the case of other segments.

Lesbian Sensitivity: One Blue Ribbon Panel member noted that lesbians may be sensitive to over-use of the “family” language, and “loved-ones” works better for them. This will also be true among any women who do not have children or spouses, which will be a bigger and bigger segment as these cohorts age. Therefore, wherever possible “loved ones” should be the preferred language in communications.

It should be noted that, like the Native American market, peer advocates have been a successful way to reach these consumers. Also, wherever possible, language used should be inclusive in order to avoid alienating these consumers.

Lower Socio-Economic Classes: Socio-economic class is a concern that cuts across many of these groups and informs our thinking about the dominant markets. Generally speaking, past campaigns have been least successful reaching women from lower socioeconomic groups. A determined effort must be made in the campaign to reach this underserved population. As much as possible, messages should be sensitive to the concerns of women with limited incomes and resources. The priorities of these women are focused on maintaining adequate food and shelter rather than on disease prevention. This group of women frequently has low self-esteem and often lacks social supports.

Consider piggybacking onto another issue to make the osteoporosis message heard. Materials should be focused specifically on no- or low-cost prevention and treatment. Emphasize coverage for screening but remember that osteoporosis medication may be unavailable to them due to cost. Organize local campaigns around free social events where food is served and promotional items are given away. Sponsor exercise classes where these women are, such as in housing projects or at local community centers. Focus campaign activities around decreasing their isolation and increasing their self esteem.

Keep marketing messages simple with minimal or low literacy writing. Television can be an effective marketing venue for this group. A primary message should be that broken bones can result in lack of independence and nursing home placement. Although these women are frequently isolated without family, some are also taking care of grandchildren. Staying independent for family messages will resonate with those in guardian roles.

### **What motivates people to take health actions?**

When considering the route to consumer action, we generally consider a process that starts with awareness and then works through successive stages until the person is motivated to undertake behavioral change. One model widely used to explain this process is the AIDA model. (See Chart III-3)

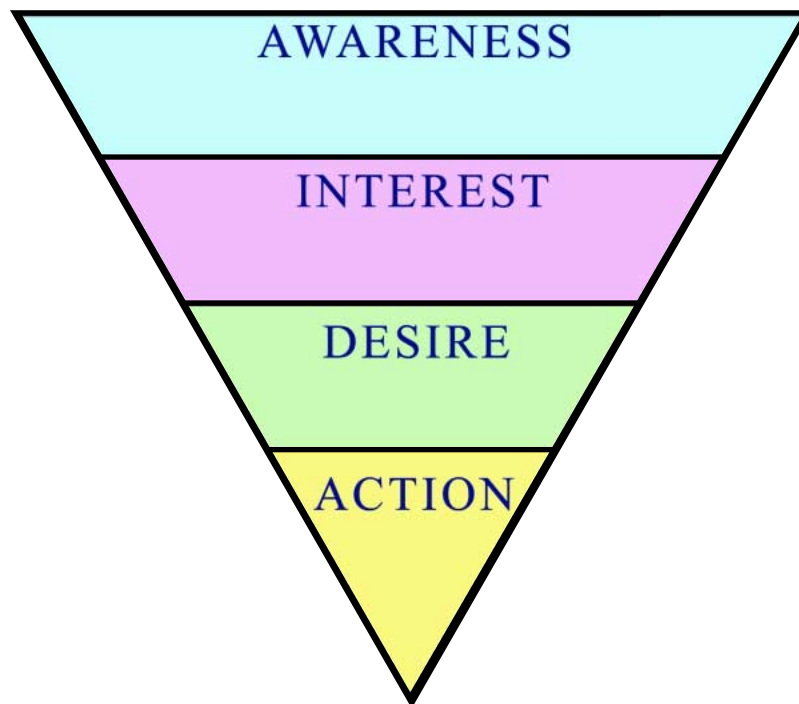
- Awareness
  - The simplest level of any awareness of the issue
  - In this case, basic awareness of osteoporosis as a health issue
  
- Interest
  - Cognitive involvement in the form of knowledge, gathering information
  - In this case, knowledge about the disease, its effects, risk factors, potential treatments, lifestyle behaviors, etc.
  
- Desire
  - Affective involvement in terms of perceived personal relevance of the issue, as well as positive attitude toward the issue or action required
  - In this case, feeling that osteoporosis is a personally relevant issue; desire to make lifestyle changes, positive attitude toward diagnostic, treatment, and maintenance behaviors
  - Motivation to deal with the issue

- Action
  - Acting, changing behavior, etc.
  - In this case, seeking information, contacting health care professional, undergoing testing, compliance with treatment/maintenance regimens, etc.

### Chart III-3 - AIDA Model

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AIDA is a four-stage hierarchical model of the effects of communication.



#### **With regard to our target populations:**

Awareness: Most consumers have already attained this stage, with some important exceptions among lower socioeconomic classes, particular racial and ethnic groups, or consumers with limited access to medical information and health care. Even among those with awareness, many may not recognize it as a problem they need to be concerned about, however. Increasing the perceived personal relevance of osteoporosis information and treatment is a key in this step.

Interest: Many consumers also seem to have reached this stage. The data from our research indicate that consumers consider themselves to be somewhat to very knowledgeable about osteoporosis. There are, again, some critical exceptions, especially among consumers who may be poor, live in remote areas, and have literacy problems or language barriers to information sources.

Desire: For much of the population, this is the first stage on which to concentrate. Again, both the research from this project and previous studies show that consumers are fairly knowledgeable, but their

motivation to act is low. They don't see osteoporosis as a disease that needs to be a priority or about which they can do anything. In some groups, notably African Americans (but not limited to that group) consumers may not perceive that osteoporosis is a serious health threat to them.

Action: Action is the “gold standard” for any intervention program. Again, research indicates that awareness and knowledge of osteoporosis have not, historically, translated into action. Efforts should be concentrated on designing communications that will reach each target segment with messages oriented toward motivating action, both short-term and longer-term lifestyle changes. In particular, fostering sustained action over time is critical. Based on this research, it appears that a mild fear appeal with a corresponding positive message and a direct, clear and culturally relevant action plan is the way to go.

Since awareness levels among many in our target audience are already high, our primary goal is to motivate to action. When asked during focus groups what motivated them to take action, the women in this project gave the following top four responses:

- (1) Fear
- (2) To be healthier and feel better in general
- (3) To keep from being in same condition as friend or family member
- (4) Family (desire not to be a burden, take care of them, etc.)

Note that these responses fit well with what is known about the age cohorts, in that the themes of family, maintaining independence, feeling better, and avoiding unpleasantness are all repeated here. It should be pointed out that these responses were uniform across ethnic and racial lines.

### **Conclusion**

Using the preceding theoretical foundations to focus the osteoporosis campaign, different population segments can be more easily targeted for effective intervention. It is clear that a national campaign of any kind must be adapted to the vast array of subgroups around the country. To do this successfully, one must understand the individual values and motivation of the particular group of elder women targeted.

## Chapter IV

### Phase III Focus Group Report

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#### Executive Summary

Focus groups were held with 122 elder women around the country to solicit feedback on several components of a national campaign. These included graphics and messages for print material, national spokespeople, and promotional items. Findings underscore the importance of incorporating bold colors over pastels for written material; simple and direct messages rather than plays on words or puns; and whole body whimsical skeletons were chosen over skeleton hands only. A postmenopausal female was the most desired individual to assume the role of spokesperson. Lastly, although participants generally were unable to remember the message on promotional items they had received in the past, they valued them and gave many suggestions for ones to be used in a national campaign.

#### Introduction

After collecting a vast array of materials from existing osteoporosis education programs and previous campaigns around the country, it was apparent that, for the most part, existing materials are relatively similar in design. Project staff worked with graphic designers and marketing experts with the goal of developing some materials that would catch consumers' attention at a level traditional brochures (showing elder women involved in various activities) have not. With the overabundance of medical marketing material facing consumers, finding a graphic concept that would make this campaign stand out seemed a high priority. Drawing on the information gathered from the first round of focus groups concerning fear being a major motivating factor in getting this population of women to change health behavior, the design aimed to be slightly jolting and thus attention grabbing. Our many expert interviews gave us the clear message that, despite fear providing the strongest motivation, scaring elder women with the intended message would not be effective. The graphics and accompanying message were therefore developed with the goal of giving a positive message after getting the consumer's attention.

The design concept (refer to Appendix A) consisted of skeletons engaged in a variety of activities. The accompanying messages involved plays on words involving bones or the use of well-known phrases involving bones (refer to Appendix A). These materials were tested in 13 focus groups conducted in a variety of locations around the country with older women representing the major ethnic and racial groups as well as urban/rural and regional populations. A total of 122 women took part in the focus groups which were held in California, Illinois, Georgia, Maine and New York (refer to Appendix B). During the focus groups, participants were also questioned about promotional items and spokesperson ideas for inclusion in a campaign.

#### Methodology

Participants were shown eight different "mock brochures" that contained a graphic and two part message (refer to Appendix A). There were four different message/graphic combinations in each of two colors (one bold and one pastel). They were instructed to select

the one that appealed to them most, without discussing their choice with anyone else. Discussion probes were then asked to determine why each made the choice she did.

The women were then shown each element of the brochures separately. Individual boards with each of the four graphics in black and white (to remove the color variable) were held up, and participants were asked to write down the first word or phrase that came to their minds. A number of probes followed. They were then shown each of the four primary message phrases in black on white boards and asked to write down whether the phrase was a familiar one. Additional probes followed this activity as well.

A number of questions were then posed concerning possible spokespeople for a campaign. Women were asked to choose between different combinations of two categories of professions for this role (refer to Appendix A). The final question attempted to find out what promotional items women had received in the past were used frequently and if the accompanying advertisements were remembered.

## Findings

*Mock Brochure Choices:* (Refer to Appendix A for brochure that corresponds to letter)

The majority of participants chose one of two brochures (A and G), both of which were the bold blue with yellow writing. In each case, the message (Bone Up on Bone Loss, Tone Your Bones! And Battle Bone Loss with Exercise) was most often identified as what caught participants' attention. Brochure H, the same as brochure G but in pastel green, was selected the most frequently among the remaining selections. (Refer to Chart IV-1 for sample of comments about each choice).

The majority of respondents stated they made their brochure selection based on the message rather than the graphic. Color was a factor frequently, though less often than the message. Very few respondents reported making the choice based on the graphic alone.

Although far more women preferred the blue with yellow brochure over the green with pink, the women who chose the green generally had very strong positive feelings about that color. Generally, however, respondents felt the yellow on blue was eye catching and stood out well.



**Chart IV-1 Mock Brochures Choice Comments**

<b>Card</b>	<b>Positive</b>	<b>Negative</b>
A	<ul style="list-style-type: none"> <li>- Bone Up is current expression and jumped right off page to me</li> <li>- Good color and message</li> <li>- Liked phrase-to the point</li> <li>- Color caught my eye</li> <li>- Looks like he's dancing-like it</li> <li>- Interested in bone loss</li> <li>- Conveys why we're here-to learn about bone loss</li> <li>- Clever wording</li> </ul>	<ul style="list-style-type: none"> <li>- A little cluttered</li> </ul>
B	<ul style="list-style-type: none"> <li>- Liked color-more feminine</li> <li>- Color and picture</li> <li>- Simple and to the point</li> <li>- Brighter</li> <li>- Clear</li> <li>- Message sounded good</li> <li>- Picked it for message</li> </ul>	
C	<ul style="list-style-type: none"> <li>- Wanted to know what to eat</li> <li>- Liked milk reference</li> <li>- Wanted to know more about milk</li> <li>- Liked colors and that it was about food</li> <li>- Thought it would tell me about food how much and what to drink</li> <li>- Love drinking milk but confusion about</li> <li>- Message was about nutrition</li> <li>- Liked "appetite"</li> </ul>	<ul style="list-style-type: none"> <li>- Mentioned milk-don't like milk</li> <li>- Milk toast phrase</li> <li>- Many Native women lactose intolerant</li> <li>- Glasses looked like alcoholic's</li> <li>- Milk toast means "weak"</li> </ul>
D	<ul style="list-style-type: none"> <li>- Liked milk message</li> <li>- Color and "milk toast"</li> <li>- Because I didn't know what it meant</li> <li>- Liked "appetite"</li> <li>- Liked wording</li> </ul>	<ul style="list-style-type: none"> <li>- Many Native women lactose intolerant</li> <li>- Don't like milk</li> <li>- Glasses looked like alcoholic's</li> <li>- Milk toast means weak</li> </ul>
E	<ul style="list-style-type: none"> <li>- Important message</li> <li>- Skeleton picture</li> <li>- Stand up to bone loss message</li> <li>- Liked title</li> </ul>	<ul style="list-style-type: none"> <li>- Weird position of skeleton</li> <li>- Don't like "Bone Vivant"</li> <li>- Too subtle for most people</li> </ul>
F	<ul style="list-style-type: none"> <li>- Stand up to bone loss message</li> <li>- Green relates to spring and movement</li> <li>- Message-focus on keeping my balance</li> </ul>	<ul style="list-style-type: none"> <li>- Didn't get it</li> </ul>
G	<ul style="list-style-type: none"> <li>- Wording of message</li> <li>- Color</li> <li>- Liked "tone your bones"</li> <li>- Message made me think of exercise</li> <li>- Hoped it would show my exercises</li> <li>- Took it for skeleton position and color</li> <li>- Tells you it is possible to take care of your bones and be flexible</li> <li>- Liked color and message</li> <li>- Color and formation of skeleton</li> <li>- Catchy message</li> <li>- Important message</li> </ul>	<ul style="list-style-type: none"> <li>- Skeleton needs to bend knees</li> <li>- Never able to touch my toes</li> <li>- Thought skeleton was falling down</li> </ul>
H	<ul style="list-style-type: none"> <li>- Took it because it said "exercise"</li> <li>- Rhyming words</li> <li>- Exercise message and color</li> <li>- Wording</li> <li>- Because it talked about exercising</li> </ul>	<ul style="list-style-type: none"> <li>- Never able to touch my toes</li> <li>- Position of skeleton not safe</li> <li>- Message made me think of dancing</li> </ul>

**Graphic Boards:**

**Board #1 (2 hands toasting)**

The majority of responses to this board were neutral or negative. It reminded almost one quarter of participants of alcohol. Considerable confusion was expressed about the picture. When asked if it made them want to look closer, only two women replied positively. (Refer to Chart IV-2 for sample comments).

**Chart IV-2 Graphic #1: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Drinking milk for good bones</li> <li>- Cheers!</li> <li>- Flexible joints</li> </ul>	<ul style="list-style-type: none"> <li>- Scary</li> <li>- Hard to understand</li> <li>- Death ...not positive image</li> <li>- Weird</li> <li>- Bad for your health</li> <li>- Poor picture-makes no sense</li> </ul>

**Board #2 (Hand holding pamphlet)**

The majority of responses to this graphic were neutral. There were more negative than positive comments, and the level of confusion was similar to Board #1. As with #1, most participants did not want to look closer at this picture. (Refer to Chart IV-3 for sample comments).

**Chart IV-3 Graphic # 2: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- One's good health is in one's own hands</li> <li>- Strength</li> <li>- Happy skeleton</li> <li>- That exercise is good</li> <li>- Happy</li> <li>- Peppy dance</li> <li>- Hot foot!</li> <li>- Agility</li> <li>- Healthy bones</li> <li>- Shows good hand on good living</li> <li>- It's all right to have a hand help you</li> </ul>	<ul style="list-style-type: none"> <li>- Corpse</li> <li>- No interest</li> <li>- Don't get that at all</li> <li>- Don't like the skeleton</li> <li>- Unrealistic</li> <li>- Scary</li> <li>- Ugly</li> <li>- Gloom</li> <li>- Hard to see and understand</li> <li>- A nothing picture</li> <li>- Too contrived</li> <li>- Too blurry</li> </ul>

**Graphic #3 (Touching toes)**

Although the majority of comments were again neutral, positive comments far outnumbered negative ones, and the graphic elicited frequent chuckling. Participants expressed little confusion about this picture. Many respondents reported wanting to look further at this graphic. A number of responses focused on whether the respondent could or could not assume the skeleton’s position. One member who was an experienced exercise instructor expressed the opinion that the skeleton’s position would not be safe for a woman with osteoporosis. (Refer to Chart IV-4 for sample comments).

**Chart IV-4 Graphic # 3: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Healthy, fit</li> <li>- Exercise is good for you</li> <li>- Good one!</li> <li>- Great exercise!</li> <li>- Nice structure!</li> <li>- Glad I can do that!</li> <li>- Extraordinary</li> <li>- I liked it</li> <li>- Only one that communicated anything to me</li> <li>- Benefits of exercise</li> <li>- Shows someone is taking care of themselves- that’s a positive thought</li> <li>- Calls you to action</li> <li>- I like toe touching</li> </ul>	<ul style="list-style-type: none"> <li>- Not a good exercise for osteoporosis patients</li> <li>- Back too curved and no bend in knees</li> <li>- Difficult, painful, and impossible</li> <li>- Could be much better picture</li> </ul>

**Graphic #4 (Clicking heels)**

This graphic elicited the largest number of positive responses. Little confusion was reported. When asked whether it made them want to look more closely, participants expressed mixed reactions. Members of the Chicago suburban, Latino, and Indian Island groups all wanted to look closer. No one in the other Native American group responded that she would look closer, however. (Refer to Chart IV-5 for sample comments).

**Chart IV-5 Graphic #4: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Dance, burlesque, fun</li> <li>- Exercise helps</li> <li>- Person in very good condition</li> <li>- Fun one</li> <li>- Feeling good about yourself</li> <li>- Jolly dancer person</li> <li>- Whee!</li> <li>- Dancing for pure joy</li> <li>- Fun, dancing, laughter</li> <li>- Ballet dancer-life is good</li> <li>- Someone leaping for joy</li> <li>- Kick up your heels and celebrate</li> <li>- Excitement, dancing, enthusiastic</li> <li>- Calls to action</li> <li>- Happy person dancing</li> <li>- I'm alive. Yippee!</li> <li>- Happy feet</li> <li>- Happy-limber</li> <li>- Dance-good exercise</li> <li>- Whee! Great!</li> <li>- He's happy.</li> <li>- It's a happy picture.</li> <li>- Healthy-able to dance and jump.</li> <li>- Exercise is a way of life.</li> <li>- It is fun to jump and click your heels</li> </ul>	<ul style="list-style-type: none"> <li>- Acrobat, but not a pleasing one</li> <li>- Grotesque</li> <li>- Will I lose weight and can't control my limbs?</li> <li>- Never could do this</li> <li>- Not for my age</li> <li>- Weird</li> <li>- Scary-Halloween</li> <li>- All skeletons are ugly</li> <li>- Not much sense to it</li> <li>- Pretty impossible for anyone I know to do</li> <li>- Looks like fun but not something older people can relate to</li> </ul>

*Discussion:*

Clearly, there were mixed reactions to the skeleton concept.

Graphic #1 as is would not be an effective one to use. If used in a national campaign, however, we would anticipate that the skeletons would be created for that purpose specifically rather than using ones already available. If so, the hands could be drawn more clearly, and milk glasses would be used, creating much more clarity than the graphic used for testing. This would make the association with alcohol less likely and make the graphic more readily recognizable for its intended purpose.

Graphic #2 as pictured was not particularly effective. However, many participants liked the message it conveyed of reading up on osteoporosis, and this message could easily be conveyed in a more compelling graphic. The skeleton on the brochure in the picture caught the attention of many respondents.

Graphics #3 and #4, though eliciting mixed responses, were clearly the preferred choices. Perhaps the toe touching skeleton could be seen doing a more appropriate exercise and the heel kicking skeleton could be dancing. Depending upon the kind of dance, this might be a way of using a nostalgic image to reach elder women. Especially with the Latino population, dancing is a form of exercise and much loved. Graphic #4 was viewed as a happy one, conveying a positive “I can do anything” message. This would fit well with the campaign goal of empowering women to take action.

Although some women would seem to prefer more straightforward, traditional graphics, the skeleton concept, when clearly pictured, did appeal to a significant number of participants. With more time and funding, softer and more creative skeletons could easily be developed. For many women, this concept would clearly stand out from other campaigns, and for others, the graphic needs to be familiar and serious. The more whimsical would seem to have a place in a campaign along side a more traditional graphic showing, perhaps, women alone and with families.

**Message Boards:**

**Board #1 (Bone Appetit)**

The majority of respondents found this phrase unfamiliar, though many commented during the discussion that “bon appetit” was familiar. In both the Latino and Filipino groups, the phrase caused confusion and elicited the response that it would not translate well. Otherwise, although there were mixed reactions, many respondents associated it with positive images. (Refer to Chart IV-6 for comments).

**Chart IV-6 Message #1: Verbatim Comments**

<b>Positive</b>	<b>Negative</b>
- Happy eating	- Reminds me of French cooking which is bad for you.
- Good food	- Too cutesy
- Good wishes	- Put it in English!
- Very catchy phrase	- Silly, corny, not to the point
- Cute	- Bad spelling
- Eat healthy for good bones	
- I like plays on words	
- Good eating. Enjoy your meal.	
- I liked it. It would catch my eye.	
- Clever	
- Good play on words	
- It is very important the way you eat.	
- Good bones, enjoy!	
- Yum	

**Message #2 ( Bone Up)**

A slight majority of respondents reported having seen this phrase before. Some Latino group members associated it with “jocks”, “street talk” and felt it had a sexual reference. While several participants questioned whether the phrase was identified with studying and would therefore have a negative connotation for some women, others liked it because of it’s identification with education. (Refer to Chart IV-7 for comments).

**Chart IV-7 Message #2: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Like it, cute, catchy</li> <li>- Clever</li> <li>- Eat so your bones will be healthy and good.</li> <li>- Study and learn about the disease</li> <li>- Study for good nutrition and strong bones</li> <li>- Good idea</li> <li>- Good, easy to understand for most folks</li> <li>- Care about what you’re eating</li> <li>- Take care of your bones</li> <li>- Inform ones’ self to prevent osteoporosis</li> <li>- Cute</li> <li>- I liked it.</li> </ul>	<ul style="list-style-type: none"> <li>- Don’t like it</li> <li>- Not good English</li> <li>- Silly</li> <li>- Wouldn’t use it</li> </ul>

**Message #3 (Tone Your Bones)**

The majority reported never having seen this phrase before, though some of those stated they had seen “tone your muscles.” Considerable confusion was expressed about the phrase by members in the NYC, Latino, and Indian Island groups. Reactions were again mixed, but many women associated it with a positive health message. (Refer to Chart IV-8 for comments).

**Chart IV-8 Message #3: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Makes sense</li> <li>- Associate it with a song</li> <li>- Catchy</li> <li>- Exercise-right food for your bones</li> <li>- Catchy</li> <li>- Cute</li> <li>- Get in shape</li> <li>- Healthy and strong</li> <li>- Good phrase</li> <li>- Do your exercises!</li> <li>- Exercise and eat right</li> <li>- My favorite-need to work on bone health</li> <li>- Exercise for good strong bones</li> <li>- Good slogan</li> <li>- Nice title, makes you want to learn more</li> </ul>	<ul style="list-style-type: none"> <li>- Negative</li> <li>- Not sure what you’re trying to say</li> <li>- You tone your muscles, not bones</li> <li>- Cutesy poo</li> <li>- Doesn’t do anything for me</li> <li>- Would not associate it with exercise</li> <li>- Tries too hard to be catchy</li> </ul>

**Message #4 (Bone Vivant)**

The large majority of respondents had not heard this phrase before. Several members in culturally specific groups did not feel it would be good for use with their subgroups. Even a Franco American member thought it needed something else to work with her community. Reactions were mixed with the majority of participants not favorable. (Refer to Chart IV-9 for comments).

**Chart IV-9 Message #4: Verbatim Comments**

Positive	Negative
<ul style="list-style-type: none"> <li>- Associate it with happy life</li> <li>- Happy fellow</li> <li>- Physical fitness</li> <li>- Catchy</li> <li>- Lighthearted</li> <li>- Long live bones</li> <li>- French cooking-the good life</li> <li>- French, fun</li> <li>- Happy bones</li> <li>- Enthusiasm, strength</li> </ul>	<ul style="list-style-type: none"> <li>- Don't connect it with anything</li> <li>- Too foreign</li> <li>- I don't know what it means so it doesn't mean anything to me.</li> <li>- French cooking, not our kind of nutritional emphasis</li> <li>- Put it in English</li> <li>- Cutesy poo</li> <li>- Too trite</li> <li>- Do not like it!</li> <li>- Associate this saying with gaiety and drinking-this is a very serious message-you don't want this</li> <li>- Yuck</li> <li>- Have no idea what it is</li> <li>- Too cutesy for me</li> <li>- This one leaves me cold</li> </ul>

*Discussion:*

Clearly, these message boards elicited a wide variety of reactions. Some women definitely appreciated the play on words while it meant nothing to or irritated others. Although “Bone Appetit” and “Bone Vivant” resonated for some women, their value in a national campaign would seem limited. Two participants in one group, both of whom have been diagnosed with osteoporosis, expressed anger at attempting to be “funny” in connection with a disease of this nature. Others found “Bone Up” and “Tone Your Bones” to be conveying the kind of message that is needed. As a note, members of the Indian Island group suggested two additional messages that might be effectively used for Natives. They were “Get Your Native Bones Tested” and “We’re the original bones!” A Latino respondent suggested using “Viva Bones” for her population.

Almost all participants felt messages should be concise and to the point. This was felt to be particularly true for specific ethnic groups for whom English is a second language. Some of the popular tested messages, however, did involve plays on words. This would indicate that this technique can be effective if used judiciously.

## **Spokespeople:**

Participants overwhelmingly preferred a female to a male spokesperson. A male physician or a male with osteoporosis were the only acceptable alternatives to a female spokesperson. A senior male/female couple was mentioned as a possibility in a couple of groups.

For a target audience of older women, the participants again overwhelmingly favored someone approximately their general age.

Of all the categories covered (refer to protocol in Appendix A), the only one universally seen as unacceptable was a politician. Following is the breakdown of responses:

### ***Political Figure vs Actress***

The vast majority preferred an actress.

### ***Doctor vs Famous Athlete***

Doctors, especially female doctors, were preferred more often, but athletes received many votes, particularly if the athlete had osteoporosis or had been affected by it in some way.

### ***Talk Show Host vs Politician***

It was almost unanimous that a talk show host would be better.

### ***Actress vs Doctor***

A doctor (again primarily female) received slightly more votes than an actress.

### ***Famous Athlete vs Actress***

The majority chose athlete over an actress. Many of those favoring the actress were Latino and felt a novella star would be excellent. One woman stated, "These women do what novella stars tell them to."

### ***Doctor vs Politician***

Except for some members of the Hoopa group who didn't want either, doctor was the unanimous choice.

### ***Talk Show Host vs Famous Athlete***

More participants chose talk show host, but in two cases the talk show host was qualified by the choice of a specific person (Oprah and Dr. Phil).

### ***Actress vs Talk Show Host***

More chose actress.

### ***Political Figure vs Athlete***

The unanimous choice was athlete.

### ***Doctor vs Talk Show Host***

The vast majority selected doctor.

It should be noted that members in both the Eureka and Hoopa groups expressed some negative feelings towards doctors that were not present in the other groups.



### *Specific people*

Many people were suggested as possible spokespeople. Oprah was mentioned far more frequently than anyone else with her name eliciting a positive response whenever it was brought up. She seemed to be popular across different ethnic groups. One woman said, “She’d have everyone taking their calcium!” The women on *The View*, specifically Barbara Walters, were mentioned several times. Barbara Bush and Laura Bush were named multiple times as well, with the elder Bush’s name being brought up slightly more often. Interestingly, they were not felt to be too political. The following names were raised in more than one group:

Diane Sawyer

Katie Couric (already involved in another high profile campaign)

Carol Burnett

Ann Richards (written a book about her battle with osteoporosis but is a politician)

Joan Benoit (in Maine groups)

Doris Roberts

Latino women raised the following names of Latino celebrities:

Irma Serrano

Cristina Saralegui

Ana Guevera (athlete)

Antonio Novello

Rita Moreno

Tantoo Cardinal, a 53 year old Native American actress, was identified in the Indian Island group and supported by the Hoopa women. She was described as “a strong woman.”

Although there were a number of male celebrities offered as suggestions, the gender preference strongly pointed to a female as the preferred spokesperson.

Throughout the groups, there was an interest in having someone who was dealing with the disease, preferably in herself. Suggestions ranged from someone “humped over” from the disease because she hadn’t engaged in prevention activities to someone in her 50’s who is taking steps to increase her bone density. A number of women felt an ordinary person would be more effective than a celebrity as a spokesperson. Some believed such a person would not be doing it for publicity or money and therefore would be more sincere.

A participant in the Indian Island group urged we use “someone who has been through hardships, worked all their lives, struggled, taken care of their family” and who has to worry about money. In another group, anger was expressed towards a high profile person like Nancy Reagan who, though dealing with a tragic disease does not have to worry about paying for necessary care.

For American Indian elders, a member of the Hoopa group suggested “going into the communities and recruiting out of the tribe.”

### *Discussion:*

When given a choice between two categories of spokespeople, the majority of respondents always chose the physician over any other group. Yet, suggestions for individual spokespeople included only two physicians (Susan Love and Antonio Novello). This may simply indicate that there are few nationally known physicians, but it does suggest that a physician (in particular a female) could have an impact at some level, national or local, as one of the spokespersons for the campaign. Though several specific athletes were suggested, athletes as a group did not get chosen as often as any other category but politician. Although Oprah was identified more than anyone else, the talk show host category in general was not as popular.

The responses to this question would seem to suggest that a national celebrity spokesperson like Oprah would be most effective in conjunction with one or a group of women who are “ordinary” people dealing with thinning bones. A physician, probably on a local or subgroup basis, would further add to the impact.

It is clear that women want to be able to identify with a spokesperson and to believe that person has felt, at some level, the impact of worrying about low bone density. The challenge is to identify a celebrity who, though wealthy and advantaged, can convey an everywoman image. Further, responses would indicate that, in addition to one national spokesperson, a celebrity from an ethnic subgroup could have a significant impact with elder women from that particular culture.

### **Promotional Items:**

Participants had received many promotional items in the past, but most of them were unable to remember the message that went with the item. Very few reported looking at the message several times a week. They did, however, have many ideas about items they would like to see in a national osteoporosis campaign. By a wide margin, magnets were most frequently named as a useful item and one which these women tended to look at often. The association of magnets with holding pictures of grandchildren was a positive one. There was disagreement about whether a skeleton-shaped magnet should be used with some strongly favoring the idea (including glow-in-the-dark or one with moveable parts) and others feeling it is ghoulish. A bone shaped magnet was suggested as well as one containing a message about calcium rich foods with a picture of a glass of milk or cheese on it.

Second to magnets, pens were the most popular item, though respondents’ feelings were definitely mixed. Suggestions were made that the pen be not too thick or heavy.

Pillboxes, perhaps with samples of Tums or calcium supplements, were mentioned frequently as were notepads and key chains.

Also suggested on more than one occasion were letter openers, mugs or cups, tote bags, flashlights, T-shirts, pins, bookmarks, small tape measures, and a device to help open cans and jars. A number of women suggested a calendar be used with specific ideas ranging from a magnetic one to go on the refrigerator to a wallet size to a Native Men of Maine design! One of the suggestions was to have a monthly calendar with each month containing different campaign messages (such a calcium rich recipes, examples of bone building exercises, suggestion to urge a friend to get tested, etc.)

Although bumper stickers were favored by many, there was some strong dislike for those expressed as well. Address labels were brought up frequently as a promotional item that was definitely NOT wanted and felt to be far overdone.

Some other interesting suggestions were pedometer, something with a bone handle, and a stuffed bear with an osteoporosis message on its sweater. Several women brought up the idea of using a ribbon theme like those used for breast cancer and AIDS awareness campaigns. Although the vast majority of women seemed to like receiving promotional items, several women thought these were a waste of money and said they pay no attention to them.

#### *Discussion:*

Most women were able to readily describe items they like receiving, but very few were able to identify the message on those items. Although some items were identified (like a refrigerator magnet listing calcium sources) that might be effective in educating and reminding women to act, it is doubtful that promotional items in and of themselves will spur women to action. However, their benefit in reaching the underserved, who are not yet educated about the disease in many cases and who are more likely to view free promotional items as a positive factor in a campaign, may be significant.

One of the most popular and least expensive items would be a flat magnet either in an interesting shape and/or containing an osteoporosis education message. These could relatively inexpensively be adapted for cultural differences. Though more expensive to produce, a month by month calendar would give an opportunity to send a variety of messages.

From participants' feedback, it would seem that consumers are flooded with promotional items but that they view receiving them to be positive. Creating one to stand out in the flood of items elder women are given would be important as well as challenging.



## Chapter V

### Recommendations

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A national osteoporosis education and action campaign for postmenopausal women will be one that is long and continually evolving to respond to what is and is not working. To meet the needs of a highly diverse population of elder women, it will need to be able to be adapted for individual communities. To further impact the campaign, within the next decade, millions of leading edge baby boomers, a group with characteristics and values totally different than the current elder subgroups, will join the target population. The campaign should therefore be designed to enable changes to be made in marketing, messages, and materials as easily and economically as possible. Directed by an advisory board, the campaign needs to have an overall national component with more individualized local adaptations.

The following recommendations are guided by the principles highlighted in the Theoretical Marketing Foundations section of this report as well as the three phases of research carried out over the past eighteen months.

#### **Advisory Board**

It is recommended that a national advisory board be established to oversee the campaign and to be part of the periodic evaluation. This board should consist of experts from the fields of osteoporosis, geriatrics, business and marketing, policy, and the media as well as members of Federal and State organizations. In addition, the consumer should be represented, perhaps by someone from an older adult or retiree membership organization like the American Association of Retired Persons (AARP) or the Older Women’s League (OWL). It is vital as well that the major ethnic and racial subgroups have representatives on the advisory board. A suggestion for the media member would be Susan Dentzer who participated in the Surgeon General’s Workshop on Osteoporosis and Bone Loss and who is affiliated with a number of major media sources. The mission of the board would be to monitor the campaign, evaluate its effectiveness and make recommendations for changes. To be effective, a campaign has to build momentum and support and keep the groundswell growing. The Board will be responsible for assessing how successfully this is happening and planning strategies for assuring its future success. To be able to accomplish this task, the campaign will produce statistics on agreed upon milestones or goals for the Board prior to each meeting.

#### **National Level**

##### *Three Key Messages*

The campaign’s overall message should be that osteoporosis is a preventable and treatable disease that can cause pain and suffering and rob a woman of her independence and lifestyle. It needs to be emphasized that it is never too late to take action. In general, the message must be simple and direct and tell women what to do. Our research indicates that the message needs to be positive but also be clear about the consequences of not changing behavior. While there are other items that could be

stressed which would reduce the risk of bone loss, such as not smoking and eating a well rounded diet rich in fruits and vegetables, it is generally agreed by our experts that the emphasis should be on the most important ones in order to impact the highest number of women. Therefore, the three main components of the message should be as follows:

### **1. *Get Tested***

Due to the variation in testing and its availability, it is recommended that the generic word “testing” be used rather than the name of a particular test. Emphasis should be made that testing is a covered service for Medicare recipients and for younger postmenopausal women with most other insurance coverage. Whenever possible, take screening to the consumer since access is a major problem, especially for the underserved population. When not possible, work with local communities to remove barriers to access. Another barrier to testing is the elder woman’s reticence to ask her health care provider for testing. Educate women about what and how to ask for testing.

In addition to access, emphasis should be on the test itself and the fact that it is simple, painless, and respectful of a woman’s modesty.

### **2. *Increase Calcium Intake***

The second key component involves the importance of increasing calcium intake.

This is more complicated due to demographic issues. For example, there is a high incidence of lactose intolerance among some ethnic groups, and some of the fresh vegetables high in calcium are simply not available or affordable in all parts of the country. In addition to its nutritional importance, food is an integral piece of certain cultures’ heritage. Specific national recommendations should focus only on the need to increase calcium and a general indication of the kinds of foods that contain high levels. Local communities can provide more specifics and tailor the message to that subgroup. Suggestions for disseminating the message locally will be made later in this report.

### **3. *Engage in Weight Bearing Exercise***

Lastly, the importance of weight bearing exercise is the third essential component of the overall message. We strongly recommend the development of a national program modeled after one of the senior exercise models already in place. One highly successful such program is Bone Builders, sponsored by Retired and Senior Volunteer Program (RSVP). It is a weight bearing exercise model based on research performed at Tufts University. Strong Women Stay Young by Dr. Miriam Nelson resulted from this research. Bone Builders started in Albany, NY and now has classes in many locations around the Mid Atlantic and New England states. The program utilizes trained senior volunteers to lead exercise classes at no cost for elder women. Other than administrative costs, the weights used in the class comprise the only expense, and getting donations for these has been no problem. Classes are fun and provide socialization that decreases isolation and raises self-esteem, both of which would be expected to increase motivation to continue in the class. In a national campaign, these classes could be run in congregate living centers, housing projects, community centers or churches. Because few resources are needed besides weights and a room, the classes can easily be taken to elder women where they are. Transportation concerns would be kept to a minimum. Detailed information may be obtained from Virginia Gilbert at 301-891-6786 who started the first RSVP Bone Builders and still provides training to instructors.

## **Spokespeople Are Crucial**

An effective campaign should have an overall national component and a customized local piece. We recommend a national spokesperson be used who is readily identified with the campaign and who is generally respected by a diverse group of elder women. Our Phase 3 Focus Group results suggest Oprah Winfrey would be an excellent choice. Her recent very public 50th birthday establishes her as a woman who has reached the age in which bone density begins to decrease. She is a woman of color whose popularity seems to cut across racial lines and someone who is seen as understanding the issues facing “common people.” Her popularity seems to reach across age groups, thus enabling her to reach family members, a vital conduit to elder women. Her talk show would provide a ready forum for addressing the campaign’s issues when appropriate, and the success of her “book club” has already proven that her recommendations have credibility to women. Using a spokesperson from a lower risk ethnic or racial group might have the added advantage of drawing in African American women who have gotten the message they do not need to be concerned about osteoporosis. Alternatives to Oprah are identified in the Phase III Focus Group Report. The use of a popular celebrity would hopefully be able to generate more interest among the media for the campaign kick-off.

In addition to a national celebrity spokesperson, focus group results suggest the importance of using one or more “ordinary” women to serve as campaign figures. We suggest considering using a group (perhaps six) of ethnically diverse elder women who could ideally receive credibility by appearing initially or periodically with the celebrity spokesperson. The group of women would appear in Public Service Announcements (PSA’s) engaging in activities related to the key campaign messages. For example, they could be discussing the need to do weight bearing exercise or be going to their first exercise class, encouraging each other to get tested or discussing one’s recent experience having the test, going grocery shopping to buy high calcium foods, or listening to their granddaughter urge them to take care of their bones. One might consider having “teams” of two women each with each “team” pushing the others to follow one of the three messages. Segments could use humor as well as serious discussions about economic concerns related to campaign recommendations. These should be done in such a way that consumers feel they know the women and look forward to the next “installment.” It would be important to give the group a catchy name to afford them name recognition.

## **Dissemination of the Message**

It is critical for a successful campaign to have messages disseminated by many groups as well as in a wide variety of venues both at the national and local levels. While not the primary target of the campaign, middle age women with elder mothers can have a huge impact on getting our primary population to act upon the campaign messages. Widespread dissemination will increase the likelihood of this secondary population becoming aware of the campaign. Although our research did not focus on educating health care professionals, a vital component of a campaign, they are an essential group to utilize to reach elder women with our message. Women need to hear the message both from health care providers as well as from outside sources. Groups should include health care provider associations, non-profit organizations, and for-profit companies. For economy and efficiency, existing channels should be used whenever possible.

### *Health Care Providers*

One of the critical groups to engage in this task are national organizations representing health care providers. Some distribution channels through which we can reach this segment are as follows:

- American College of Physicians
- American Geriatrics Society
- Association of Asian Pacific Community Health Organizations
- Chinese American Medical Society
- Indian Health Service
- International Parish Nurse Resource Center
- National Association of Hispanic Nurses
- National Association of Nurse Practitioners in Women's Health
- National Black Nurses Association
- National Conference of Gerontological Nurse Practitioners
- National Rural Health Association
- Visiting Nurse Associations of America

These organizations might be used in a variety of ways, with the American College of Physicians perhaps playing the most central role. Most of the above organizations represent health professionals who work with groups representing underserved elder women. If these groups can be urged to both educate their members about osteoporosis and the need for testing in postmenopausal women as well as using their membership to disseminate information to their patients, many women will be reached. All of these groups have websites, and at the very least, posting the campaign messages online would heighten awareness.

### *Non-Profit Organizations and Public Agencies*

As part of the national campaign, there are numerous non-profit organizations or federal departments that could play a vital role in dissemination. Many of these have local distribution channels throughout the country. Depending upon the group, they could relay the messages via distributing literature, providing space for programs, or providing volunteer forces to help in a variety of ways. Again, utilizing existing channels is economical and efficient. Our suggestions for organizations to consider are as follows:

- Area Agencies on Aging (AAA)
- Faith based organizations with national affiliation with newsletters /media centers
- General Federation of Women's Clubs
- Housing and Urban Development (HUD)
- Japanese Association of Women
- National Asian Women's Health Organization (NAWHO)
- Older Women's League (OWL)
- Red Hat Society
- Senior Corps (Foster Grandparents, Retired and Senior Volunteer Program [RSVP], Senior Companion Program)

The Area Agencies on Aging network is the logical choice to play a major role in this campaign in a number of ways. In most parts of the country, AAA's are well-integrated into local communities. Elder women see them as helpful and credible resources. The AAA's can serve as sources of a corps of volunteers to spread



the word about an osteoporosis campaign in a variety of community settings including senior citizens centers, nutrition sites, legal services for the elderly offices, ombudsperson offices. AAA's advisory boards represent particularly important tie-ins to local communities in counties throughout the United States. The AAA office, itself, should also serve as a central clearinghouse for osteoporosis campaign information. That information should be disseminated at local meals sites and other projects administered either directly or through subcontracts with local community organizations.

Our expert interviewees as well as focus group participants highlighted the potential importance of faith-based organizations in this campaign. On a national level, many denominations have the structure already in place to effectively disseminate information to their members.

The General Federation of Women's Clubs, while not serving just elder women, represents service groups already interested in women's issues. The groups could be used to both educate their members about osteoporosis as well as to make use of member volunteers to disseminate the message to other elder women. The Elder Floridians osteoporosis campaign experienced great success using this channel.

The Department of Housing and Urban Development (HUD), by its very nature, has an avenue for communication with lower socioeconomic groups of elder women through state housing authorities. HUD could disseminate information to its local offices around the country which could be a vital conduit to this underserved population.

Japanese Association of Women and the National Asian Women's Health Organization (NAWHO) are two groups of and for Asian American women which would have an interest in spreading the message. NAWHO has previously run an osteoporosis education program for the target population in the San Francisco Bay area and has further shown its commitment by participating in the Foundation for Osteoporosis Education and Research (FORE) Summits in 2003.

The Older Women's League (OWL), while primarily an advocacy organization, is suggested as an additional resource because of its focus on the target population. Part of the focus of a national campaign is to advocate for elder women having access to testing and thus would fit well with Owl's mission. With chapters in many states, the channel is in place for reaching women around the country.

The Red Hat Society is a national organization of older women that reports to have over 400,000 members in 20,000 chapters located in all 50 states. While not a service organization, its mission is to celebrate and enjoy being older. Maintaining strong bones and independence fit well with this mission. Through the national organization, members can be educated about osteoporosis at the very least and perhaps encouraged to take active roles within their communities in the dissemination of information.

The Senior Corps programs are natural vehicles for dissemination with half a million Americans age 55 and older already involved in one of the programs. As with the Red Hat Society, disseminating information to those women already involved would result in a large number of elder women being reached. Utilizing the volunteers in the programs for other components of the campaign would be cost effective since the structure already exists.

### *For-Profit Channels for Dissemination*

For-profit companies represent another channel for dissemination. Although also an important source for partnering, which will be addressed later in this report, for-profit national businesses can play an important role in disseminating the message as well. Suggestions for these channels are as follows:

- Large discount retail chains
- National food store chains
- Curves
- Restaurant chains
- Insurance providers/HMO's
- Pharmacies

In particular, businesses that serve a disproportionate number of lower socioeconomic elder women have the potential to be highly effective in reaching large numbers of this target group. Wal-Mart is the obvious choice for this with its presence throughout the country with particular emphasis on rural areas. In addition, it has a history of taking part in community service. Other chains such as Dollar Stores might also be considered.

With one of the three key campaign messages involving nutrition, grocery stores are a natural channel as well. Some of the largest grocery chains, in addition to Wal-Mart, are Safeway, Kroger, and Albertsons. All of these own a number of other grocery chains operating under different names. If one or more of these could be enlisted to champion the nutrition message, the potential exists to reach across subgroups.

Another national for-profit business that has rapidly spread around the country is Curves, the fitness chain that has been particularly successful attracting older women. Though franchised and therefore individually operated, this company would obviously be a perfect fit for partnering with at least the exercise portion of the message. Curves seems to be attracting women who have not previously engaged in regular exercise.

Restaurants constitute another type of business with national reach. Engaging a moderately priced national chain to disseminate campaign messages through their restaurants possibly in the form of placemats, for examples, would help reach elder women across the country. Highlighting calcium rich menu items could be a strategy for this channel.

## **Marketing**

On a national level, it is imperative that the message be promoted in a variety of venues. Women need to be continually coming into contact with this message. While later in this report, we will be making suggestions for local campaign promotion, we recommend some key national components.

### *Media*

The results from our Phase I Focus Groups show that many elder women read a significant amount. Depending upon the level of education, what they read obviously varied, but magazines (particularly Prevention and Modern Maturity) were very popular as a source of health information. Results also suggested that health newsletters from insurance companies or hospitals would also be important venues for promotion.

Television has the potential to reach women from almost all the subgroups, including those underserved ones. On a national level, Public Service Announcements will be important and can include national spokespeople. It was also suggested that an established program such as *The View* would be an excellent venue for addressing osteoporosis. To reach a more diverse group of women, having osteoporosis woven into the story line of a popular show with an elder female character (such as *Everybody Loves Raymond* with Doris Roberts as the mother) would be ideal. Doris Roberts was identified as an elder woman who also seemed to have cross-racial appeal.

Though an important media source especially in rural areas, radio would probably best be used on a local level.

### *Internet*

Although clearly not having widespread use among the target population, the internet should nonetheless be part of a national campaign. A recent survey by the Pew Internet and American Life Project found that the use of the internet among those 65 and older jumped by 47% in the last four years. Although only 22% use it currently, 58% of Americans ages 50-64 use it. Given the rapid increase in numbers of current elders using the internet along with the percentage using it among the age group that will reach 65 in the next ten years, clearly the internet needs to be considered as a marketing venue. According to the report, 66% of those seniors who use the internet have used it to get health information. The Phase I Focus Group results indicate that many elder women get health information from adult children who relay materials they have found online. Utilizing family members to encourage elder women to get tested is a campaign strategy recommended by many experts, and internet promotion would be a means for this.

We would recommend having a campaign website that contains the key messages in detail as well as lists of volunteer opportunities, exercise classes by region, special osteoporosis events or components of other events (such as cultural festivals or health fairs), to name a few. It is crucial, of course, that it meet the universal access requirements.

### *Toll Free Telephone Number*

It has been shown in other campaigns that a toll free information and resource number is well utilized. This can be a valuable resource for women with various osteoporosis awareness levels. If available in several languages, the number could serve as an entry point for women who have little or no knowledge about the disease. Local referrals would be made. A catchy number such as 1-800-FOR-BONE would be easy to remember. If feasible, hooking it into an already existing line, such as the Medicare information line, would make it more economical. The National Osteoporosis Foundation (NOF) or the Foundation for Osteoporosis Research and Education (FORE) might be other resources for such a service.

### *Developing the Identity Program*

It is imperative that this campaign have an identity that is recognizable wherever the consumer crosses its path. One of the ways to foster this is through the use of a logo and/or theme that appear on letterhead, website, pamphlets, promotional items, etc.

Because it is clear from speaking with experts and from the focus group findings that materials need to be customized for certain subgroups, particularly ethnic ones, a constant logo or graphic will assure the campaign has a national identity and be part of a unified whole. The most successful national campaigns have utilized a unifying theme. The Breast Cancer pink ribbon theme is a prime example.

In developing materials, attention should be paid to colors, font size and style, as well as language. Bold colors are generally read more easily than pastels. Well-contrasting print and paper should be used. The use of simple font styles is recommended for use with older adults. Medium or bold face type in 12 or 14 point size is also most effective for this target population. Written materials should contain as few words as possible to get the message across, and general campaign materials need to conform to an eighth grade literacy level. It is imperative that members of specific subgroups be involved in adapting materials for their people. As much as possible, however, materials should be inclusive and simple to necessitate as little adaptation as possible and thus keep costs down. In our Marketing Foundations Report, we suggest some factors to consider in order to assure the greatest likelihood of changing women's behavior. It is essential to design materials with the values of elder women as a guiding force.

A substantive package of information should be developed to send to women calling the toll free number as well to give to women at health fairs and other locales where printed information is being distributed. This could be given a name such as Bone Building Kit and contain simple pamphlets about osteoporosis and the three key messages, a promotional item, coupons for high calcium foods, and recipes for simple calcium rich dishes. Additional items could be added such as a card containing questions for women to ask their doctors about testing or first person accounts by elder women who have increased their bone density. These should be adapted for non-English speaking women. It would be important for the kit to contain the logo and be packaged in an eye-catching way. Perhaps a bone sticker could be used to seal it.

We recommend the use of a catchy promotional item such as a uniquely shaped magnet (refer to Phase III Focus Group Report) or, at greater expense, a monthly calendar with each month conveying a different piece of the overall message. The spokespeople could be tied into some of the messages through photos or quotes. To have any value at all beyond providing a free gift, promotional items should be unique and stand out from the hundreds of others elder women encounter.

#### *Participatory Marketing - The Use of Volunteers*

Frequently in our research, we heard about the effectiveness of using elder women to reach their peers around health education and support. Not only does the use of volunteers make sense from an economic perspective, it also provides a one-to-one personal touch from someone with whom an elder woman can identify. In addition, taking part in the marketing campaign would appeal to an elder woman's yearning for social connectedness and her desire to fill free time with useful pursuits. A program as simple as having women call friends to encourage them to get tested could aid in reaching many additional women. Volunteers could be used to drive other elder women to testing appointments or distribute information at health fair booths, to name just a few.

Though volunteers would be used primarily at the local levels, it would be important to have these women feel they are part of a national group. Giving the volunteer component a name such as "Bone Brigade" and having the local groups be tied in with a unifying pin or other item bearing the logo would afford the group an identity. Different ethnic groups could use a related but appropriate name. Certificates and awards would be generated nationally with local adaptation. Local groups could nominate volunteers for national recognition at events attended by a national spokesperson representative.

### *Special Events*

To attract media attention, we suggest having a “splashy” national campaign kick-off and media blitz. This could coincide with the osteoporosis month that already exists or with another high visibility event. Using the kick-off as a forum for announcing a new osteoporosis research finding would be ideal. Having a postage stamp printed to highlight the cause would give the campaign added visibility and assist with the goal of having women “run into” the message in various venues. The national celebrity spokesperson and “average women” group, if used, would be announced during the kickoff and the logo unveiled.

Although it is imperative that the campaign be adapted by local communities to meet the needs and culture of those subgroups, a national umbrella must tie these local campaigns together and provide the nationwide recognition to attract partners and channels for dissemination. It was apparent during the focus groups that elder women appreciate feeling part of a national commitment to a cause.

### **Local Level**

Repeatedly during our research, we were given the overwhelming message that no national campaign will be effective in changing women’s behavior without involving the local communities in adapting the campaign for their subgroups. This is particularly true for non-mainstream communities. Past campaigns have failed when they have not included the local communities, primarily ethnic ones, in the planning. There is much heterogeneity among individual races, and in some cases, like Asian Americans, even the languages vary. Messages and materials must be translated into local languages and culturally adapted. Respected people, both professional and lay, should be identified with whom to work. Volunteers must be from the local communities as well (refer to the Marketing Foundations Report for considerations when adapting campaign for specific subgroups).

In addition to ethnic and racial subgroups, specific messages and interventions must be geared for the level of awareness of the particular target group (refer to Chart III-3 in the Marketing Foundations Report). For populations with little awareness of osteoporosis, the emphasis will need to be on education about the disease and what it can do to a woman. For those women with the desire to change but needing to be pushed to action, the emphasis would be on making exercise classes more easily available, for example (refer to the Marketing Foundations Report for specific recommendations).

### **Spokesperson**

Although the national spokesperson(s) will hopefully pull in elder women on the local level in culturally diverse communities, having an additional spokesperson who is a respected member of the local community or subgroup should be considered. Some suggestions for an native American and a Latino spokesperson are identified in the Phase III Focus Group Report. Many focus group participants, however, did not feel the person needed to be famous but more importantly someone the members of the local communities could identify with. Depending upon the celebrity level, a local spokesperson could be more available to participate at local events and on local promotional Public Service Announcements.

## Dissemination

In addition to disseminating information to the local level through national channels, local businesses and organizations will play a vital role. Some suggestions for places to post materials and/or hold activities related to the key messages include the following:

- Banks
- Bingo halls
- Busses-inside and outside
- Houses of worship, health ministries
- Dressing rooms of clothing stores, especially those with high percentage of elder clientele
- Fitness clubs
- Food pantries
- Hair/nail salons
- Laundromats
- Meals on Wheels trays
- Pharmacies
- Public libraries
- Public bathrooms
- Restaurants
- Subway platforms / inside subway cars
- Vans providing elder transportation services
- Work sites
- YWCA

Local chapters of some of the national channels mentioned above should take a leadership role in the dissemination on the local level. For example, individual chapters of women's service organizations or local Red Hat Society chapters could carry out the campaign locally when able and appropriate for the particular community.

## Marketing

On the local level, promotion should be carried out via newspapers and television/radio stations. Hospital/health clinic and senior center newsletters have been effective in the past to spread health messages. These resources would be excellent places to utilize local spokespeople identifiable to the community. Grocery stores can engage in promotion through demonstration of high calcium recipes and by having displays of culturally appropriate high calcium foods that are available locally.

Health fairs have been well attended by elder women in the past and are an inexpensive way to get the message across. Many professionals have suggested making osteoporosis part of another message rather than make it yet another issue with which we are asking women to be concerned. Marketing at venues that already have caught women's attention would be congruent with this thinking. Free heel screening has been a successful offering around the country, and pamphlets, promotional items, and demonstrations of weight bearing exercises can be given. Health fairs are an ideal site for distributing nutritional information as well.

Tapping into cultural celebrations has been suggested as an effective way to get the message heard in specific ethnic communities by "piggybacking" onto other events. People are already coming together in large numbers. This is particularly important in lower socioeconomic communities where osteoporosis is not a priority, if indeed

women have even heard of the disease. It is frequently difficult to get these women to come to a health related event.

For many elder women, houses of worship are a major social center and should be central in the campaign. They can both promote the campaign as well as serve as a site for exercise classes, volunteer meetings, and lectures. Particularly in rural areas and among certain ethnic groups, faith-based organizations can serve a key role in the local campaign.

### **Volunteers**

Having a strong local volunteer force is vital component on the local level as well. A community service organization or faith-based organization could take a leadership role organizing volunteers in their own locale. Elder women from one's own community personalize the message and assure more likelihood that messages will be heard and changes sustained. During the Phase III Focus Groups, participants repeatedly asked for the messages to come from women with whom they could identify.

### **Partnering and Joint Ventures**

In addition to the national channels for dissemination, successful health campaigns have utilized strategic partnerships to help give the campaign funding, increased visibility, and in some cases credibility. Such alliances would seem to be critical for the success of a national osteoporosis campaign. Some suggestions for partners are as follows:

#### *Alliance for Better Bone Health*

Aventis and Proctor & Gamble have a preexisting partnership, *Alliance for Better Bone Health*, through which they have sponsored pieces of other osteoporosis programs both here and abroad. This would seem to be a natural partnership to pursue. Pharmaceutical companies obviously have a vested interest in convincing women to get tested for osteoporosis. The results of our Phase I Focus Groups, however, do indicate that some elder women mistrust advertising by pharmaceutical companies to a certain extent at least. This would suggest such a partnership be carefully planned.

#### *Food Corporation*

Forming a partnership with a large food products corporation would seem a natural fit for this campaign. An example of one would be Kraft Foods. Although producing a wide variety of foods, cheese and high calcium foods comprise a significant number of their products. Funding as well as message dissemination on packaging and advertising would be two major benefits of such a partnership. Partnering with a food corporation would get the message on grocery shelves, a strategic location for reaching elder women. In addition, a corporation might do sponsorship marketing such as with a well-advertised celebrity golf tournament or a lift-a-thon. During the kickoff portion of the campaign, the corporation might be willing to donate a percentage of their profits on a single item to the campaign.

Another productive partnership might involve the International Dairy Foods Association (IDFA) that represents many different companies related to the production of dairy products. This kind of campaign could fit nicely with the IDFA mission. Because the membership of the IDFA is comprised solely of businesses large and small with a vested interest in products high in calcium, a partnership with this organization would provide a conduit to a vast array of dissemination venues as well as marketing opportunities.

### *Academic Education*

In addition to private sector corporate joint ventures, partnering with academic entities already focused on elder or osteoporosis education would be a natural collaboration. One such program is the National Association of Geriatric Education Centers which has already been part of some successful osteoporosis campaigns. During the course of this project, professionals involved with a number of these centers have expressed their commitment to a national osteoporosis campaign. This partnership would bring considerable expertise and resources for widespread dissemination of the message as well as access to the technology available on university and medical school campuses. The National Osteoporosis Foundation (NOF) and the Foundation for Osteoporosis Research and Education (FORE) would be resources for collaboration as well.

### **Conclusion**

The momentum for a national osteoporosis campaign is gathering with initiatives starting to surface within Federal agencies. Representatives from the Centers for Medicare and Medicaid Services (CMS) have expressed interest in collaborating with the U.S. Administration on Aging to conduct an osteoporosis campaign. CMS has already tested some materials in focus groups for use in an osteoporosis initiative. With a national network of agencies in place to serve elder women, the U.S. Administration on Aging stands poised to be the ideal department to coordinate a national campaign. During the course of our research, we have had contact with over 250 elder women and have found them eager to both learn about osteoporosis and, more importantly, to change their health behavior to build stronger bones. It is apparent that the time is right for a national osteoporosis awareness and action campaign.



## **Appendix A**

### **Study Instruments and Protocols**

## PHASE I FOCUS GROUP PROTOCOL

### BEFORE LEAVING

- *Pack needed materials and bring extras of everything*
- *Remember pens/pencils, forms, recording device, additional batteries or extension cord, blank tapes of appropriate length (bring extras)*

### PREMEETING

- *Be sure room is set up properly and is accessible, comfortable, private and conducive to open conversation*
- *Test recording device and set up for recording, but do not turn it on*
- *Identify location of bathroom facilities*
- *Collect Participant Profile forms; ask those who did not return a form to complete one before the session starts*

### WELCOME, INTRODUCTIONS & PURPOSE

I'd like to welcome everybody and thank you for coming today. My name is \_\_\_\_\_ and this is/these are \_\_\_\_\_ who will be assisting us today.

We are here today because the University of Maine has received funding from the Federal Government (U.S. Administration on Aging) to find out more about how and where women get information about their health, in general, and about a disease called osteoporosis, in particular.

Osteoporosis is a condition that occurs when bones get thin or develop small holes. It can cause pain, broken bones and loss of body height. Women are much more likely to develop osteoporosis than men and risk increases as women get older. About one half of women who live to be 85 will have suffered a broken bone as a result of osteoporosis.

There are other groups just like this one meeting throughout the United States to help us understand your point of view – the perspective of older women – regarding health information and osteoporosis. Your participation will ultimately help all people at risk of developing osteoporosis by contributing to the creation of health education materials and programs.

Your participation today is completely voluntary and everything you say will remain completely confidential. We are only interested in what is said, not who said it, so no names will be attached to comments. *[Pass out release forms]* Please take a look at this form as I read it to you. *[Read release form and answer questions as necessary]* If you agree to what is stated in this form, kindly sign your name on the “participant” line and date it. *[Collect forms]*.

Keep in mind that we're not trying to come to agreement as a group and there are no right or wrong answers. We want each of you to have a chance to share your own honest point of view. It may be necessary to give you a “one minute more” limit so that so that we can give another person an opportunity to talk or move to another issue to cover as much ground as possible. Please understand that there will be time at the end for you to tell us anything that you didn't have a chance to share. And, it's easiest if we talk one at a time.

Before we begin, let me just mention a few minor details. *[Note availability of refreshments if appropriate; mid-session break if planned; and location of bathroom if this is not a familiar facility to all participants]*

Okay, let's get started.

- *Turn on recording device and be sure it's running*

## DISCUSSION GUIDE

**Q1** Let's start by talking about health in general, not just osteoporosis. We all get health information from many different people and places. We learn about health in many different ways. I'm wondering about all the ways you get health information. Can you tell me about them?

### *Probes*

- By "health information" I mean information about medical problems and diseases, about medicines and treatments, about preventing illnesses by changing habits and behaviors ... things like that.
- We sometimes get health information from professionals and sometimes from people who are not professionals such as personal acquaintances. Do you sometimes learn about health from people you know? [NOTE: This probe must be asked if participants have not fully addressed the subject of specific individuals who offer health information]
- Do you ever read about health? Hear about it on TV or radio?

**Q2** Where do you usually get the best and most reliable health information?

### *Probes*

- Are there certain sources of information you trust more than others?
- Where have you gotten good health information in the past?
- Remember that we can learn about health from people, by reading, on TV and radio, and through other sources.
- [NOTE: Do not move on without participants addressing specific individuals who offer the best/most reliable health information]

**Q3** Now that you've shared sources of good health information, I'd like to ask about sources you don't trust. What are ways you have gotten health information that was not reliable?

### *Probes*

- What people, places or types of health materials do you choose to ignore?
- Are there certain sources of information you trust less than others?
- Where have you gotten unreliable health information in the past?
- Remember that we can get good and bad information about health from people, by reading, on TV and radio, and through other sources.

*Break (if planned) and turn tape over or replace with new tape*

*Shut off recording device during break and TURN IT ON BEFORE RESUMING*

**Q4** Sometimes we get health information, but we don't change our habits or behaviors. Other times, receiving health information causes us to change in some way ... we may decide to seek medical care or take medication ... we may change our habits to stay healthier ... or we may change our behavior in other ways. Have any of you ever done something different as a result of getting health information?

*Probes*

- Where/how did you get the information that caused you to change?
- What was it about the information itself or the source of information that encouraged you to change?
- I'm wondering what exactly motivated you to change ... what were you thinking?
- Did you feel optimistic or hopeful about remaining healthy or becoming healthier? Or perhaps you were scared or nervous about what would happen if you didn't change?

**Q5** Now let's talk specifically about osteoporosis. As I said earlier, osteoporosis is a condition that occurs when bones get thin or develop small holes. It can cause pain, broken bones and loss of body height. Women are much more likely to develop osteoporosis than men and risk increases as women get older. If any of you have done anything to reduce your risk or the impact of osteoporosis, I'd like to hear what you did and what motivated you to do something about it.

*Probes*

- Exactly what health information did you receive and from where?
- What was it about the information itself or the source of information that encouraged you to change?
- I'm wondering what exactly motivated you to change ... what were you thinking?
- Did you feel optimistic or hopeful about remaining healthy or becoming healthier? Or perhaps you were scared or nervous about what would happen if you didn't change?

I see that it's time to wrap up our session. I want to thank you all very much for the valuable information you have shared today. Your comments will play a role in helping all those who have or are at risk of developing osteoporosis.

We will remain here briefly after the session in case there is anything else you would like to share with us.

## Osteoporosis Focus Group-Phase I

### Focus Group Participant Profile

Please answer each of the questions below by checking the appropriate response(s) or filling in the blank. Your answers will remain completely confidential, so do not write your name on this page. Thank you.

1. Age: \_\_\_\_\_

2. Marital Status:

- Married/Partnered       Never married  
 Divorced/Separated       Widowed

3. Race/Ethnicity:

- Non-Hispanic White       Other Hispanic  
 Black       Asian and Pacific Islanders  
 Mexican American       American Indian  
 Puerto Rican       Franco American  
 Other (specify) \_\_\_\_\_

4. Annual Household Income:

- Less than \$10,000       \$10,000 - \$14,999  
 \$15,000 - \$19,999       \$20,000 - \$24,999  
 \$25,000 - \$29,999       \$30,000 - \$34,999  
 \$35,000 - \$39,999       \$40,000 and over

5. Highest Level of Education:

- None       Grammar/Grade School  
 Some High School       High School Graduate/ GED  
 College       Graduate School

6. Living Situation

With whom do you live?

- Live alone       Live with Spouse/Partner  
 Live with Other Relative(s)       Live with Non-relative(s)

Where do you live?

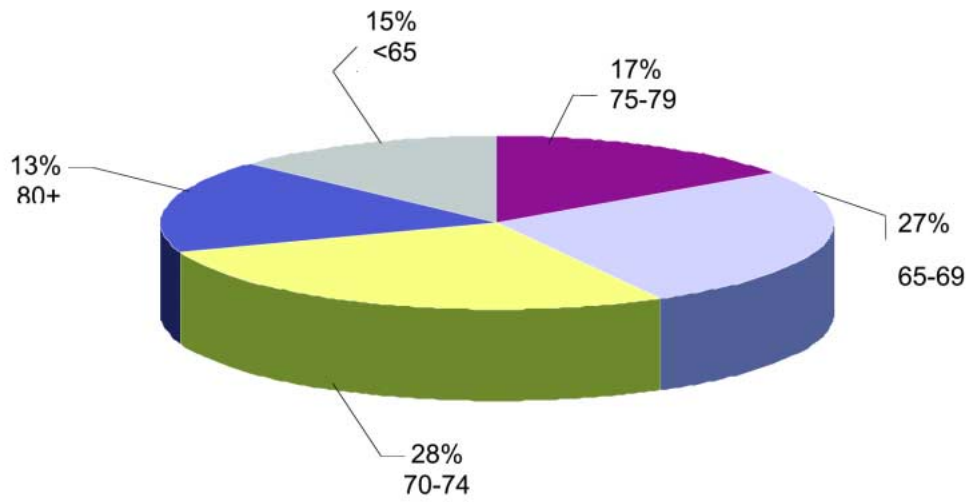
- Live in Own Home/Apartment       Live in Someone Else's Home  
 Live in Congregate Housing (assisted living, nursing home, boarding home)  
 Other (specify) \_\_\_\_\_

7. What is/was your profession (e.g., sales, teaching, homemaker)?

\_\_\_\_\_

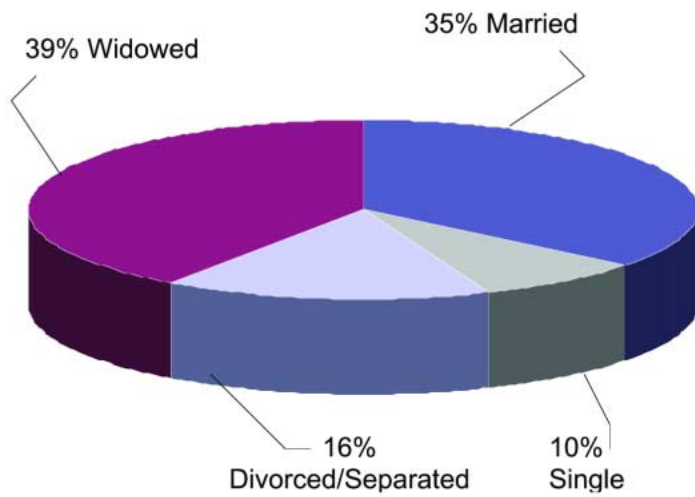
**Phase I Focus Group** *Sample Population: Age (Mean=71)*

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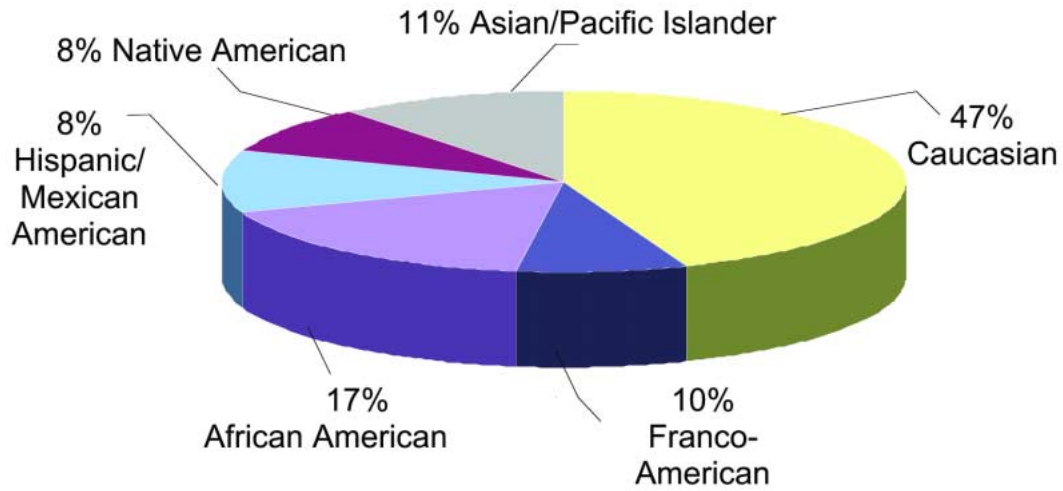
**Phase I Focus Group** *Sample Population: Marital Status*

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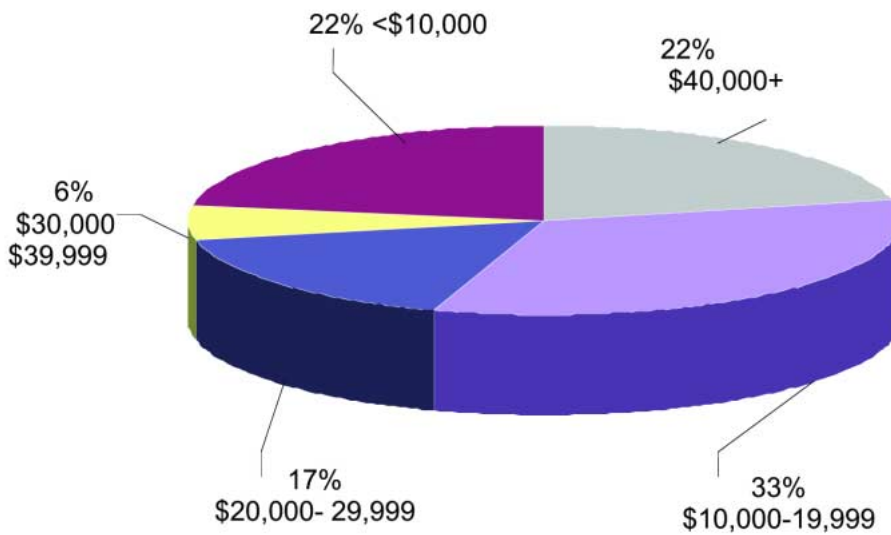
**Phase I Focus Group** *Sample Population: Ethnicity*

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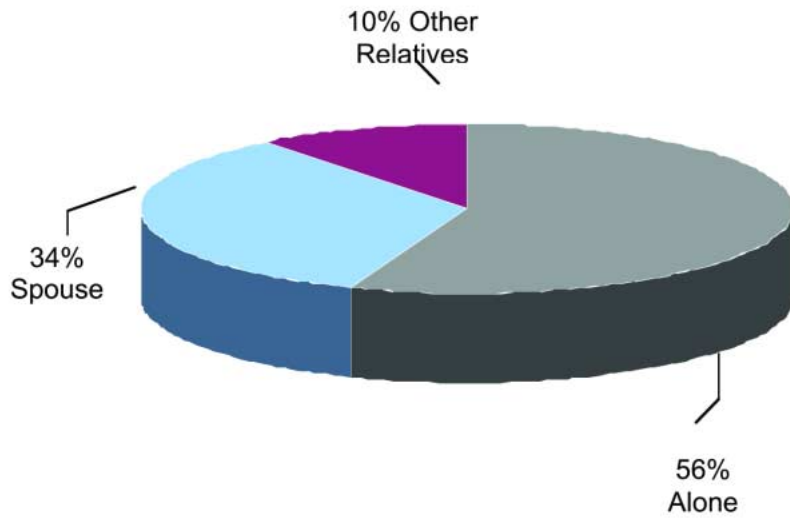
**Phase I Focus Group** *Sample Population: Income Level*

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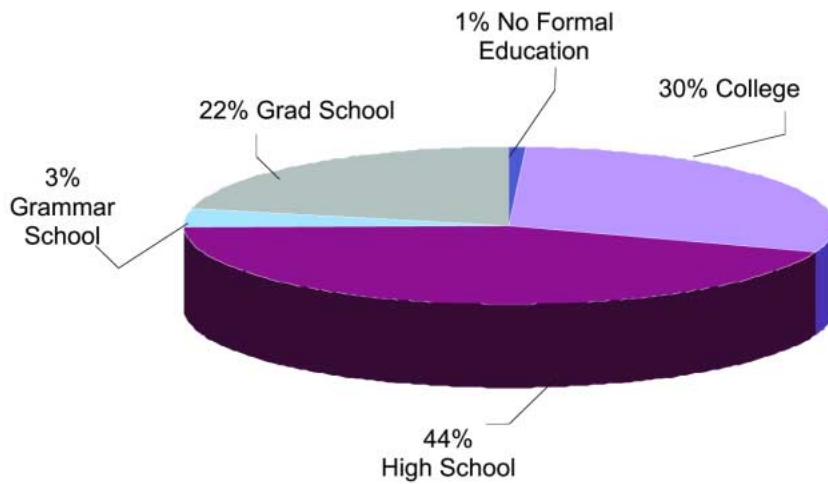
**Phase I Focus Group** *Sample Population: Living Situation*

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**Phase I Focus Group** *Sample Population: Level of Education*

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## Osteoporosis Focus Group

### Informed Consent Form

You have been invited to take part today in a group to get your ideas about items designed to teach older women about osteoporosis ( a disease of thinning bones). This group is part of a larger study being done by the University of Maine Center on Aging and funded by the U.S. Administration on Aging. There are other groups just like this one meeting throughout the U.S. to help us understand your point of view regarding some items that we have developed for teaching older women about osteoporosis. By taking part, you will help people at risk of getting osteoporosis by helping us create useful health education programs. Before we start, we will have you fill out a short form that asks some questions about you (like age, marital status, race, etc.).

During the next 2 hours, we will be asking for your opinions about a number of things. These items have to do with teaching women about osteoporosis and getting them to do what they can to prevent and/or treat this bone disease. You will be asked questions about the choice of color and kinds of messages on a card, your opinion about people to be a famous spokesperson, and your ideas for items to be given away (like magnets or pens) that will help remind women about the disease. We will be voice taping the group, but your comments will be kept completely private. The tape will be used to review comments and ideas, but the names of the people who took part will not be used at all. The tapes will be kept in a locked office at the Center on Aging and destroyed at the end of the study. Out of respect to other people taking part in this, you may not share anyone else's comments outside of this group.

Please note that your involvement is completely voluntary. While we do not expect there to be any risks from taking part in this group, should you feel uncomfortable in any way, you may choose not to answer a specific question or you may leave. By taking part, however, you will help us create better methods of teaching women about preventing and treating osteoporosis.

If after today's group you have other questions about the research, you may contact Dr. Lenard W. Kaye at the University of Maine Center on Aging at (207) 581-3444. If you have any questions about your rights as someone taking part in this group, you may contact Gayle Anderson, Assistant to the University of Maine's Protection of Human Subjects Review Board, at (207) 581-1498 or e-mail [gayle.anderson@umit.maine.edu](mailto:gayle.anderson@umit.maine.edu).

## Osteoporosis Focus Group - Phase II

### Questions for Professionals Involved with Osteoporosis Programs

1. Where do you think this population gets their health information primarily? Differences among ethnic/socioeconomic groups?
2. What do you think they find most reliable? Differences among different groups?
3. What sources do they not consider reliable? Again, differences among groups?
4. What types of messages do you think work to get women's attention? Suggestions for reaching specific subgroups (like poor, inner city, ethnic)?
5. What does your program do for marketing? Are there informal networks you've found particularly effective?
6. In your experience, what brings people to your program? Which groups have been the most difficult to get engaged? Why do you think this is?
7. In your experience, what seems to be the most frequent motivation for women following through with your program?
8. What sorts of educational outreach programs do you have and what ideas do you have for some that would be helpful if you had the funding?
9. How does your patient support component work? Do you have thoughts on how else to utilize a buddy system approach to reach elder women?
10. What components of your program have you tried and found not to work in educating and motivating women to change their behavior? Why do you think these weren't effective?
11. What have been the most successful parts of your program? Why do you think these have worked so well?
12. What are the most important issues you feel we should keep in mind when we formulate the final awareness campaign?

## Interview Questions for Professionals in Specialty Fields

1. What themes and messages about osteoporosis should be highlighted in materials distributed to older post-menopausal women in order to alter their attitudes, knowledge, and risk-taking behaviors? (Please provide specific themes to emphasize and wording examples for messages).
2. In what ways should the themes and messages be customized, if any, to reflect the special challenges of reaching minority populations of older post-menopausal women? (Please provide examples for particular minority groups such as African Americans, Asian Americans, Latinos, American Indians, etc.).
3. Through what means should the message be delivered for various groups of older women? That is, what tools and mechanisms are best used to reach post-menopausal women (i.e., brochures, ads, public service announcements, websites, etc.)
4. In what ways should these tools and mechanisms be customized, if any, to reflect the special challenges of reaching minority populations of older post-menopausal women? (Please provide examples for particular minority groups such as African Americans, Asian Americans, Latinos, American Indians, etc.).

## **Osteoporosis Focus Group - Phase III**

### **University of Maine Center on Aging Osteoporosis Action Campaign: Design and Communications Focus Group Protocol January 2004**

#### ***Structure***

A minimum of 8 focus groups will be held during the month of January 2004 in the Omaha, Atlanta, Chicago and Philadelphia metropolitan areas, as well as in rural California and several locations around the state of Maine. Additional locations may be added. Each focus group will consist of 10 - 15 participants and will last up to two hours with a break after approximately one hour.

#### ***Facilitation***

Each focus group will be conducted by a trained facilitator who has primary responsibility for the events of the sessions. The facilitator is responsible for explaining the session to participants and for obtaining informed consent. He/she will facilitate focus group discussion, ensure that all participants have an opportunity to speak, and audiotape the proceedings.

#### ***Supplies***

The following supplies will be brought to each focus group session:

- Audio device with extra dated and numbered tapes for recording
- Consent forms
- Demographic survey with lined/numbered paper attached
- Extension cord
- Name tags (optional)
- Pad and pen for facilitator use
- Pens for participants
- Picture boards and related visual cues
- Power cord and extension cord for audio equipment
- Refreshments (optional)
- Two new sets of batteries for audio equipment

#### ***Participants***

Focus group participants will be post-menopausal women 60 and over who have volunteered to participate. They will be informed in advance of the auspice and general purpose of the investigation. Participants will be selected and invited in advance by the host organization staff.

#### ***Location***

Focus groups will be held at handicap-accessible host locations, often human service organizations. The sessions will take place in private rooms or areas with a table and chairs to comfortably accommodate the number of women present. The room will be in close proximity to restroom facilities.

## **Discussion Guide**

Participants will be welcomed as they enter the room and invited to take refreshments and find a seat. The facilitator will answer only those questions that do not influence or introduce bias into the investigation and politely circumvent others.

### **UPON ARRIVAL, TEST AUDIO EQUIPMENT TO BE SURE IT RECORDS**

*I'd like to welcome everyone here today and thank you all for coming. My name is \_\_\_\_\_. Before we begin, I just want to take care of a few minor details. First of all, the ladies' room is (describe location). Our discussion should last about two hours and we will take a break half way through. If you need to use the rest room at another time, please feel free to do so.*

*As you already know the purpose of our discussion today is to get your opinions on materials about osteoporosis, a bone disease that affects many older women. I will be asking several questions and showing you some pictures and I hope you will all feel free to speak up. There are no right or wrong answers, so anything you have to say about the topic being discussed is important. Some of you may at times disagree with each other and that's fine. We want to hear all opinions. Your honest and open responses will contribute to important research about helping people take action to reduce their risk of osteoporosis. Because we are limited to two hours, I may have to interrupt at times to keep things moving along. I hope you'll understand.*

(Allow opportunity for quick questions)

*Everything you say here today is completely confidential. Your names will not be associated in any way with the information discussed. This also means that, outside of this session, you should not repeat anything another group member says. We should all respect each others' confidentiality. Okay?*

(Await verbal consent or nods)

*Your participation today is completely voluntary. We will not be discussing or viewing anything that we believe is unpleasant or disturbing. But, if you choose to you may leave now or, if you feel uncomfortable at any point during the discussion, you may leave whenever you wish.*

*Any questions before we go on?*

(Hand out consent form and pens)

*I am passing out a consent form for you to read. Let me read it to you (read from form). Any questions?*

(Hand out demographic survey with attached lined paper)

*I'm handing out a very brief questionnaire that you will NOT put your name on because we are only interested in getting some information on the group as a whole. We will not keep information about you personally. Please answer the questions and then hold on to it. I will collect them at the end of the session.*

(Allow time for survey completion. If anyone has trouble writing, explain that they may simply share their responses verbally when others will be writing a few responses later in the session.)

## START TAPE AND MAKE SURE IT IS RUNNING

(Start by putting piles of “mock brochures” on the table)

*I have some osteoporosis information here for you. There’s only enough for each of you to take one total – not one of each – so please help yourselves to any single brochure of your choosing.*

(Wait for each woman to select one and be sure each person takes one only)

### Question 1

*I’m wondering why each of you selected the one you chose. What was it about that one that made you take it instead of the others?*

(To the extent possible have everyone refer to the mock brochures by identifying number.)

*Probe:*

*What were you thinking as you were trying to make the decision?*

*Probe:*

*Was it something about the appearance?*

*Probe:*

*Did you look at the wording before you picked it out?*

*Probe:*

*Was there something that you didn’t like about the ones you didn’t pick?*

### Question 2

*Please get out the pen and lined paper handed out with your survey. Rather than saying your answers, I will be asking you to write down a few words in a moment. Do you see where it shows the number one on the top of the page? That’s where you will begin writing in a moment.*

(Show first design elements only)

*Take a look at this picture. Now next to the number one, please write the first words that come to mind when you look at this picture. There are no right or wrong answers. Just the first words that come to mind.*

(Allow just a brief period of time in which they can write their immediate responses. Politely discourage verbal responses.)

*Now we are going to do the same thing with some other pictures, one at a time. For this next one, please write the words that come to mind next to number two. Be sure not to change any earlier words that you wrote. We want to see your first reaction.*

(Show second design element only)

(Repeat process for each design element)

### Question 3

*Now let's talk a little bit about the words you wrote down. Tell me about what you wrote for picture number one.*

*Probe:*

*Can you tell me more about that?*

*Probe:*

*Is it a picture that would make you want to look closer?*

*Probe:*

*Did it remind you of anything?*

(Repeat for each subsequent design element)

### STOP TAPE

(Give participants a 15 minute break to use the bathroom and get more refreshments.)

### TURN OVER TAPE, TEST, AND RESUME RECORDING

### Question 4

*Now we are going to look at some words and phrases. Some may be familiar to you and others may not. This time I'm going to ask you to write your quick response next to number X.*

(Display first wording)

*Is this a phrase that you've seen before? Please write down either "yes" or "no." You don't need to write anything else ... just "yes" or "no."*

*Now let's talk about this a little. Whether you are familiar with this phrase or not, what do you think it means?*

*Probe:*

*Is this an expression (wording) that you ever use?*

*Probe:*

*Who do you associate this language with? Who uses this expression?*

*Probe:*

*What is your overall reaction to it?*

(Repeat for each of the other expressions/phrases)

### Question 5

*I wanted to talk about famous people who become associated with a particular product. You may have seen the ice skater Dorothy Hammill in commercials and advertisements for “the little purple pill” and Bob Dole as the spokesman for Viagra. For a long time the actress Betty White was associated with a humane organization for animals.*

*Let’s think about osteoporosis now. What type of person would be a good spokesperson for encouraging women to get tested and treated for osteoporosis?*

*Probe:*

*How do you feel about the spokesperson being a man vs. a woman?*

*Probe:*

*Would you prefer to see someone your own age or younger?*

*Probe:*

*Which do you think would be better ... (list one at a time giving opportunity for responses; skip any pairs that have previous been addressed in discussion.)*

*A political figure or an actor/actress?*

*A doctor or a famous athlete?*

*A talk show host or a politician?*

*An actor/actress or a doctor?*

*A famous athlete or an actor/actress?*

*A doctor or a politician?*

*A talk show host or a famous athlete?*

*An actor/actress or talk show host?*

*A political figure or an athlete?*

*A doctor or a talk show host?*

*Probe:*

*Can you name specific people who you think would be good spokespeople?*

*Probe:*

*What about someone who is well-known in your community or state instead of a nationally known person?*

### Question 6

*Many times we get things called promotional items for free. Examples of promotional items are pens with an organization’s name on them and refrigerator magnets with information on them about an organization or a professional such as a doctor or painter. Key chains, calendars, pill organizers, and mugs may also be imprinted with information about a service or program. Do you know the kinds of things I mean? (Await response) Can you tell me what types of these things – these promotional items – you have kept in the past and what person or organization they advertised?*

*(For each, make sure they say whether or not they know the name of the person/organization being advertised.)*



*Probe:*

*Which of these items do you look at or use several times each week?*

*Probe:*

*Can you think of items we haven't discussed that would be good promotional items that can be imprinted with a reminder to get tested and treated for osteoporosis?*

### **Closing**

*I would like to thank you for your participation. I also want to restate that what you have shared with me is confidential. No part of our discussion that includes names or other identifying information will be used in any reports, displays, or other publicly accessible media coming from this research. Finally, I want to provide you with a chance to ask any questions that you might have about this research. Do you have any questions for me?*

(Give opportunity for questions and answers)

*If you have any questions after you leave today, you can contact \_\_\_\_\_ at \_\_\_\_\_*  
(hand out card with phone number)

*Thank you again.*

**TURN OFF AUDIO EQUIPMENT AND CONFIRM THAT TAPE IS MARKED WITH DATE AND LOCATION**

### Osteoporosis Focus Group - Phase III

Please answer each of the questions below by checking the appropriate response(s) or filling in the blank. Your answers will remain completely confidential, so do not write your name on this page. Thank you.

1. Age: \_\_\_\_\_

2. Marital Status:

- Married/Partnered       Never married  
 Divorced/Separated       Widowed

3. Race/Ethnicity:

- White (non-Hispanic)       Hispanic  
 African American       American Indian  
 Asian and Pacific Islander       Franco American  
 Other (specify) \_\_\_\_\_

4. Annual Household Income:

- Less than \$10,000       \$10,000 - \$19,999  
 \$20,000 - \$29,999       \$30,000 - \$39,999  
 \$40,000 - \$49,999       \$50,000 and over

5. Highest Level of Education:

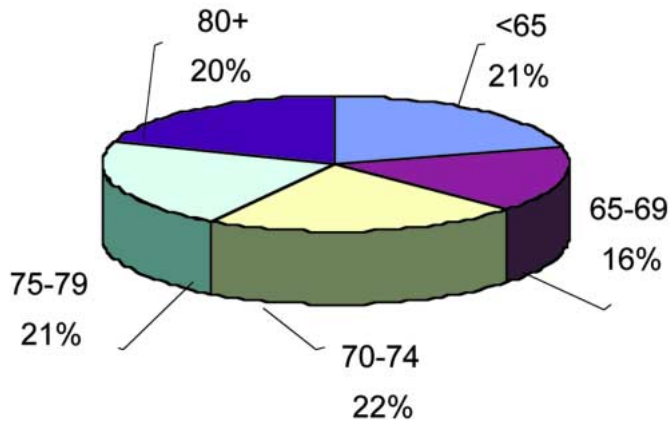
- None       Grammar/Grade School  
 High School/ GED       Associate/Vocational/Technical  
 College       Graduate School

6. Do you usually use any of the following:

- Cane       Walker  
 Wheelchair       Scooter

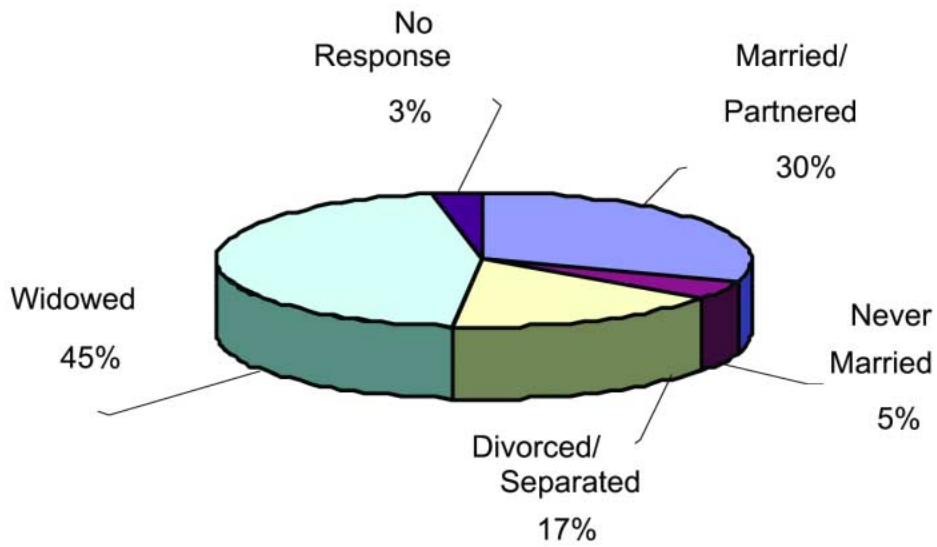
**Phase 3 Focus Group** *Sample Population: Age (Mean=72 Years)*

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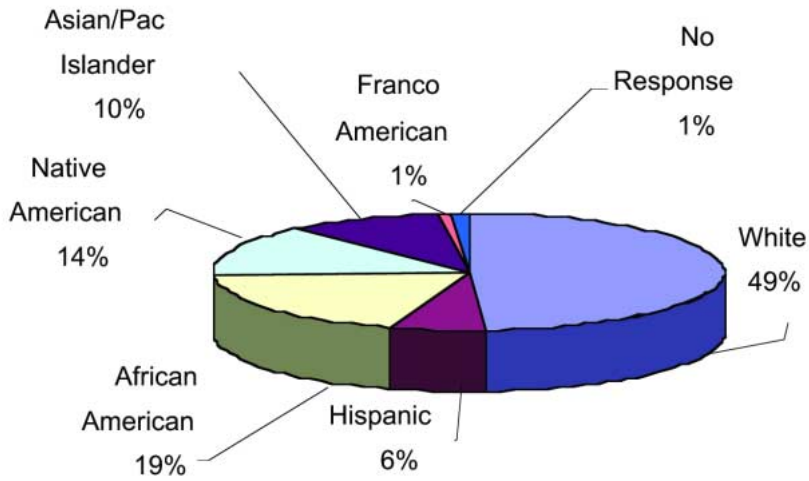


**Phase 3 Focus Group** *Sample Population: Marital Status*

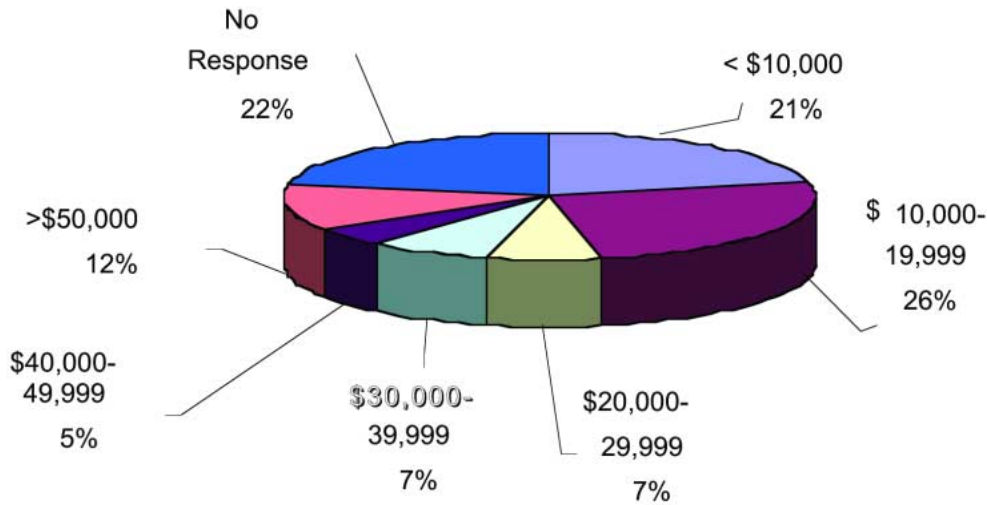
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**Phase 3 Focus Group** *Sample Population: Ethnicity*

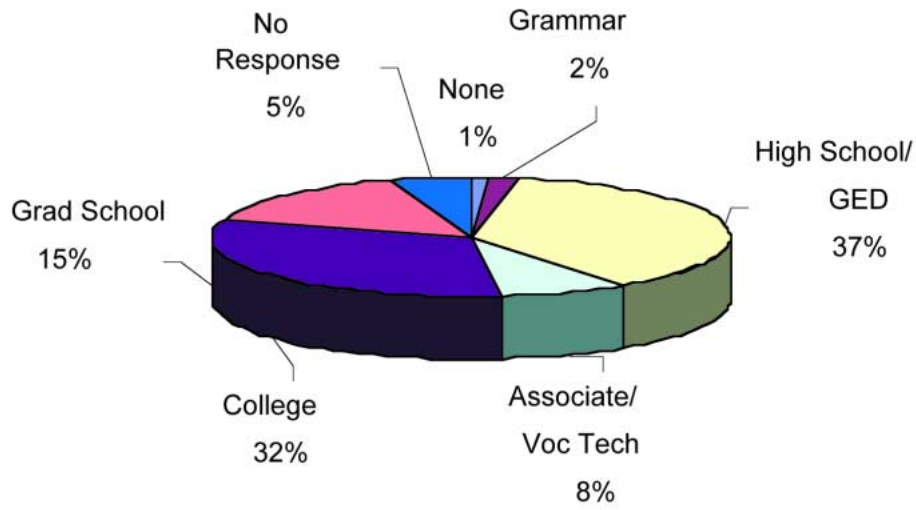


**Phase 3 Focus Group** *Sample Population: Ethnicity*



**Phase 3 Focus Group** *Sample Population: Highest Education Level*

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## Osteoporosis Focus Group

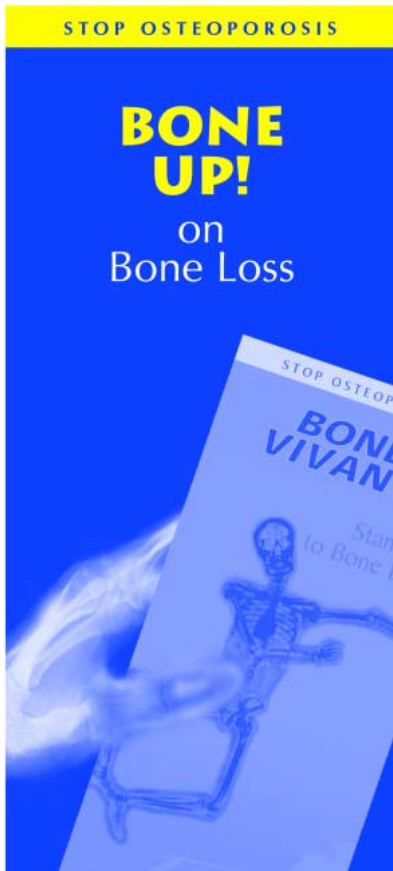
### Informed Consent Form

You have been invited to take part today in a group to get your ideas about items designed to teach older women about osteoporosis ( a disease of thinning bones). This group is part of a larger study being done by the University of Maine Center on Aging and funded by the U.S. Administration on Aging. There are other groups just like this one meeting throughout the U.S. to help us understand your point of view regarding some items that we have developed for teaching older women about osteoporosis. By taking part, you will help people at risk of getting osteoporosis by helping us create useful health education programs. Before we start, we will have you fill out a short form that asks some questions about you (like age, marital status, race, etc.).

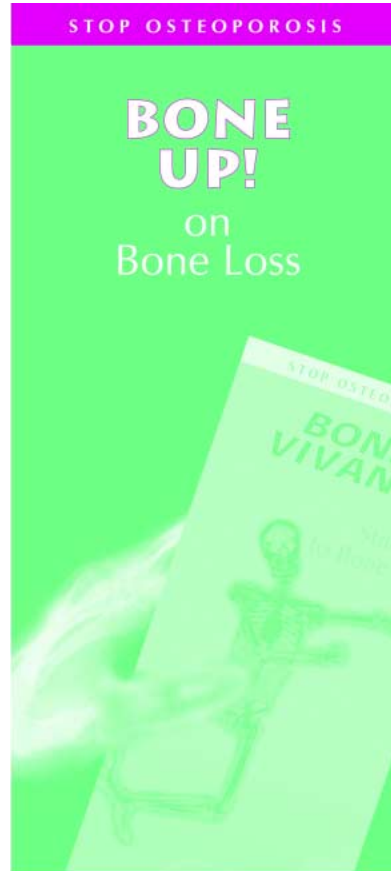
During the next 2 hours, we will be asking for your opinions about a number of things. These items have to do with teaching women about osteoporosis and getting them to do what they can to prevent and/or treat this bone disease. You will be asked questions about the choice of color and kinds of messages on a card, your opinion about people to be a famous spokesperson, and your ideas for items to be given away (like magnets or pens) that will help remind women about the disease. We will be voice taping the group, but your comments will be kept completely private. The tape will be used to review comments and ideas, but the names of the people who took part will not be used at all. The tapes will be kept in a locked office at the Center on Aging and destroyed at the end of the study. Out of respect to other people taking part in this, you may not share anyone else's comments outside of this group.

Please note that your involvement is completely voluntary. While we do not expect there to be any risks from taking part in this group, should you feel uncomfortable in any way, you may choose not to answer a specific question or you may leave. By taking part, however, you will help us create better methods of teaching women about preventing and treating osteoporosis.

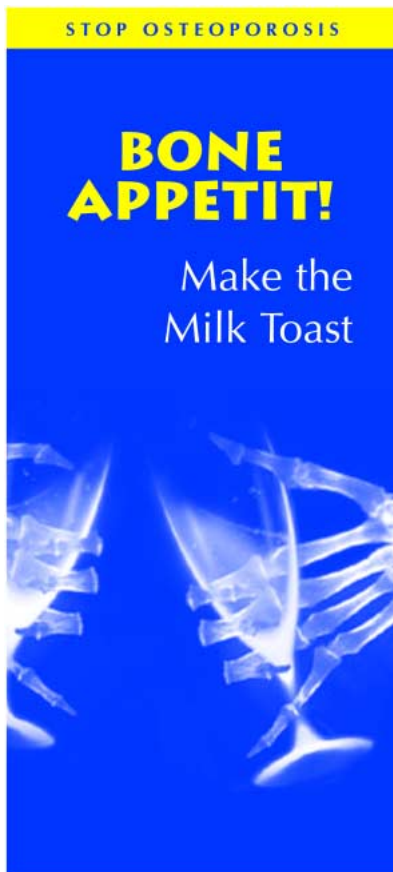
If after today's group you have other questions about the research, you may contact Dr. Lenard W. Kaye at the University of Maine Center on Aging at (207) 581-3444. If you have any questions about your rights as someone taking part in this group, you may contact Gayle Anderson, Assistant to the University of Maine's Protection of Human Subjects Review Board, at (207) 581-1498 or e-mail [gayle.anderson@umit.maine.edu](mailto:gayle.anderson@umit.maine.edu).



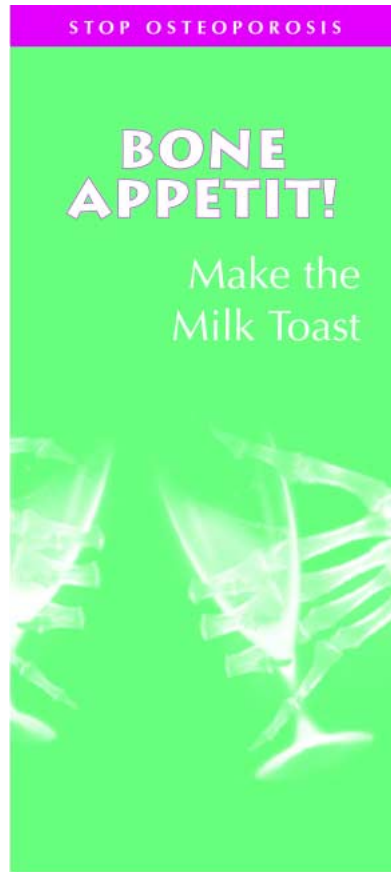
Brochure A



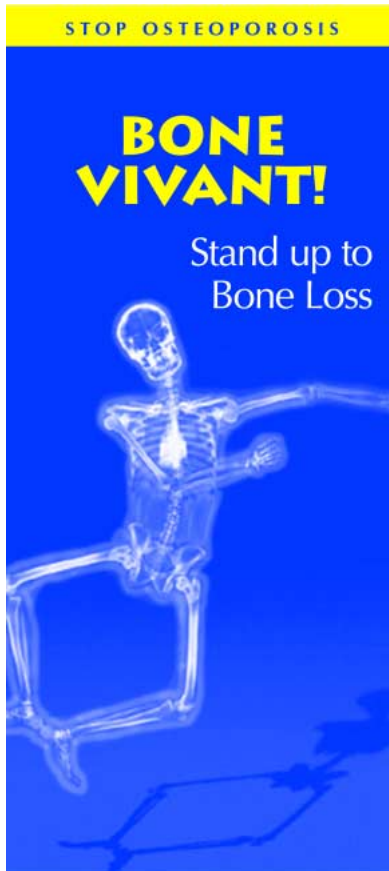
Brochure B



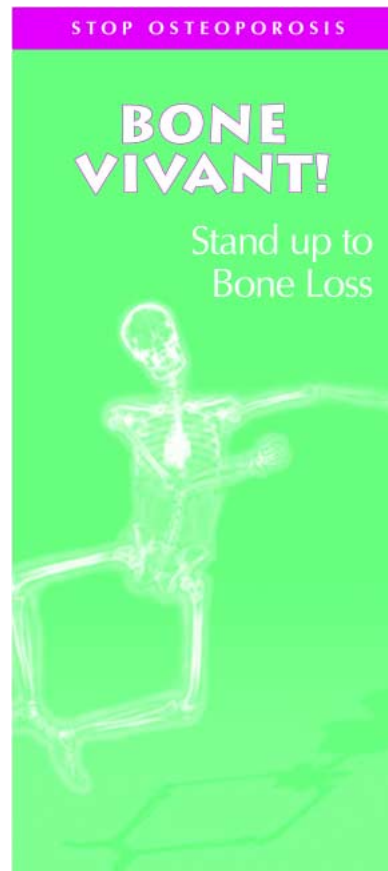
Brochure C



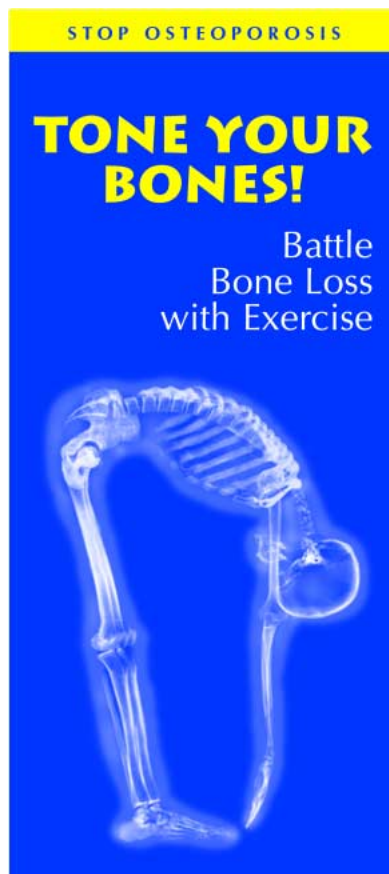
Brochure D



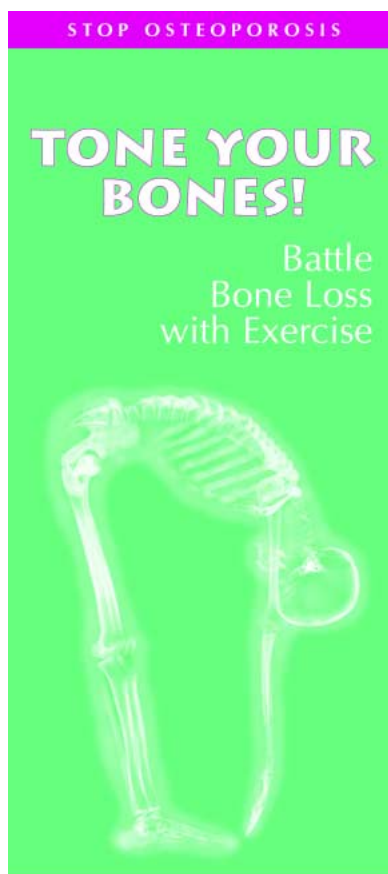
Brochure E



Brochure F

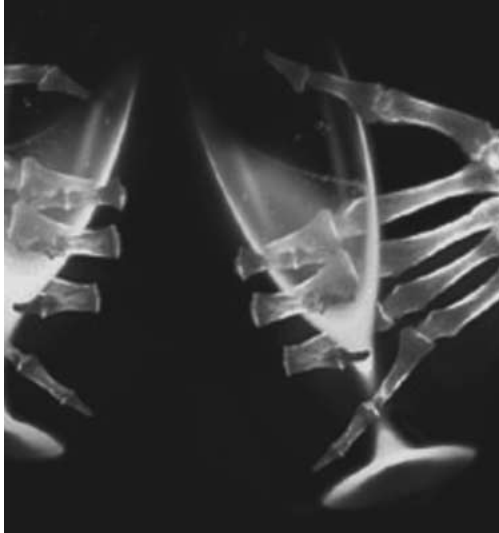


Brochure G

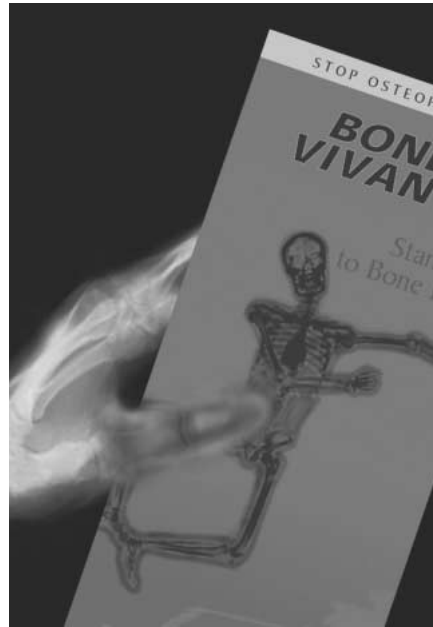


Brochure H





Graphic 1



Graphic 2



Graphic 3



Graphic 4

**BONE  
APPETIT!**

Message 1

**BONE  
UP!**

Message 2

**TONE YOUR  
BONES!**

Message 3

**BONE  
VIVANT!**

Message 4

## **Appendix B**

### **Focus Group Sites**

## Focus Group Sites- Phase I

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<b>Location</b>	<b>Composition</b>	<b>Site</b>
<b><u>California:</u></b>		
San Francisco	.....Asian American	.....Senior Center
San Francisco	.....Latino	.....Senior Center
San Francisco	.....African American	.....Senior Center
<b><u>Kansas</u></b>		
Manhattan	.....Caucasian	..... AAA
<b><u>Maine</u></b>		
Bangor	.....Caucasian	.....AAA
Bangor	.....Caucasian, Franco American	.....NCOA office Employed
Biddeford	.....Franco American	.....Community Center
Indian Island	.....Native American	.....Penobscot Reservation
Presque Isle	.....Caucasian, Franco American	.....AAA
Waterville	.....Caucasian, Franco American	.....Community Center
Wilton	.....Caucasian, Franco American	.....Rural Community Center
<b><u>New York</u></b>		
New York City	.....Visually impaired, Mixed races	.....Lighthouse International
<b><u>Pennsylvania</u></b>		
Chester	.....African American	..... Inner city Senior Center

**Focus Group Sites- Phase III**

---

<b>Location</b>	<b>Composition</b>	<b>Site</b>
<b><u>California:</u></b>		
Eureka .....	Mixed.....	Meal site
Hoopa .....	Native American.....	Hupa Reservation
San Francisco .....	Filipino .....	Meal site

<b><u>Georgia</u></b>		
Atlanta.....	African American .....	Senior Center
College Park .....	African American .....	Senior Center

<b><u>Illinois</u></b>		
Calumet City .....	African American .....	Meal site
	Caucasian	
Chicago .....	Latino .....	Hospital

<b><u>Maine</u></b>		
Bangor.....	Caucasian .....	Senior Center
Bangor.....	Mixed .....	Congregate Living Fac.
Indian Island .....	Native American.....	Penobscot Reservation
Orrington.....	Caucasian .....	Meal site
Penobscot .....	Mixed .....	Meal site

<b><u>New York</u></b>		
New York City .....	Caucasian .....	Private Home



**Appendix C**  
**Focus Group Coordinators and Facilitators**

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## Phase I Focus Group Facilitators and Coordinators

**Brenda Barker**

Director of Community Service  
Aroostook Agency on Aging  
Presque Isle, ME

**Roberta Downey**

Executive Director  
Eastern Agency on Aging  
Bangor, ME

**Sandy Gregor**

Coordinator  
Seniors Plus Community Center  
Wilton, ME

**Marjie Harris, LCSW**

Project Director  
Center on Aging  
University of Maine  
Orono, ME

**Erlene M. Paul**

Director  
Penobscot Nation  
Department of Human Services  
Indian Island, ME

**Cynthia Stuen, DSW**

Senior VP for Education  
Lighthouse International  
New York, NY

**Darlene Yee, Ed.D**

San Francisco State University  
San Francisco, CA

**Carmen Bedard**

Center Coordinator  
Muskie Community Center  
Waterville, ME

**Traci Fowler**

Program Manager  
The National Council on Aging  
Bangor, ME

**Lawrence W. Gross**

Executive Director  
Southern Maine Agency on Aging  
Portland, ME

**Eloise M. O'Neill**

Executive Director  
Seniors Plus  
Lewiston, ME

**Muriel Scott**

Executive Director  
Senior Spectrum  
Augusta, ME

**Norma D. Thomas, DSW**

President  
Center on Ethnic and Minority Aging, Inc.  
Philadelphia, PA



### Phase III Focus Group Facilitators and Coordinators

**Kathryn Bernier**

Executive Director  
Hammond Street Senior Center  
Bangor, ME

**Emily Burns-Love**

Senior Services Worker  
Penobscot Nation  
Indian Island, ME

**Carolyn Coombs**

Dining Room Manager,  
Orrington Meal Site  
Eastern Agency on Aging  
Bangor, ME

**Jean Gearing**

Arthritis and Osteoporosis Program Manager  
Division of Public Health Chronic Disease  
and Health Promotion  
Atlanta, GA

**Jessica Getzel**

3967 Sedgwick Ave.  
Bronx, NY

**Marjie Harris, LCSW**

Project Director  
Center on Aging  
University of Maine  
Orono, ME

**Karen Higgins**

Administrator  
Phillips-Strickland House and Boyd Place  
Bangor, ME

**Jane Horton**

Dining Room Manager,  
Penobscot Meal Site  
Eastern Agency on Aging  
Bangor, ME

**Susan Kaye, MSW, MBA**

Packard Judd Kaye  
Bangor, ME

**Lisa Keeler**

Community Programs Manager  
Illinois Dept of Public Health  
Office of Women's Health  
Chicago, IL

**Deborah Krzesni RD,**

Consultant Dietician  
Area 1 Agency on Aging  
Eureka, CA

**Kristin Nadeau**

Program Associate  
Center on Aging  
University of Maine  
Orono, ME

**Gail Ward**

Director of Nutrition  
Eastern Agency on Aging  
Bangor, ME

**Stella Wu Chu, MA, RD**

Nutritionist, Office on Aging  
Dept. of Aging and Adult Services  
San Francisco, CA



**Appendix D**  
**Phase II Experts Interviewed**

## Professionals Interviewed in Phase II

**Judy Andariese, RN**

Director, Osteoporosis Prevention Center  
Hospital for Special Surgeries  
New York, NY

**Maria Baeza, LCSW**

Clinical Social Worker  
Bangor, ME

**Elaine Chambers, RN**

Director, Breast and Osteoporosis Center  
Eastern Maine Medical Center  
Bangor, ME

**Gloria Edwards, PhD.**

Director Program for Multicultural  
Health Services  
University of Michigan  
Ann Arbor, MI

**John Hennon, EdD**

Geriatric Education Center  
University of Pittsburgh  
Pittsburgh, PA

**Sharon Hoelscher Day, M.A.**

Family and Consumer Services  
University of Arizona Cooperative Extensions  
Phoenix, AZ

**Karen Kim**

"Living Healthy: The Asian American  
Woman's Osteoporosis Education Initiative"  
National Asian Women's Health Organization  
San Francisco, CA

**Peggy Lassanske**

President, Elder Floridians Foundation  
Tallahassee, FL

**Robin Long**

Caring Connections  
Bangor Brewer YWCA  
Bangor, ME

**Betsy McClung, RN**

Associate Director  
Oregon Osteoporosis Center  
Portland, OR

**Michelle Mosner, RD**

Coordinator, NYSOPEP  
Clinical Research Center  
Helen Hayes Hospital  
West Haverstraw, NY

**Charlotte Nelson**

Executive Director  
Iowa Commission on the Status of Women  
Des Moines, IA

**Roberta Newton, PT, PhD**

College of Allied Health Professions  
Temple University  
Philadelphia, PA

**Ruth Palombo**

Director, Office of Elder Health  
Massachusetts Department of Public Health  
Boston, MA

**Mary Pittaway**

Nutrition Services Supervisor  
Missoula City-County Health Dept.  
Missoula, MT

**Laura Robbins, DSW**

Director of Education  
Hospital for Special Surgeries  
New York, NY

**Mary Snobl**

Minnesota Board on Aging  
Wisdom Steps Liaison  
St. Paul, MN

**Shirley Weaver, PhD**

Associate Director  
Harvard Upper New England  
Geriatric Education Center  
Boston, MA

**Gerry Weil**

Director, Bone Builders  
RSVP Vermont  
Rutland, VT

**Appendix E**  
**Blue Ribbon National Steering Committees**

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## Blue Ribbon National Steering Committee on Aging and Older Women

**Bonita Lynn Beattie, PT**  
Assistant Vice President  
Research and Demonstrations  
Director  
Health Education Programs  
National Council on the Aging  
Washington, DC

**Susan Collins,**  
US Senator for Maine  
Senate Special Comm. On Aging and the  
Committee on Health, Education, and Labor  
Washington, DC

**Lou Glasse**  
National OWL, and Chair  
Task Force on Women  
Gerontological Society of America  
Washington, DC

**Sandy Markwood**  
CEO  
NAAAA  
Washington, DC

**Janet S. Sainer, M.S.W.**  
Special Consultant  
Brookdale Foundation Group  
New York, NY

**Jane E. Smith, CEO**  
Business and Professional Women USA  
Washington, DC

**Laura M. Young, Ph.D.**  
Executive Director  
The Voice of Midlife and Older Women  
Washington, DC

**Gloria Cavanaugh,**  
President and CEO,  
American Society on Aging,  
San Francisco, CA

**Laura Gitlin, Ph.D.,**  
Director  
Community & Homecare Research Division  
Thomas Jefferson University  
Philadelphia, PA

**Nancy Hooyman, Ph.D.**  
Professor and Past Dean  
School of Social Work  
University of Washington  
Seattle, WA

**Carmela G. LaCayo, Ph.D.**  
President/CEO  
National Association for Hispanic Elderly  
Pasadena, CA

**Phyllis H. Mutschler, Ph.D.**  
Executive  
National Center on Women and Aging  
The Heller School  
Brandeis University  
Waltham, MA

**Robert J. Schreiber, MD**  
Medical Director of Geriatric  
Lahey Clinic-Burlington  
Burlington, MA

**Marta Sotomayor**  
Executive Director  
National Hispanic Council on Aging  
Washington, DC

---

## Blue Ribbon National Steering Committee on Osteoporosis Education and Research

**Dennis Black, M.D.**

Professor, University of California  
at San Francisco  
San Francisco, CA

**Deborah T. Gold, Ph.D.**

Associate Professor  
Department of Psychology, Psychiatry,  
Behavioral Sciences and Medical Sociology  
Duke University  
Durham, NC

**Susan L. Greenspan, M.D.**

Director, Osteoporosis Prevention and  
Treatment Center  
University of Pittsburgh  
Pittsburgh, PA

**Cathy R. Kessenich, D.S.N., ARN**

Associate Professor, University of Tampa  
Nurse Practitioner, Osteoporosis Testing Center  
Tampa, FL

**Douglas P. Kiel, M.D.**

Associate Professor of Medicine  
Harvard Medical School Div. of Aging  
and Brown University School of Medicine  
Director of Research, Beth Israel Medical  
Center/Hebrew Rehab. Center  
Boston, MA

**Betsy L. McClung, M.N., R.N.**

Associate Director, Oregon Osteoporosis  
Center  
Portland, OR

**Robert R. Recker, M.D.**

Professor, School of Medicine  
Director, Osteoporosis Research Center  
Creighton University  
Omaha, NE

**Olympia J. Snowe,**

United States Senator  
Washington, DC





## **Appendix F**

### **Local Advisory Board**

## Local Advisory Board

**Marie R. Albert, D.O.**

Sunbury Primary Care  
Corinth Family Medicine  
Corinth, ME

**Brenda Barker**

Director of Community Services  
Aroostook Agency on Aging  
Presque Isle, ME

**Laurel Coleman, MD, FACP**

Geriatric Medicine  
Augusta, ME

**Nelson E. Durgin**

Executive Director  
Phillips-Strickland House  
Bangor, ME

**Christine Gianopoulos**

Director  
State of Maine  
Department of Human Services  
Bureau of Elder and Adult Services  
Augusta, ME

**Ann M. Hanlon, M.D.**

Sunbury Primary Care  
Hampden Family Medicine  
Hampden, ME

**Pam Allen**

Executive Director  
SeniorsPlus  
Lewiston, ME

**Elaine Briggs**

Special Projects Director  
Aroostook Agency on Aging  
Presque Isle, ME

**Roberta Downey**

Executive Director  
Eastern Agency on Aging  
Bangor, ME

**Betty Forsythe**

Assistant to the Director  
State of Maine  
Department of Human Services  
Bureau of Elder and Adult Services  
Augusta, ME

**Lawrence W. Gross**

Executive Director  
Southern Maine Agency on Aging  
Portland, ME

**Muriel Scott**

Executive Director  
Senior Spectrum  
Augusta, ME

**UMaine Center on Aging  
Maine Center for Osteoporosis Research and Education**

*Osteoporosis Awareness Campaign Local Advisory Board Meeting*

**Monday June 2, 2003**

**10:00am — 1:00 pm**

Eastern Agency on Aging

450 Essex St.

Bangor, ME

## **MINUTES**

### **I. Introductions**

Len Kaye (Center on Aging)

Roberta Downey (Eastern Area Agency on Aging)

Muriel Scott (Senior Spectrum)

Dr. Laurel Coleman

Elaine Briggs (Aroostook Area Agency on Aging)

Brenda Barker (Aroostook Area Agency on Aging)

Nelson Durgin (Philips-Strickland House)

Dr. Cliff Rosen (Maine Center for Osteoporosis Education and Research)

Marjie Harris (Center on Aging)

Leah Ruffin (Center on Aging)

### **II. Overview**

#### **A. Dr. Rosen reviewed state of Osteoporosis awareness in Nation and Maine**

- Previously thought to be age related. Treated poorly by many doctors.
- Now have great drugs/ new technology
- Many doctors still not asking/screening older adults for risk.
- Few older adults asking doctor about screening.
- Risk factors—previous fractures/bone density/ aging (post menopausal)
- Challenges—help older adults become aware 1) of serious implications of disease 2) previous fractures are highest risk indicators 3) testing & treatment is available.
- Calcium supplement compliance among older adults a problem. Less than 50% compliance in trials—size of pill and remembering supplements key issues. Question of effectiveness for prevention of fractures.

### **III. Overview of the Goals and Objectives of the Grant and its Partnerships**

#### **A. Grant by US Administration on Aging to 3 partners**

- UMaine Center on Aging
- National Osteoporosis Foundation
  - i. Conducting national survey of older adults
- Foundation for Osteoporosis Research and Education
  - ii. conducting 2 national summits in CA

#### **B. Focus: Post Menopausal Women who are not communicating with their Doctors about Osteoporosis.**

#### **C. Center on Aging**

- Conducted Focus groups in 5 states including ME
- 2003 Goal: To produce clear marketing recommendations for awareness campaign. Testing to begin fall 2003

### **IV. Status of Activities**

#### **A. Focus groups completed**

- Data gathered/tallied
- Preliminary reports written

### **V. Findings to Date**

#### **A. Discussion of Methodology**

- Participants noted to be of higher education/involvement with health care/connected to agency serving older adults.
- Participants very interested in topic

#### **B. Discussion of Cultural/ Ethnic Diversity**

- Comments on high percentage of cultural/ethnic diversity covered in focus groups. Will enlighten field.
- Need to customize materials to target diversity in older adults
- Food and prevention seen as important by Asian Americans. For other groups change in diet may mean significant change in cultural norms.
- California African American group very sophisticated health care consumers yet many had been told by their doctors they were at low risk of osteoporosis and therefore did not need to be screened

### C. Discussion of Findings

- All participants very interested in prevention.
- All participants able to answer when asked about where reliable information was to be found yet many had trouble identifying sources of unreliable information.
- **Doctors**, Pharmacists, Nurses, Nutritionists (connection to diabetic services?), Parish Nursing (in middle America) seen as reliable sources
- **Reading** important across all groups.
  1. Newspapers
  2. Dr. Weil's Newsletter
  3. Prevention Magazine
- **Formal Health Programs** (Hospitals, Clinics, Senior Centers) important
- **Internet** used by less than \_ of respondents but very important for those who did access.
- **Drug Company advertisements** seen as unreliable by some respondents
  1. Discussion: Drug Co studies show ads work
  2. May influence older women unconsciously or through print
- **Behavior Change** noted as motivated by doctor's advice.
- **Behavior Change** influenced first by fear. Family also seen as key.
- **Prevention and Independence** very important to older women.
- **Exercise** seen as important. Buddy System suggested.
- **Fear of falling** number one concern of older women.

### D. Time Line

- Project on schedule
- Phase II occurring during the summer
  1. Developing materials/formats
  2. Testing in selected Maine markets

## VI. Discussion of Questions

### A. What themes and messages about osteoporosis should be highlighted in materials distributed to older post menopausal women in order to alter their attitudes, knowledge, and risk taking behaviors?

- Population is group of well feeling, less educated, older adult women.
- There is a disconnect between name and effects of disease.
- Use of fear discussed. Group in favor of showing effects and then positive message.
- Noted effectiveness of showing older adults disease is real, how it may affect them, offering action steps, and positive control message.
- Offering facts then information about how to control disease speaks to independence
- Fear of disability is universal
- California group suggested using images in marketing. "Broken Bone" disease—technical

name may be too confusing.

- Cost very important. Need to make sure older adults understand screening is free/covered by Medicare. (Medicare confusing to older adults and physicians)
- There is confusion about what kind of bone density test is better. Individual doctors use what they are most familiar with.
- Generic talk about bone density testing most helpful.
- Key Question: “Have you had a fracture, any fracture, after menopause?”
- Keep messages simple.
- No medical data on exercise and fracture risk.
- Question of size of population who do not have a doctor or access health services through the emergency room. Women 50-64 may be most underserved.
- Concern current fear of HRT may influence older women’s perception of osteoporosis medication.
- Our Message: Here is the disease, here is how it affects you, it is preventable, go to your doctor and ask for a bone density test.
- Use generic word “treatments”, i.e. There are treatments that can help.
- Stay away from risk prevention in message. Often strikes without risks. Risks poorly understood at this point by medicine.
- Focus is awareness rather than testing.
- Many older women may fear it is too late. Need to include it’s never too late.
- Testing and treatment leads to longer, more independent lives.
- “Live Longer, Live Better” (EAAA)

**B. In what ways should the themes and messages be customized, if any, to reflect the special challenges of reaching minority populations of older post menopausal women?**

- Remember diet change may mean significant cultural change.
- Need several spokespersons from different ethnic/cultural backgrounds.
- Messages need to be clear and not restricted to any one group

**C. Through what means should the message be delivered for various groups of older women? That is, what tools and mechanisms are best used to reach post-menopausal women (i.e., brochures, ads, public services announcements, websites, etc?)**

- Use of real women in advertising (not Dorothy Hamil type). Mammogram campaign as example.
- Use of care giving attitudes—“I need to do this for family”.
- Community based (health fairs, community centers) suggested as outreach strategies for underinsured.
- Dentists as another access point of information. Tooth loss related to osteoporosis.
- TV & media excellent sources to disseminate information.
- Use of graphics? Bone micro architecture not persuasive image, however images of spine

before and after quite effective. Need real person, not the oldest older adult.

- National spokes person? Has worked in other campaigns. Mom from “Everybody Loves Raymond” mentioned as example
- Messages: 1.) She looks just like I do now. 2) look at devastating impact of disease. 3) I should get tested.
- Question of monetary limitations? COA is funded through pre-implementation stage.
- TV PSA’s very important. Colon cancer PSA effective example.
- PSA’s need funny/catchy slogan.
- Print: not just for doctor’s offices, health fairs. Need to expand coverage.
  - i. Bingo halls, beauty parlors, churches, w/home delivered meals, food pantries, food stamps, monthly checks
  - ii. Word Search Placemats at restaurants—Govenors/Dennys
  - iii. Beauticians sent information with licensing paperwork to pass out to customers.
  - iv. Restrooms and dressing rooms
  - v. Churches involvement needed
  - vi. Information given to families of older adults

**D. In what ways should these tools and mechanisms be customized, if any, to reflect the special challenges of reaching minority populations of older post menopausal women?**

- Need to make sure translations are appropriate and correct. Test in particular ethnic/cultural setting.
- Need to work in conjunction with cultural community groups and organizations. Spend time developing relationship. Provide group ownership of ideas/project to increase involvement.
- Need to ID key person in different cultural communities to work with.
- Illiteracy a concern—graphics?
- Visual impairment—large font/simple graphics

**VIII. Next Steps**

- A. Center on Aging will develop materials in conjunction with local marketing experts.
- B. Next Meeting will highlight products.
- C. Testing will begin in selected Maine markets.

**VII. Set Date for Next Meeting**

- A. Date: **Tuesday, September 9<sup>th</sup>, 2003 10am.**
- B. Location: **Eastern Area Agency on Aging**

Respectfully Submitted,

Leah Ruffin, LMSW





**UMaine Center on Aging  
Maine Center of Osteoporosis Research and Education  
Osteoporosis Awareness Campaign Local Advisory Board Meeting**

**Tuesday, September 9, 2003**

**10:00 a.m.—1 p.m.**

Eastern Agency on Aging

450 Essex St.

Bangor, ME

Present: Susan Kaye, Marjie Harris, Pam Allen, Betty Forsythe, Larry Anderson, Peggy Hayes, Leah Ruffin, Laurel Coleman, Elaine Briggs, Brenda Barker, Marie Albert, Nelson Durgin, Roberta Downey

**I. Introductions**

**II. Status of project and report on activities since last meeting**

- A. Research has been completed
- B. Now looking at marketing strategies.
- C. Marjie Harris to attend National Summit and return with Information

**III. Presentation of preliminary marketing campaign**

*Susan Kaye, MSW, MBA*

A. How Does Marketing fit with this social service campaign?

- 1. Marketing is more than commercially funded television ads
- 2. Marketing has to be a Win-Win situation for everyone
- 3. *Long-term relationships* and sustainable success is key
- 4. Marketing is focused on *changing thinking* and *behavior*
  - a. derives from psychology's learning theory
- 5. Marketing strategies and tools are very powerful
  - a. It may not be helpful to think of marketing as "good" or "bad"
  - b. Although we know of campaigns we assign a negative connotation (i.e. Joe Camel) the lesson is that marketing works.
- 6. Using marketing to target a social problem will be a very powerful tool for positive change.

## B. What is health care marketing?

1. In the increasingly competitive health care business marketing is essential.
2. There have already been successful marketing tools for human growth
  - a. Smokey the Bear
  - b. “Got Milk”?
3. It is important to remember that successful health care marketing is a process—not a one time message.
  - a. One example lies in the National High Blood Pressure Program.  
In 1972, less than 30% of Americans understood risks. By 1983 70% understood risks & in 1985, 90% understood.
  - b. This showed a slow start which grew in momentum.
  - c. However, 50% did not take action by the late 1990’s
  - d. The campaign started to target this 50% & saw action results
4. Our lessons include:
  - a. Marketing is not a one time event but a process
  - b. Marketing is done more than once
  - c. Overtime data increases and you target more specifically
  - d. Awareness does not automatically transfer to behavior change
  - e. Historically, one campaign for all populations has not worked

## C. What do we want to share?

1. We’ll use the marketing principles AIDA
  - a. Awareness, Interest, Desire, Action
2. We are satisfied when population reduces fractures, gets improved results on bone density tests, etc.

### 3. Our Message:

- a. osteoporosis can rob you of independence and life style
- b. It's not too late to act
- c. Do it for yourself and your loved ones
- d. Get tested, modify your diet, engage in weight bearing exercise

### 4. Integrated Marketing Communication is the foundation of the campaign

### 5. There is no right time—no time is too late to start the campaign

### 6. Multiple points of intervention need multiple interventions designed

- a. See page 8 of marketing plan for examples
- b. Each person is in different phases of health

## D. How will we share the message? Cohort Based Marketing (Charles Schewe)

### 1. Framework will be based on work of Charles Schewe

### 2. Americans have life defining events that allow us to define cohorts with similar characteristics

- a. post world war II cohort (58-75 years old)
- b. world war II cohort (76-81 years old)
- c. depression era cohort (82-91 years old)

#### i. Page 5 of the marketing plan offers synopsis of the focused cohorts

- d. Each cohort scores high in valuing “Family”, “Nostalgia”, and “Respect for authority”
- e. Cohort synopsis can be helpful but we need to remember it is based on the large population and represents the majority opinion.

### 4. This project needs to focus on “segments”

### 5. There is no one primary viewpoint—every group is a segment

*Comment: We need to look at rural and lower socioeconomic groups. Needs may be different.*

6. Mass marketing is least effective—target marketing the most

*Comment: Project may be lacking data for most vulnerable and isolated populations (lower socioeconomic/rural). Can EAAA provide?*

7. It is true this group may be harder to motivate & harder to reach as they are traditionally dealing with day-to-day survival.

*Comment: Why is the project not focusing on leading edge baby-boomers?*

8. Primarily, the project's funding specifies women 60+, and baby boomers are being targeted by other groups about this issue. The project will address as best can within the parameters of the funding.

*Comment: We should try to make messages applicable to future cohorts*

9. Maslow's hierarchy of needs provides us help when looking for challenging groups to reach.
10. The project will use a "push" (targeting familial influences to push into action) and "pull" (getting people to reach out)

E. The Four P's of the marketing mix:

- a. Product, Price, Place, Promotion
- b. The marketing mix is tailored to each segment

2. Product: testing, diet & exercise

3. Price: there could be a price to diet, testing, exercise, or misconceptions about price. Time sacrifice also can be a price

4. Place: a distribution channel. Need as many as possible—pharmacists, senior centers, hair-dressers, supermarkets, etc.

5. Promotion: different ways to communicate

*Comment: Even though focus groups indicate advertising is not a positive model, the actions of the people show they pay attention.*

*Comment: The team should not ignore advertising.*

*Comment: Suggestion to target the bone density test—explain the ease & lack of pain.*

*Comment: Link test to other health care issue*

*Comment: May need more than one target spokesperson*

*Comment: Mother-daughter campaign may be useful*

*Comment: Does the “ask your doctor” message work for physicians? Do they need more education?*

6. The National Summit is looking at physician education.

*Comment: The target group seems to wait for physicians to ask about symptoms. Would the HRT gap be something that can be utilized? They can't talk hormones—now what?*

*Comment: The question is how to get physicians more knowledgeable.*

*Comment: Other states are more rural, particularly in the Southwest and the Northwest. May be an increased problem in states where people have lower access to physicians & testing equipment.*

#### **IV. Questions for Discussion**

A. What should osteoporosis be called in a national campaign?

1. Call it by name—then offer “thin bone disease” as an explanation.
2. Changing name all together is too confusing.

B. What has failed in the past in terms of osteoporosis awareness or action campaigns, in particular, and other health awareness/action campaigns, in general? Why?

1. Ask Dora Mills: Bureau of Health; Department of Human Services?
2. Longevity is important. past funding problems
3. Lack of emphasis at access points—health centers, pcp's
4. Lack of access
5. Question about how much to use the fear factor? We want to keep this a message of hope.
6. In the past, an effective campaign used a double picture, some one younger/older, who has osteoporosis. Use many different types of women.

C. What are some national organizations with which to form strategic partnerships around the issue of osteoporosis?

1. AARP, NCOA, American Association for Home Services for the Elderly (AHC)

2. CMS (Center for Medicare Services)
3. Chronic Care Consortium
4. National Family Caregivers Association
5. National (and State) Council on Aging
6. American College of Rheumatology. This is year 3 of “bone & joint”
7. National Osteoporosis Month

D. What additional non-medical channels can be used to reach this target population?

1. National Area Association of Aging
2. AARP
3. National Church affiliations
4. Hair Dressers
5. National Transportation Coalitions (rides for the aging)

E. What other strategic alliance partners can be used to promote individual parts of the campaign (like dietary, exercise)?

1. Breast Cancer Alliances
2. Strong Women—Strong Bones
3. Matter of Balance—Matter of health
4. EMMC
5. Supermarkets—Food Producers
  - a. total cereal 100%
  - b. OJ w/Calcium
  - c. “Look for the blue label”
  - d. “coupons”
6. Public Transit –posters in buses, etc.
7. National Labor Associations

8. Employers with pensions & EAP's  
a. Maine State Employee Association

9. National Associations of EAP's

10. Teachers Associations

F. What are some ideas for Slogans or key concepts to incorporate into a slogan?

1. "How Do You Stand"

2. "Don't Be A BoneHead—Take Care Of Your Bones"

G. Who are some nationally known women who could put a face to the disease?

1. Mother from Everybody Loves Raymond- Doris Roberts

2. Mosaic of people

3. Animated bone

4. Mother/Daughter

5. All the former first ladies

6. Sports person—golf/tennis pro

7. Someone who's mother has osteoporosis

8. Female movie stars of the generation

9. Barbara Walters

10. Cookie Roberts

11. Need to meet 3 criteria:

a. Credible

b. Expertise

c. Attractiveness: look like the population thinks they look like.

12. Physicians, nurses, teachers

13. Golden Girls

14. Olympia Dukakis

15. Pharmacists

#### **V. Next Steps in Project**

A. Design firm (Packard Judd Kaye) in Bangor to come up with visuals for message.

B. Slogan/ Logo test material

1. Plan to test people's reaction to materials at some sites.

C. Have received a non-funded extension to the project

D. Give recommendations to AoA

#### **VI. Set date for next meeting**

A. Wednesday December 3, 2003 10-1pm @ EAAA

B. Thank you for your participation.

Respectfully submitted,

Leah Ruffin, LMSW



**UMaine Center on Aging**  
**Maine Center for Osteoporosis Research and Education**  
**Osteoporosis Awareness Campaign Local Advisory Board Meeting**

**Wednesday, January 7, 2004**

**10:00 a.m – 12 p.m.**

Eastern Agency on Aging

450 Essex Street

Bangor, ME

**Minutes**

Present: Marie Albert, Pam Allen, Nelson Durgin, Betty Forsythe, Ann Hanlon, Marjie Harris, Lenard Kaye

**I. Welcome**

**II. Status of project and report on activities since last meeting**

Marjie Harris and Len Kaye

*A. Oakland Summit*

Marjie attended this Summit and reported that it was very worthwhile. Experts in the fields of gerontology, multicultural health, osteoporosis, and representatives working with the underserved populations attended. The work focused on the messages and methods of dissemination that would be most effective in a national campaign.

Many of the contacts Marjie made at the Summit have been helpful in organizing the current round of focus groups. A summary of the ideas from the Summit was distributed to the Board.

*B. Medicare campaign*

Medicare is ready to embark upon a campaign with a similar goal as ours. All the grantees of this project and the representatives responsible for the Medicare one had a conference call recently to talk about collaborating. There was much enthusiasm for this. The Board felt this would be very beneficial in reaching more women since AoA and Medicare, while under the same overall department, have access to two different but broad audiences, medical and social services.

Drs. Hanlon and Albert commented that Medicare does not cover annual routine medical screening in general and that access to care needs to be pushed in a lot of ways. They book mammograms and DXA at the same time since the offices are side by side. Women are more likely to feel a mammogram is important, but when booking them together, the DXA piggybacks. They feel this is an important strategy.

Drs. Hanlon and Albert also mentioned that the medications to treat osteoporosis are very expensive and not covered by Medicare. It is difficult to tell a woman that she has osteoporosis and that medication is available but not affordable.

### *C. Development of focus group materials*

Project staff has been working with Packard Judd Kaye in Bangor to develop a design concept for use in the campaign. The goal was to develop materials that would incorporate the fear that seems to be the greatest motivator but convey a positive message.

## **III. Discussion of round 2 focus group materials**

The first of the second round focus groups is scheduled for later this week. Groups are scheduled in Maine, NYC, Nebraska, California, Georgia, and Chicago. Marjie reported that she has been unable to arrange a group of Asian women at this point. Nelson Durgin made some suggestions for possible contacts. The focus group materials for round 2 were distributed and discussed.

### *A. Message/design*

The Board felt positively about the “Tone Your Bones,” “Bone Appetit,” and “Bone Vivant” slogans. “Bone Up” was not popular with some because it reminded them of studying.

“Cheers to Milk” with a glass of milk pictured was mentioned as an idea. Members felt clear messages such as “Tone Your Bones-Battle Bone Loss with Exercise” would be most effective. The “Milk Toast” phrase reminded several people of a dish served by many in their childhood and on. An alternate slogan was suggested of “Cheers to Milk”.

Suggestions were made for skeletons to be dancing, assuming a victory position, swimming, and walking vigorously. Someone else suggested a side view of a skeleton standing very straight.

The blue brochure was far preferred over the green by the Board.

Betty Forsythe asked if she could have copies of the materials to show her colleagues for their feedback. Marjie felt there might be a copyright concern but agreed to check with the graphic design people who developed the materials and get back to Betty.

### *B. Spokespeople*

Members had many suggestions for spokespeople. Having an older woman (mid-60’s) and not a politician were felt to be important. Some specific ideas included Olympia Dukakis, Mary Tyler Moore, Angela Lansbury, Doris Roberts, and Elizabeth Dole. Carol Burnett was felt to be a particularly appropriate person because she had been through hard times and was someone women could relate to because of this. Dr. Albert suggested having a character rather than a real person or a group of older women who were not famous. She suggested calling them the “Bone Ladies” and have them doing different activities that promote strong bones, such as exercising.

### *C. Promotional items*

There were many suggestions for promotional items that might be effective such as sticky pads and magnets. There was a lot of enthusiasm for a magnet in the shape of a skeleton, possibly one that glows in the dark. A magnet in the shape of a glass of milk was mentioned as well. The possibility of partnering with a pharmaceutical company, the makers of Tums, or the Dairy Council to pay for the items was also discussed.

The importance of making use of heel test screening at health fairs and at other locales with underserved populations was emphasized.

## **IV. Description of remaining stages of project**

Hopefully, the focus groups will be concluded by early February. Data will be analyzed and used to guide recommendations for the final report.

The project will be concluded by the end of March.

## **V. Final recommendations for campaign**

Marjie and Len will send a draft of the final report to board members for their input.

## **VI. Closing remarks**

Marjie and Len emphasized how greatly they appreciate the help of the Advisory Board and members' willingness to give of their time and expertise. This will be the final meeting though we will be communicating electronically for feedback.

Respectfully submitted,

Marjie Harris, LCSW



## **Appendix G**

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