March of Dimes Community Voice Evaluation Annual Report January—December 2009

Prepared for:

Governor's Office of Children's Care Coordination

Women's Health for Underserved Areas & Infant Mortality Initiatives

Prepared by:

Center for Research on Women

University of Memphis

March 2010

THE UNIVERSITY OF MEMPHIS
Center for Research on Women

Contents

Prepared by:
Center for Research on Women
337 Clement Hall
The University of Memphis
Memphis, TN 38152
Phone: 901-678-2770
crow@memphis.edu
http://crow.memphis.edu

Lead Principal Investigator:
Dr. Lynda M. Sagrestano,
Director,
Center for Research on Women

Co-Principal Investigators:
Dr. Phyllis Betts,
Director,
Center for Community Building and
Neighborhood Action (CBANA)

Dr. Joy Clay, Associate Dean of Inter-disciplinary Studies;
Professor, Division of Public and Non-Profit Administration

Dr. Ruthbeth D. Finerman, Chair,
Department of Anthropology

Key Personnel:
Teresa A. Diener,
Project Coordinator

Carrie A. Brooks,
Former Project Coordinator

Naketa Edney,
Research Associate

Carolynn Clark,
Virginia McKay, Laura Meek,
Jesseca Smith, Julia Marshall
and Amber Sanders,
Graduate Research Assistants

March 2010

Executive Summary **4**

Introduction **10**
Purpose of Evaluation 10
Evaluation Plan 11
Methods 11

Results **12**
Data Overview 12
Participants
Question 1: How Effective is the Curriculum? 12
Participants' Perception of Preparedness to Discuss the curriculum 14
Participants' Knowledge of Curriculum 15
Question 2: How Effective is the Administration/Implementation of the program? 16
Recruitment 16
Question 3: How Effective is Program Penetration/Dissemination? 17
Taking it to The People: Contact Reporting 18
Geographic Mapping of Penetration and Dissemination 20
Interim Evidence of Penetration 21
Representativeness 21
Connectivity 21
Question 4: How Effective is Community Voice on Long-Term Outcomes? 22

Recommendations **23**
Tables and Figures
Appendices
References

Acknowledgements

We wish to thank the following individuals whose help proved invaluable in completing the evaluation. Mia Earl, Director of the Community Voice project, and her staff, Mary Jackson, Outreach Specialist and Jan Hill, Recruitment Coordinator, collaborated with the evaluation team for this comprehensive evaluation. In addition, they provided feedback by participating in interviews. Thanks also to Valencia Nelson, State Director of Program Services, TN Chapter, March of Dimes, and Antionette Holman, Coordinator of Infant Mortality Reduction Initiative, for their input throughout the year and specific feedback and assistance they have offered in support of this program evaluation.

We offer special thanks to the participants of the Community Voice program for their participation in the evaluation. Their dedication to reducing and preventing infant mortality in the Memphis and Shelby County area is inspiring.

Executive Summary

In 2007, the Center for Research on Women (CROW), in partnership with the Center for Community Building and Neighborhood Action (CBANA), the Department of Anthropology, and the Division of Public and Non-Profit Administration, all located at the University of Memphis, began work to evaluate the Community Voice program's effectiveness in Shelby County.

Community Voice (CV) began its funding stream in August of 2007, and the program was officially launched in February of 2008. The CV program is a capacity-building intervention, designed to deepen understanding of pre-conception health and prenatal care among community-based populations. More specifically and emphatically, it is "A Program to Decrease African American Infant Mortality by 'Taking it to the People.'"

The four-year comprehensive evaluation of Community Voice is funded by the Governor's Office for Child Care Coordination to examine outcomes, but also to understand the potential of the program's replicability in other parts of the state and/or country. The evaluation documents and studies the effectiveness of the curriculum, administration of the program, program penetration/ dissemination, and long-term outcomes of the Community Voice program.

The evaluation team employs process evaluation, standardized pre and post-testing for training participants, asset mapping and other contextual analysis to grasp neighborhood involvement that may impinge on the successful implementation of Community Voice among particular social networks or in particular neighborhoods, and measures of diffusion and penetration.

Following is a summary of this report, categorized by evaluation question:

1) How effective is the curriculum?

- Participants rated the training very favorably. The timing of the sessions, materials used for teaching, and the curriculum were considered effective. Delivery of the content was also rated very favorably.
- Few factual errors or omissions were observed during the trainings. Those factual errors that were observed were infrequent.
- Omissions often resulted from time expended on paperwork related to the training and evaluation, particularly during the first session, or tardiness of participants.
- A total of 541 participants took the knowledge pre-test; only 9.9% of those passed the test (score of 80%) before the training.
- A total of 458 took the knowledge post-test after completing the Community Voice training; 447 (97.6%) of those participants passed the knowledge post-test.

2) How effective is the administration and implementation of the program?

- Community Voice trained 447 new Lay Health Advisors (LHAs) in calendar year 2009.
- Over the two year (2008-2009) course of the program, 761 LHAs have been trained.
- Recruitment efforts were successful in reaching African American women of childbearing age. Over 90% of the participants were women and 83% were African American. The mean age of participants was 30.86 years, with 75.1% of the participants under the age of 45.
- Participants tended to live with members of the target population. Over half (56.5%) lived in households with women from age 14 to 44, and 30.7% were in households with children under three years old.
- Many participants (26.6%) were pregnant, trying to become pregnant, or living with another household member who was pregnant at the time of the training.
- Almost a third (29.2%) of participants report that someone in their family had experienced an infant death.
- Attrition rates were similar to the first year of the program. The attrition rate from recruitment to actually attending sessions was 18.8%. Attrition from starting the training to completing the training was 8.6%.
- Recruiting and partnership development are key factors in cultivating participants for training. Although recruitment efforts have increased the numbers of participants, efforts now need to focus on narrowing in on the target population in the specified zip codes.
- As the program has grown, balancing the demand for providing training with recruitment of new participants and follow up with LHAs has become a strain. To meet

the demands of the program, two full time outreach specialists and a full time recruiter are needed.

3) How effective is program penetration and dissemination?

- Community Voice participants begin training with a moderate to high level of motivation to spread the word to pregnant family members and close friends.
- Many participants in the program lived, went to church, or participated in community activities in the neighborhood s where their trainings were located.
- In calendar year 2009, of the 447 trained LHAs, 116, or 26.0% were residents of the target zip codes.
- Most participants expect to provide information to others when asked, rather than spontaneously. Motivation is more proactive where spreading the word is related to professional or organizational roles.
- At the end of the training, participants identified SIDS, drugs, domestic violence and prenatal care as topics they felt most prepared to discuss; 12% indicated that they felt prepared to discuss "all" topics.
- Following training, Lay Health Advisors (LHAs) are asked to report on their interactions with people in the community via contact reporting forms. Of 447 LHAs trained during the 2009 calendar year, 38 (8.5%) returned contact reporting forms.
- Over the 2-year course of the program (2008-2009) , 2033 contact reporting forms were returned by 56 LHAs.
- In CY 2009, LHAs reported discussing content from Community Voice with approximately 2865 people as individuals or in groups.
- LHAs reported talking most frequently about infant mortality, drug use, Community Voice, SIDS, prenatal care, pre-term labor, smoking, alcohol use, and child safety.

4) How effective is Community Voice on long-term outcomes?

- The impact of the program on birth outcomes and infant mortality rates cannot yet be documented. Trends over the four year program period will be reported in the final evaluation report.

RECOMMENDATIONS

A series of recommendations were developed based on progress toward goals from Calendar Year 2008, and data from calendar year 2009. Recommendations are organized in the following chart, with columns for 1) previous recommendations, 2) progress on previous recommendations, 3) whether or not the recommendations have been met, and 4) further and/or new recommendations.

Executive Summary

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Curriculum			
Review expectations of topics to be covered and revise the curriculum design to ensure sufficient time to cover the entire curriculum.	The curriculum has been revised for the 2009 calendar year, and content from session one has been moved to session two to allow time for paperwork to be completed, but content often is still not covered in the allotted time.	Partially	
Develop time management strategies to ensure sufficient time to cover the entire curriculum.	Outreach Specialists are exhibiting better time management and continuing to exhibit enthusiasm in trainings. Because of this enthusiasm, Outreach Specialists should remain mindful of time management	Partially	1. Expand session one by 30 minutes to allow time for paper work; 2. Shift some of the content from session one to session two; 3. Hold group discussion until second session.
Review current role playing exercise design and develop consistent expectations regarding their inclusion.		Yes	
Review current strategies for addressing controversial topics such as Back to Sleep and breastfeeding and develop a consistent expectation for how to effectively address such topics.		Yes	
Consider shorter and more intensive training.		Yes	
The curriculum itself might include more information on the father's role in pregnancy and parenting, and the role of the male Lay Health Advisors in serving as mentors to other males when "taking it to the people." This curriculum revision should also include strategies/ expectations for how to effectively engage males during the training.	Although the curriculum does address sperm health and preconception health, more emphasis is needed on the role of men across the reproductive life span in the curriculum.	Partial	Emphasize the father's role across all stages of the reproductive lifespan in the curriculum. Create brochures targeted to men.
Consider adding listings for governmental and grassroots development organizations in the resource guide (e.g., environment court.)	The 2010 resource guide is being reviewed and additional resources/recommendations are being researched in detail for 2010 revisions .	No	
			Create a systematic way of training Outreach Specialists to address topics such as grief, domestic violence, mental health, and cultural awareness.

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Program Administration/ Implementation			
Clarify governance roles and responsibilities of the Community Voice project within the broader Infant Mortality Initiative.		Yes	
Clarify governance role and responsibilities of the Core Leadership group as they relate to the Community Voice project.		Yes	
Develop recruitment procedures (to include identifying/refining specific target organizations to be recruited and building recruitment partnerships with target organizations).		Yes	
Consider hiring full-time recruitment personnel as high priority.	Part-time recruiter has been hired.	Partially	
Reassess the incentive structure to assure that it aligns with program goals and expectations.		Yes	
			Hire second outreach specialist to increase training capacity to meet the demands of the program, and take burden of training off of non-OS staff.
			Evaluate roles and responsibilities of project coordinator, recruiter, and outreach specialists to ensure that all duties are being met, including following up with LHAs after trainings.
			Create resources for LHAs with pragmatic advice on handling situations related to domestic violence and grief.
			Expand the resource guide to provide referral networks, especially with respect to domestic violence and grief counseling.
			Expand the number of agencies that CV is working with and focus on those that connect to the key target demographic.
			Rather than targeting specific classes of high school students, consider trainings for high schools that are voluntary and after school groups and programs.
			Consider holding trainings at the Adolescent Parenting Program, an alternative school for pregnant teens.

Executive Summary

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Dissemination/Penetration			
Continue to focus on recruitment strategies and encourage greater emphasis on the institutional and organizational strategies being developed.		Yes	
Strengthen the social marketing plan:		Partially	
1. Refine the community-based marketing strategy.	A Community Voice Facebook Page was created	Partially	Web page needs to be created and support materials should be more accessible.
2. Coordinate the marketing strategy with the broader Shelby County infant mortality initiative marketing plan.		Partially	Continue to partner with ABC to find opportunities to market Community Voice.
3. Develop a health promotion campaign related to infant mortality		No	This remains a community need that the Core Leadership Committee should discuss, however it is unrealistic for Community Voice to undertake this on its own.
			Provide the LHAs with more dissemination material, such as brochures and business cards with March of Dimes Community Voice contact information on the front and a pregnancy tip on the back.
			Provide the LHAs with access to supplemental materials such as videos.
			Use social networking opportunities more strategically (e.g., “Tip of the Day” on the Facebook page).

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Long Term Outcomes			
The Infant Mortality Initiative is preparing to develop a long-term strategic plan. Such a plan would presumably articulate how the several Infant Mortality programs operating in Shelby County could leverage one another's resources and social networks. Community Voice would benefit from a stronger collaborative vision and supportive infrastructure that clarifies their role and responsibilities in the ongoing effort to reduce infant mortality in Shelby County.	ABC is expected to initiate strategic planning. Community Voice should play a role in ABC's strategic planning process.	Partially	This remains a community need that the Core Leadership Committee should pursue, however it is unrealistic for Community Voice to undertake this on its own.
			Provide refresher courses for long-term LHAs. Consider incorporating a mechanism that would allow LHAs to reach Outreach Specialiststatus.
			Review key material at the booster sessions.
			Focus on developing the Speaker's Bureau as a resource to expand visibility of CV in the community
			Capitalize on and support long-term, invested LHAs by keeping them informed, engaged, and supplied.
			Begin addressing sustainability, particularly with respect to funding.
			Develop a CV community advisory board.

Introduction

In April 2006, Tennessee Governor Phil Bredesen and Shelby County Mayor A.C. Wharton came together with over 250 community leaders and activists for the Infant Mortality Summit in Memphis. That year, the overall infant mortality rate in Tennessee was 8.7 deaths per 1,000 births, with the rate among African American babies at 16.8 and among White babies at 6.6 (Tennessee Department of Health, 2009). In Memphis and Shelby County, the overall rate in 2005 was 11.8.

However, for African American babies, the rate was 15.5, almost three times higher than the rate among White babies, 5.5 (Smith Madlock & Morrow, 2008). Out of the Infant Mortality Summit, the Infant Mortality Reduction Initiative was born. The goal of the Initiative is to increase positive birth outcomes through education and collaboration.

The March of Dimes Community Voice education program, funded by the Governor's Office of Children's Care Coordination (GOCCC) is a capacity-building intervention, designed to deepen understanding of pre-conception health and prenatal care among community-based populations. More specifically and emphatically, it is "A Program to Decrease African American Infant Mortality by 'Taking it to the People.'" Based on a curriculum and trainer's guide developed by the Community Voice Program of the South Central Perinatal Council of Virginia, "lay health advisors" are recruited and trained to "take the information they receive throughout the community." The Community Voice education program proposes to diffuse new knowledge working through indigenous and credible social networks. These networks include, but are not limited to, churches, social clubs, and other local associations and are a source of pivotal persons who are able to galvanize volunteers for the lay health advisor training.

PURPOSE OF THE EVALUATION

A pilot program called *Community Voice: Taking It to the People* was developed in Lynchburg, VA in 2000. The project was funded by a Missions Investment Opportunity Program (MIOP) grant from the March of Dimes Birth Defects Foundation (Scott, et al., 2007). This program began in response to the high African American Infant Mortality rates in that community. At that time, the rate of infant mortality for African Americans in Lynchburg was 29.4 deaths per 1,000 births. In 2003, when the pilot project ended , the African American infant mortality rate had dropped to 5.5 (Scott, et al., 2007), although the evaluation of this program was not comprehensive and outcomes could have been a statistical anomaly.

Tennessee saw promise in this approach, particularly for the Memphis community, because of the grassroots approach and the assets available in the local community. In order to validate outcomes and understand the program's replicability, Governor Bredesen and Mayor Wharton funded a comprehensive, four-year evaluation of Community Voice (CV). In 2008, the Center for Research on Women (CROW), in partnership with the Center for Community Building and Neighborhood Action (CBANA), the Department of Anthropology, and the Division of Public and Non-Profit Administration, all located at the University of Memphis, began work to evaluate the CV program's effectiveness in Shelby County.

The vision for Community Voice is that it will lead to better birth outcomes in communities where new knowledge is diffused and healthier behaviors are adopted. The evaluation of Community Voice will document and study the effectiveness of the curriculum, administration of the program, program penetration/dissemination, and long-term outcomes of the Community Voice program using:

- **Process evaluation, including** participant observation and standard field methods documenting design, implementation, and acceptance of the training and other aspects of Community Voice.
- **Standardized pre and post-testing for training participants** (knowledge, beliefs and attitudes, and intended behaviors).
- **Asset mapping and other contextual analysis** to grasp neighborhood involvement (strengths, weaknesses, opportunities and threats) that may impinge on the successful implementation of Community Voice among particular social networks or in particular neighborhoods (risk and protective factors for successful implementation or diffusion.)
- **Measures of diffusion and penetration,** including the contact reporting forms and perhaps other measures such as a systematic survey of network members/ neighborhood residents.
- **Tracking birth and maternal outcomes** from 2007 baseline through 2010 (with final report in 2011).

Methods

EVALUATION PLAN

At the beginning of the project, the four co-PI's (Drs. Sagrestano, Betts, Clay, and Finerman) drafted an evaluation plan, which included four major research questions, intended methods to address each question, and personnel responsible for overseeing each aspect.

The spreadsheet "Evaluation Question by Method," (see Appendix B) lists the evaluation questions for the project, identifies the Principal Investigator responsible for each item, and outlines the method or source that is being used to collect the data needed for each question.

The four main questions guiding the evaluation are: 1) How effective is the curriculum? 2) How effective is the administration of the program? 3) How effective is program penetration and dissemination? 4) How effective is Community Voice on long-term outcomes?

METHODS

The methods used for the Community Voice evaluation are surveys, observations, interviews, focus groups, and pre- and post -knowledge tests. A complete description of the methodology is in Appendix A. Changes and additions to the methodology implemented in calendar year 2009 are summarized below.

Surveys. A series of surveys and questionnaires are used to collect data at various points in the training process. Each of these measures was reviewed during calendar year 2009 with an eye toward reducing the length and clarifying any items that appeared to be causing confusion for respondents. Shortened versions of all measures were implemented as a result of this process.

Non-Matriculate Follow-up Telephone Interviews. A telephone interview was created during the 2009 calendar year to better understand why those who originally signed up to receive training as a Lay Health Advisor did not participate in the training. In November 2009, evaluation team members attempted to contact 71 individuals who had signed up to participate in training but did not matriculate. Of those, 33 were interviewed about their experiences, for a response rate of 46.5%.

LHA Follow-up Telephone Interview. In calendar year 2009, a telephone interview was created to contact LHAs to discuss the process of returning the contact reporting forms and gain insight into ways to make it easier for LHAs to use and submit these forms, with the goal of increasing participation. Team members attempted to contact 458 LHAs during July and August of 2009. Of the 458 LHAs, 110 had telephone numbers that were disconnected or the person no longer lived there. Interviewers were able to obtain updated numbers for 20 LHAs, as well as 148 email addresses. A total of 185 telephone interviews were completed with LHAs, for a response rate of 40.4%.

Post-Post Knowledge Test. A short (10 item) version of the knowledge test was administered during booster meetings and the Annual Community Voice Celebration during the 2009 calendar year to evaluate the extent to which LHA's retain information from the trainings over the longer term.

Data Collection Procedures. During calendar year 2009 Community Voice began implementing more trainings outside of the five week format, including 2 day trainings and 5 consecutive trainings in one week. Procedures at the beginning and the end of the sessions are the same as the original procedures (see Appendix A). The 5 consecutive training sessions are observed the same way the 5 week sessions are observed; however, for the 2 day trainings the trainings are typically observed in their entirety.

Observations. The evaluation team conducted systematic observations of 135 Community Voice training sessions during the 2009 calendar year. All observation notes were coded, and a sample of 15% of the observation notes were coded by three evaluation team members to assess whether all observations were coded in the same way by all coders. Through this process, the coders achieved a very high degree of accuracy and uniformity in the data coding process.

Interviews. The protocol to conduct interviews with professional staff associated with the Community Voice program was updated for the 2009 evaluation. Interviews took place from December 2009 through February 2010. Team members conducted nine interviews with professional staff associated with the Community Voice program.

*Focus Groups***.** The evaluation team made minor adjustments to the original focus group protocol for the 2009 calendar year. Team members conducted two focus groups in December 2009 with nearly 40 Lay Health Advisors (9% sample) from the Community Voice Education program. Evaluation team members recruited only those LHAs trained during the 2009 calendar year.

Results

The evaluation is guided by an evaluation plan with research questions, logic model, and timeline for implementation. The four main questions guiding the evaluation are: 1) How effective is the curriculum? 2) How effective is the administration of the program? 3) How effective is program penetration/ dissemination? and 4) How effective is Community Voice on long-term Outcomes? In this section, data collected in the first calendar year of the program (2008) will be compared to the data collected in the second (2009) calendar year. Research questions will be addressed to the extent possible with the data collected thus far.

DATA OVERVIEW

In calendar year 2009, a total of 541 participants completed at least one of the four measures, which include the Background Information Questionnaire (BIQ), Post Training Questionnaire (PTQ), the pre knowledge test, and the post-knowledge test. A total of 524 participants completed the BIQ and 541 participants took the pre knowledge test; 458 took the post-knowledge test, and 447 completed the PTQ.

It is expected that all participants who attend the first training session continue and attend all sessions as well as complete all measures. However, some participants attended all sessions, but did not complete all measures, which explains inconsistent numbers. In addition to the fact that some did not attend all sessions, participants might have started the training during the second session when an evaluation team member was not present. Although they were able to complete the pre knowledge test with the Outreach Specialist, they were not able to complete the BIQ.

Table 1 lists the host sites for each of the trainings conducted in calendar years 2008 and 2009, including zip codes for the locations and the number of attendees. Table 2 shows the zip codes in which participants reside. The Community Voice program is targeting 5 zip codes based on infant mortality rates, including 38106, 38109, 38116, 38118, and 38127. In calendar year 2009, of the 447 trained LHAs, 116, or 26.0% were residents of the target zip codes.

Note that throughout this report for most data tables, data for the full sample that began training will be represented in the column referred to as "participants" or "all participants", whereas only those who completed the training and passed the post test to become LHAs are included in the column referred to as "LHAs." This allows for examination of the data for both those who were successfully recruited into the first training and for those who successfully completed the training and are now in the community taking it to the people.

PARTICIPANTS

Table 3 represents the demographic and background information for participants and LHAs who completed the BIQ at the beginning of the training sessions conducted during the 2009 calendar year. A total of 524 participants completed pre-training measures including the BIQ, compared to 385 during the 2008 calendar year. Findings from the 2009 calendar year indicate that:

- Recruitment efforts have been successful in attracting African American women of childbearing age, the primary target demographic.
- Over 90.9% of the participants were women, whereas 4.8% were men. This number has declined from the 2008 calendar year (see Table 3).
- 83% of participants were African American.
- The mean age of participants was 30.86 years, with 75.1% of the participants under the age of 45.
- 17% of participants did not complete high school.
- 65.2% of participants had completed some college or had post-secondary degrees.

Participants were asked several questions related to their family and experience with pregnancy and infant mortality (see Table 4). Responses indicate:

- over 60% had experienced an infant death in their own or a close friend's family.
- over half of the respondents lived in a home with a woman in her childbearing years.
- over 26% were currently pregnant, lived with someone pregnant, or were trying to get pregnant.

QUESTION 1: HOW EFFECTIVE IS THE CURRICULUM?

The first major question guiding the curriculum has to do with curriculum effectiveness. To assess curriculum effectiveness, several indicators were considered:

- the effectiveness of the training materials
- participants' perceptions of Outreach Specialists

- how well participants learned material as indicated by the pre- and post-test scores on the knowledge test
- fidelity to the curriculum provided by March of Dimes
- LHAs' perceptions of their knowledge of the course content and their confidence in their ability to disseminate information once they complete training

Participants' Perceptions of the Training

To assess participant perceptions of the effectiveness of the materials and training sessions, data from the Post-Training Questionnaire (PTQ) were examined. The PTQ allows participants to describe their Community Voice training experience. In 2009, a total of 447 participants completed the PTQ. Of those, 439 became LHAs. Some LHAs took the post-test at a later date, and were not given the PTQ. Table 5 shows the average score for items related to the timing of the sessions, materials used for teaching, the curriculum, the instructors' effectiveness, and participants' self-efficacy during the 2008 and 2009 calendar years.

In the 2008 calendar year version, a series of semantic differential items were used to assess participants' reactions to the trainings. A Likert scale was developed for the 2009 calendar year to replace the semantic differential items to assess participants' reactions to trainings. This format was changed to limit participant confusion. The 2008 version was inadvertently used for one group during the 2009 calendar year. For each item, participants chose the answer that best described their response. Most participants indicated that the pace, length of the class, and the amount of information was appropriate and that the course was interesting, useful, clear, and organized (see Table 6).

Overall, responses to the PTQ indicated that:

- reactions to the training were very positive
- most participants and LHAs agree or strongly agree that the timing of the sessions, materials used for teaching, and the curriculum were effective, as were the instructors' abilities to deliver content
- most indicated self-efficacy with regard to knowing and disseminating the material they learned from the program
- Most indicated that the pace, length of the class, and amount of information was appropriate and the course was interesting, useful, clear, and organized

In addition to the survey data, focus group participant responses reflected positive attitudes about the flexibility in training schedules. In particular, LHAs noted that both the five-day and the two-day training sessions had value:

"I have [experienced] both ends of the spectrum: I [organized training on] two Saturdays with five hour sessions, but I also went through the five weeks of two hour sessions. I would say...the flexibility is good, just to have those options. Me personally sitting through five weeks… we kept begging… can we just speed up the process? But for some people they need that longer time to kind of process and to absorb, get a better understanding. And I think you don't want to take away from that. It's a ten hour training… You really could go longer to be perfectly honest."

"I have a very busy schedule, and for five weeks is too much because I have other things I have to do."

Data collected through observations of CV training sessions in 2009 replicate the finding that Outreach Specialists cover core course content and successfully clarify more complex or confusing material for trainees. Specialists also use personal narratives and current events to bring topics to life and to illustrate key points such as relationships between ethnicity, socioeconomic status, and health outcomes.

Observers again tracked positive and negative trainee responses to the curriculum, and positive responses dominated. During the 135 training sessions that were randomly selected for observation, coding, and analysis for this report, a total of 125 instances of strong participant enthusiasm, insight, and agreement were recorded, representing a 92.5% positive response rate.

Enthusiasm peaked when discussing opinions about high infant mortality rates, and during role playing activities. Negative reactions were rare in the last 12 months: just 23 instances of trainee disinterest (e.g. texting, sleeping) were observed in the 135 CV sessions tracked. Of note, rates of disinterest were even lower than they were in the program's first year: in 2008, 38 cases of boredom were observed in 90 training sessions.

Most significantly, participants rarely voiced disagreement with course content and recommendations. Only 5 cases of dissent were observed in the last year, concerning "Back to Sleep," breastfeeding, the role of fathers, and the relative impact of stress (9 cases were recorded in 2008). Moreover, the intensity of disagreement was slight, and Outreach Specialists succeeded in using sensitivity, respect, and

Results

facts to persuade trainees to embrace new recommendations.

Although the recommendation to put babies to sleep on their back triggered the most disagreement during the 2008 calendar year, particularly among elderly participants, attitudes of participants in the 2009 calendar year appeared to be more accepting of the practice:

"I was very disturbed because even I had [told] my grandchildren to put their babies on their stomach. I found out better from going to the class."

"I was touched by what I learned… because I'm older, and so what I did with my children growing up, I'm finding that that's not what you do [now]. Everything is updated. We put our babies on their stomachs to go to sleep, and I felt like if we put them on their backs they would choke, but I found out that if you put them on their stomach, it's not good."

Observers recorded just ten instances of factual errors in the last year. Nearly all involved problems defining and distinguishing between perinatal and prenatal periods. Some topics continued to be omitted from sessions, particularly from session one. As in the first year, omissions seem causally related to the additional time required to complete course pretests and paperwork. Tardiness among trainees also negatively impacted coverage at a small number of sites.

Interview informants were generally positive about the Community Voice curriculum and its alignment with the local Memphis community and targeted audience. Those most familiar with the specifics of the curriculum noted that they have revised the curriculum to address questions or areas of concern but have also become adept at responding to specific interests of participants.

Informants noted that the delivery schedule has become much more flexible and responsive to the needs of organizational partners and participants. Thus, evaluation of the learning outcomes of the various delivery modalities was suggested as important feedback to the program. Because the session size has increased, it was also suggested that there is a need to assess the impact of class size on learning outcomes. Program specialists and administrators appear to remain committed to providing a learning environment conducive to connecting with the participants and to encourage the exchange of personal stories and discussions of the content to affirm the value of the training.

None of the informants identified any topics in the curriculum to recommend for elimination from the training sessions although one of the program administrators suggested a need to review the curriculum to assure that the information reflects current national positions. Although there was consensus that the program should identify potential avenues for including the LHAs more in the program, most informants view LHA roles to be more targeted towards aiding in recruitment rather than in becoming involved in teaching, given the perceived need for curriculum fidelity.

Observational data collected in 2009 reinforce the finding that smaller classes foster greater rapport among trainees and between Outreach Specialists and trainees, and they create a more effective learning environment. Observers documented a high level of camaraderie at trainings. Much of this bonding can be credited to the charismatic personalities of Outreach Specialists. The revised curriculum still offers comparatively few opportunities to build group solidarity, although role playing again proved valuable to achieving rapport. Of note, role playing exercises were more consistently covered in trainings in the last 12 months as compared with the program's first year, although sessions occasionally ran out of time to cover every one of the exercises.

Participants' Perceptions of Preparedness to Discuss the Curriculum

In an open-ended format on the PTQ, the survey participants complete at the end of training, participants were asked to list topics they believed they were most prepared to talk about post training.

- Participants listed 24 topics out of the full range of topics covered during training.
- Participants identified SIDS, smoking, and prenatal care as topics they felt most prepared to discuss
- 12% wrote that they felt prepared to discuss "all" topics.

Figure 1 illustrates the 24 topics participants identified they were most prepared to talk about, and the percentage of participants who listed them.

When participants were asked to respond in an open-ended format on the PTQ about which topics they believed they were *least* prepared to talk about, responses indicated that most participants felt prepared to talk about *all* topics presented in the training. A total of 41% of participants indicated that there were no topics they felt least prepared to discuss. When participants answered open-ended questions, about topics they felt most prepared to discuss, they included:

- alcohol

- breast feeding
- child care
- disease
- drugs
- folic acid
- infant mortality
- perinatal care
- prenatal care
- racism
- statistics
- stress
- thinking ahead
- violence

After LHAs had time to integrate their learning and put it into action, those participating in the focus groups cited the following at the most useful topics:

- SIDS and "Back to Sleep"
- breastfeeding
- tobacco and second-hand smoke
- substance use
- Fetal Alcohol Syndrome
- premature labor and Kicks Count,
- nutrition
- low birth weight
- domestic violence
- environmental hazards
- listeriosis
- folic acid

Select comments included:

"The first thing I learned that I didn't know was 'Do you eat folic acid?' and I said, 'No' because I didn't know."

"Kicks count!"

"One thing that really shocked my mom was the lunchmeat [listeria]. She said, she told me, 'I used to give you lunchmeat all the time, cold, that's probably why you are hardheaded'."

Participants' Knowledge of the Curriculum

Before the start of training, participants were asked to complete a knowledge pretest. This test was then administered again at the end of the last training. In calendar year 2009 a total of 541 participants took the pre-knowledge test and only 9.9% of those passed the test with a score of 80% correct or better. A total of 458 took the post-knowledge test after completing the Community Voice training and 97.6% of those participants passed the knowledge test.

Table 7 lists the multiple choice and True/False questions and answers and the percentage of participants who answered each question correctly on the pre- and post-knowledge tests for calendar years 2008 and calendar year 2009. Results indicate:

- Participants' knowledge increased significantly on topics related to women's general health, such as the appropriate amount of weight gain for a pregnant woman.
- Participants' knowledge increased on topics related to the health of their babies, in particular, nutrition topics including folic acid and foods that can cause health risks.
- Knowledge about reducing the risk of SIDS by putting babies on their backs to sleep and babies are not more likely to choke if they do sleep on their backs increased significantly

During the Booster Sessions and Annual Celebration, a shortened (10 item) version of the knowledge assessment was given to measure the retention of information learned (Table 8). A total of 29 were completed and returned to the evaluation team, and of those, 86.2% of the LHAs scored 80% or above, indicating good retention. Although overall scores were high, some of the missed answers provide insight into areas that should be reinforced in booster sessions. For example, when asked about the number one cause of Black infant death, 31.1% of the LHAs marked SIDS, rather than preterm birth. More than a quarter (26.6%) misidentified the cutoff for low birth weight, or did not know what folic acid prevented (27.6%). Although the sample size is very small, this suggests the need to provide refresher information at booster sessions and through electronic media

In the focus groups another significant discovery was that LHAs indicated that the trainings reduced social stigma associated with infant death. They reasoned that the course increased awareness of the role of males in infant health and wellbeing and corrected myths about maternal responsibility for infant mortality.

As a caution, some risks attributed by LHA's in the focus groups to males may actually be shared by both men and women, and the attempt to ease maternal stigma could merely shift blame. Of further concern are dated references to "crack babies" as well as Fetal Alcohol Syndrome (FAS) in the curriculum. Not only does recent medical research dismiss the "crack baby" diagnosis (Chavkin, 2001), coverage of these concepts may also reinforce stigma rather than address underlying disparities. Select comments from focus groups include:

Results

"I had a baby born with a heart defect, lived like three days, but my husband was on a submarine at the time, so when I look back on that, that probably had something to do with him, the chemicals, something to do with his sperm, and the birth defect in the baby. [The submarine environment] probably had something to do with the heart defect in that child."

"One thing with my fiancé, he smokes. I'm not a smoker, I don't allow the smoke in the home, but when he comes in it's just so strong to me, I said 'you making me sick.' I don't smoke, I don't drink. When I [had] amniocentesis they said your child may be a Down syndrome child. The thing is all the smoking, and inhaling the marijuana smoke, the drinking bottles, you know how they pass [pot] from one lip to the other, you know it was affecting my baby, my baby could have inherited whatever you was doing from somebody else because that's from saliva."

QUESTION 2: HOW EFFECTIVE IS THE ADMINISTRATION AND IMPLEMENTATION OF THE PROGRAM?

To assess the effectiveness of the administration of the program, several indicators were taken into account:

- the number and type of partnerships supportive of the program
- the number of participants trained
- staffing
- implementation of marketing and recruitment
- implementation of training
- the number of Contact Reporting Forms returned

Table 9 summarizes the locations, zip codes, and dates of Community Voice training groups completed during the 2009 calendar year. The fourth column shows the number of anticipated attendees as reported by the March of Dimes Community Voice staff. The fifth column shows the number of participants who completed the background information questionnaire and the number of participants in attendance at initial sessions. The sixth column shows the number of participants who completed the post-training questionnaire and the number in attendance at the last session. Column seven shows the number of participants who passed the post-training knowledge test and successfully became Lay Health advisors.

Recruitment

Recruiting participants for the Community Voice program requires increasing public awareness about infant mortality, marketing Community Voice, partnership development, recruitment, and follow up with participants.

- 617 potential participants committed to participating in training in calendar year 2009
- 541 participants attended at least one training, and completed at least one survey or test
- The attrition rate from recruitment to actually attending at least one session was 18.8%
- Of the 541 participants who completed at least one survey or test, 458 took the knowledge post-test.
- The attrition rate from attending at least one session to taking the knowledge post-test was 8.6%
- In calendar year 2009, 447 LHAs were certified.

These results indicate that the process from outreach through the completion of LHA training requires careful management, as there are various points for attrition. Developing contacts and partnerships, following recruitees through training, and following up with LHAs is time intensive, and requires significant attention. To decrease the attrition rate would likely require increased staffing in the form of a full-time recruitment staff member.

A series of telephone interviews were conducted with individuals who had signed up for training, but did not attend. Of the 71 people the evaluation team attempted to contact, 33 were reached and interviewed (47.5%). When asked what prevented participation in the program, over 35% responded that there were scheduling conflicts. Other common responses included job related issues (16.1%), family responsibilities (9.7%), and never contacted (9.1%). Most (83.9%) participants who completed the interview were still interested in Community Voice and 25.8% of those contacted reported that they had heard about Community Voice from a health fair.

Interview informants noted that they have adopted flexible scheduling designs to respond to the needs of different types of groups, especially related to age and working schedules (e.g., teens still in school, seniors, working adults, church meetings, class meeting times). Several informants noted that some organizations continue to request training sessions. Although they want to be responsive to these supportive partners, this has also become a challenge as they seek out new sites/partners, especially with outreach specialist availability constrained due to

the vacancy.

During the interviews, recruiting and partnership development remains to be perceived as a key factor in cultivating participants for training. The informants consistently recognized and appreciated the challenge for participants to commit to attend the multiple CV sessions. Several informants noted that class size has increased as partnering organizations have been willing to open their sites to other interested participants not a member of their organization.

QUESTION 3: HOW EFFECTIVE IS PROGRAM PENETRATION AND DISSEMINATION?

To assess the effectiveness of program penetration and dissemination, several indicators were taken into account:

- the number/location of hosts/ partnerships contacted
- the number and background of participants trained
- community awareness of the issue and program
- the number of Contact Reporting Forms (CRFs) returned
- topics covered by the LHA with contacts
- the geographic locations of training sites
- where participants reside
- where infant mortality is occurring

On the Background Information Questionnaire, participants were asked about how they learned about Community Voice (see Table 10). They also were asked about their level of interest in and likelihood of telling others about Community Voice (see Table 11), and their expectations about talking with residents in the neighborhoods where their training was located (see Figure 2).

In calendar year 2009, prior to the training:

- 59.2% of participants reported that they were looking forward to spreading the word about Community Voice
- 13.1% of participants reported that they participated in Community Voice for their own information
- 22.8% said that they were not sure until they learned more about the program.

In a revised version of the BIQ, participants (n=246) were asked to indicated how many people from specified categories they would be most likely to share information with about the Community Voice Project (Figure 3). Almost half (48.5%) of the participants said they would be willing to speak with 1 to 5 friends about Community Voice; and 45.9% of participants said they would be willing to talk with 1 to 5 family members. However, 54.1% of participants said they would be *not* be willing to talk about Community Voice with people outside of their:

- Friends
- Family
- Church
- Neighborhood residents
- Co-workers or classmates

CV participants enter the training with a moderate to high level of motivation to spread the word to pregnant family members and close friends – but the motivation on the part of most participants is strongest "when asked" by their close associates. When spreading the word appears related to professional or organizational roles, motivation appears to be more proactive (even in out-of-role settings.)

Based on focus group data, the most active LHAs have personal experience with infant loss and/or work in regular contact with the target demographic (e.g., school system, health department, doctors' offices, and grassroots organizations):

"I'm a Memphis school worker, and I work with teen parents. Unfortunately I have very young girls, like 13 and 14. It's very important for me to get in, and it's like an eye opener for me, to get in on folic acid, perinatal care, and SIDS"

"I'm a family specialist at [a] high school. I have discovered that a lot of the students who are acting out… have a high incidence of infant mortality. And its making them act out because they don't understand the grief process, and so I just talk to them about their grief."

Participants report at the beginning of training that they will be somewhat to very likely to distribute information "at church, club and community events," an option that might benefit from more support on the part of the CV staff. Focus group participants recommended that LHAs be recruited to expand training at more sites:

"Why don't we utilize some of the lay health advisors? There are some that are very active like myself. Utilize lay health advisors to teach some of these classes. The problem we were having was accessibility, because MOD is stretched so thin with their staff. And I think that's really going to be the downfall of that program, because they won't be able to service Memphis."

The Community Voice program is working to provide training in neighborhoods targeted due to high

Results

infant mortality rates. Many participants in the program lived, went to church, or participated in community activities in the neighborhood where the trainings were located. Some participants only went to the neighborhoods where trainings were located to attend the trainings. Participant expectations for their interaction with residents of the neighborhoods are shown in the Figure 2.

In calendar year 2009 March of Dimes Community Voice implemented a new mode of dissemination by creating a Community Voice Facebook page. As of the time of this report they had 661 members. They continue to utilize this promising mode of dissemination.

Taking it to the People: Contact Reporting Form Data

Following training, Lay Health Advisors (LHAs) are asked to report on their interactions with people in the community. To report these conversations, LHAs were asked to complete a contact reporting form each time they spoke to individuals or groups. Out of 447 LHAs trained during the 2009 calendar year, a total of 38 (8.5%) returned contact reporting forms . In calendar year 2008, 49 (15.6%) LHAs returned forms. A total of 87 (11.4%) LHA's have returned 4,571 contact reporting forms since the beginning of the program. A total of 56 LHAs, including those trained during the 2008 calendar year, returned a total of 2033 contact reporting forms for the 2009 calendar year. The number of forms returned per LHA ranged from 1-709 forms, averaging about 13 forms per LHA who returned forms. Of the contact reporting forms returned, LHAs most often returned 10 forms.

On these forms LHAs can indicate how they made contacts and how long they talked with contacts. Of the contacts made, 81.7% were with individuals, 12% were informal conversations with a small group, 2% were group presentations, and 4.3% were email or internet contacts. The length of the interaction most frequently lasted 5-15 minutes (40.4%). Table 12 shows the age ranges of persons contacted by LHAs. **LHAs estimated contacting approximately 2,864 people** as individuals or in groups. This number has dropped significantly from the 2008 calendar year, in which 6,406 contacts were made. This drop is due, in part, to LHAs talking to much smaller groups of people.

Dissemination activity cannot be considered without taking into account one LHA who, in calendar year 2008, returned 1250 contact forms (half of all contact reporting forms and 75% of reported contacts). This LHA, who considers herself a "professional volunteer," used her work promoting HIV awareness to spread the word about Community Voice. Most of her contacts occurred in public places. In meetings with contacts, she encouraged others to contact the program and participate in training, and related information about prenatal and perinatal care and HIV causes and prevention. This LHA returned to school and was not active in the Community Voice program during the 2009 calendar year.

In calendar year 2009 another high volume LHA emerged, who returned a total of 709 contact reporting forms reaching 745 people. This LHA made many contacts through speaking with people at school and on the bus, however, most of her contacts were made through the Community Voice Facebook page, and at information sessions she organized at her church.

Pre-training responses from the BIQ about spreading the word about Community Voice were compared with what LHAs actually reported based on contact reporting forms sent to the Community Voice evaluation team (Table 13). To examine whether motivation to disseminate prior to training was related to actual return of CRFs, LHAs were divided into groups based on responses to the questions about spreading the word on the BIQ. Results indicate that those who are motivated to participate in Community Voice for their own information and those motivated to spread word were equally likely to send in CRF's, whereas those who were not sure were less likely to send in CRFs.

LHAs also indicated what they discussed with each contact by choosing from a list of 17 topics provided on the contact reporting form. Participants were able to choose more than one answer from the list. Figure 4 indicates which topics LHAs reported discussing when they disseminated information.

Figure 5 indicates that for both the 2008 and 2009 calendar years female LHAs were more likely to report discussing topics such as the Community Voice program and Infant Mortality, whereas male LHAs were more likely to report discussing some of the more specific topics, such as drug and alcohol use. Interestingly, male LHAs reported discussing breastfeeding more often than did female LHAs, during both the 2008 and 2009 calendar years. This illustrates the need for more dedicated men in the program.

More than 25% of the CRFs indicated that people the LHAs contacted were 18 or under and pregnant. A contributing factor to high risk pregnancies is the age of a

pregnant mother, specifically one under the age of 16 (Gilbert, Jandial, Filed, Bigelow, & Danielson, 2004; Fergusson & Woodward, 1999; Fraser, Brockert, & Ward, 1995). The high percentages of reporting forms indicating contact with individuals 18 or under and pregnant indicate that LHAs are spreading the word to a high risk group.

The last question on the contact reporting form asked LHAs to select circumstances in which they made contacts by choosing from a list of 14 potential contact contexts that are provided on the form. Participants were able to choose more than one answer from the list. Figure 6 shows the percentages of contexts or circumstances in which LHAs were able to disseminate information about perinatal care and infant mortality.

Evaluation team members began contacting LHAs during July of 2009 to discuss the process of returning the contact reporting forms, and to gain insight on better ways to submit these forms. A total of 185 telephone interviews were completed (40.4%). More than half (68.3%) reported that they had the opportunity to speak with someone about Community Voice and 29.6% had turned in contact reporting forms. This suggests that nearly one half of the LHAs who made a contact also turned in a CRF, although those willing to participate are not a random sample of LHAs. Of the LHAs contacted, 22.2% shared suggestions for making the process for reporting contacts easier, including putting the forms online (53.6% of the 22.2%), sending reminders to LHAs (25.0%), emailing the forms (18.8%), and faxing forms (18.8%).

When asked if there was anything Community Voice could do to make it easier to talk to others about what they learned, only 7% of LHAs contacted reported suggestions. The most common suggestion was having more CV brochures to distribute when talking to people (25%). Other suggestions included having more practice during the trainings (14.3%), and receiving information from CV about related topics through email/mail (16.7%).

Many focus group participants shared stories of "taking it to the people":

"We do go out in the community, and we do share about March of Dimes, SIDS, it was crazy cause it was like "well my mom told me that I should do this with my baby" and now they are learning and some of the young girls even breastfeed, which is one of the best natural things you could ever do for your child."

"As soon as I got out of the training the issue was coming up… and not only was it coming up in the media, it was coming up in the newspapers, the radio, and commercials. So I started taking it to my church, and when someone said, 'why are you talking about that?' I said 'Can't you see this is what's happening? You need to be informed.'"

"It's just been wonderful to be able to raise awareness about how people need to prepare, really the idea of preparing to become pregnant… it's all a matter of smoking, drinking, all of that drama and all of that, so trying to raise awareness to, especially our younger people, and the older people so they can tell other younger people about how they can prepare, including the dads."

Some focus group participants were concerned that the public lacks awareness about infant mortality and about the Community Voice program and expressed the opinion that the program is not adequately publicized:

"We have developed what we call an infant mortality force. Our goal is to raise awareness because we don't hear CV very often. Even though these two rooms are full with LHAs you never hear about CV in the community, which is kind of defeating the purpose I think. But when you see it on T.V. and they talk about infant mortality and you hear ABC, that's a Shelby County initiative, but you never hear about CV. So my goal was to get out there and be active and let people know about MOD in reference to infant mortality. It's free, it's for the public, so I try to get out there and be that voice."

"A lot of people don't know the training that's available and that it's free and that we'll come to your church, we'll come to your office, we'll come to your school, or your place of work, we'll have a birthday party."

"MOD is still not emphasizing enough of infant mortality, they're more stuck on the premature birth, which you know we already know is a factor, of course, but I think in order to get that message out there they need to do a PSA or you know, something that has something to do with CV because that's what this program is about"

However, the focus group participants agreed that there is strong support for the program among those who are familiar with it. The participants cited many strategies to further publicize the program, including:

- billboards
- flyers
- television news coverage
- business cards for LHAs to hand out
- wallet-sized cards with basic health facts for pregnant women for LHAs to pass out

LHAs also suggested targeting 201 Poplar (the Shelby County Criminal Justice Complex) as a way to recruit men for the Community Voice program.

Results

Geographic Mapping of Penetration and Dissemination

In order to fully understand the maps, background on the geographic context is needed. As with correlates of poverty more generally in Shelby county, risk factors for infant mortality and other poor birth and early childhood developmental outcomes have geographically decentralized from the historical "inner city" neighborhoods to what we can consider "neighborhoods in transition" shifting from higher income to lower income. These neighborhoods are farther removed physically from the inner city and its traditional concentration of human services (for example, the Health Loop clinics and The Med). Anti-poverty and health disparities interventions are challenged to catch up to these new patterns, and Community Voice is no exception.

Data for the 2008 report reveal that CV sites were concentrated in traditional high poverty areas. Responding to feedback from the 2008 evaluation, the CV team made significant strides to widen the net. Combined data for 2008 and 2009 CV sites (see map in Appendix N) reveals new CV outreach in neighborhoods that have only more recently begun to experience concentrations of poverty. Similarly, in 2009 the neighborhoods where LHA's live and convey the Community Voice message (see Table 2) are more diversified to include neighborhoods in transition.

CV's long-run efficacy depends on sustained success in "reaching families where they live," which means keeping abreast of changing demographic patterns in Memphis and Shelby County: the CV message must both be spread to areas of growing risk and be brought to scale in terms of numbers of people receiving the message and spreading the word. That is, the message must be widely disseminated and penetrate deeply among the targeted population. The importance of targeting CV outreach to areas of growing need is critical to spreading the word.

The Significance of Neighborhood Change

Analysis by the Center for Community Building and Neighborhood Action classifies Shelby County neighborhoods (census tracts) in terms of four zones. Zone 1 includes "classic distressed" (historically high poverty) neighborhoods; Zone 2 includes "vulnerable swing neighborhoods" (in transition from higher to lower income where quality of life indicators have declined but not reached the level of Zone 1); Zone 3 "neighborhoods of choice" where demand for housing reflects positive assessments of quality of life; and Zone 4, where indicators are uptrending after significant renewal and investment efforts ("uptrending neighborhoods" such as the HOPE VI Uptown renewal area or downtown to South Bluffs.) Both Zone 1 and Zone 2 neighborhoods are critical for Community Voice dissemination strategies. Zone 2 neighborhoods include a disproportionate share of high-density, multi-building apartment complexes where address level data on risk factors reveals identifiable concentrations of higher risk populations; hosting CV sites in apartment complexes is a smart strategy that CV began to implement in 2009 and that can and should be expanded.

The Shelby County Zone Map (Figure 7) frames this discussion of geographic dissemination strategies; both Zones 1 and 2 are associated with infant deaths and high-risk births as seen by comparing the Zone Map with the zip-code maps on birth outcomes in the appendix. Significantly, when infant deaths are reported as a percentage of all births in a zipcode (or multiplied by 10 and reported as the infant mortality rate per 1000 births), Zone 1 zipcodes stand out. It is extremely important, however, to understand that most Zone 1 zipcodes have been losing and continue to lose population – especially younger people of childbearing age. If there are relatively few births, even a high *rate* of infant death will mean relatively few at-risk families that need to be reached. On the other hand, when we look simply at the *actual number* of infant deaths, we see that Zone 2 zipcodes are the places to reach more at-risk families. This pattern holds when we look at low birth weight, teen mothers, mothers without a high school education, and mothers in poverty*: the movement of these high risk populations to Zone 2 means that outreach in Zone 2 is critical and may reach more families at risk of infant death – even if the percentage of families experiencing infant death remains higher in Zone 1.*

The density maps, also in the appendix (Appendices O—R), reveal geographic clusters of at-risk families within zipcodes. Heat maps are highly useful for outreach: the darker and smaller "clusters within clusters" mean a larger number of at-risk families in closer proximity to one another. As the rings spread out and become lighter in color, the fewer and farther between are families at risk. Heat maps enable CV to even more strategically target outreach *within* zipcodes. Comparing heat maps with zipcode maps that include the distribution of apartment complexes in Memphis and Shelby County, *the wisdom of an outreach strategy that would target apartment complexes and build partnerships with apartment owners and managers in a*

The risk factor map series (Appendices S-V) follows the density maps. Following 2008 recommendations, 2009 sites are moving into Zone 2. Comparing the location of 2008 and 2009 sites with risk maps, it is clear that there is plenty of room for expansion: to the extent that sites draw people from surrounding neighborhoods, and/or result in dissemination within surrounding neighborhoods, they should be well-distributed within and across high risk neighborhoods. (See also Table 2 for distribution of individual participant zip codes, which suggest the potential reach through participants' own neighborhood networks).

Interim Evidence of Penetration

Complementing evidence from the distribution of training sites within high risk zip codes, other evidence that the Community Voice message is being disseminated and is penetrating with the targeted population (as well as evidence of challenges) is drawn from participant-supplied data (quantitative data from surveys and tracking forms, presented above) and from qualitative observations of training (participant comments), follow-up participant focus groups, and interviews with CV personnel. The discussion below focuses on two pre-requisites for effective dissemination and penetration: representativeness and connectivity.

Representativeness

African American representation among participants is strong (83%), befitting the emphasis on health disparities and reducing infant mortality and improving birth outcomes among African Americans (see Table 3) White participants will be most effective if they are integrated into deliberate multi-racial networks (through institutional or organizational affiliations, for example); it is not clear to what extent white students and participants in an HIV support group – the primary sources of non-African American participation in the first year -- are connected to appropriate networks. (First year data also reveals that their dissemination motivation however was low).

Youthful and child-bearing age participants are well-represented in both 2008 and 2009 (see Table 3), with over 75.1% of participants under 45. Reaching this demographic is not to be taken for granted with community outreach strategies, where in fact the elderly are most often over-represented. Just as importantly – since most dissemination appears to be happening among close friends and family, a total of 56.5% of participants live in households with *other* girls and women from ages 14 to 44, while 30.7% are in households that include children under three years old. Even higher than the 14% recorded for 2008, 26.6% of 2009 participants are themselves pregnant, trying to become pregnant, or living with another household member who is pregnant. All of this suggests ease of participant access to young people and adults who need to hear the CV message.

In both 2008 and 2009, there is some over-representation of better educated participants, with 23.4% having a bachelors, graduate, or professional degree and another 23% some college; to the extent that these CV participants are in agencies, organizations, and other networks where dissemination is related to professional positions and roles that are highly connected to less educated people, representativeness for these participants may be less important than "connectivity," which is discussed below.

Also of note, 33.5% of CV participants report that someone in their family has experienced an infant death (see Table 4); the density of family networks suggested by this apparently high percentage can be a strength for dissemination. (Whether this is an unusually high percentage of exposure compared to the general population requires some statistical analysis that has yet to be carried out.)

Connectivity

That participants come from a spectrum of both Zone 1 and Zone 2 zip codes all over the county is impressive; this "reach" appears to be a function of participant relationships (including professional) with sponsoring organizations and agencies in zip codes where participants do not live. Host sites zip codes diversified in 2009, and there remains as yet untapped potential to penetrate Zone 2 to an even greater degree by working more closely with apartment complexes and community-based organizations in Zone 2. The importance of organizational and agency sponsorship is evident in high attendance sites compared to low attendance (and cancelled) sites in community centers and churches (which may have been overestimated as a recruitment partner in the first year.) This organizational and agency connectivity is also evident in how participants heard about CV opportunities, where (comparable to 2008) 83.6% of participants have an organization, agency, or institutional connection (service club, sorority, employer, school). (see Table 9)

Results

About half of CV participants identify personal connections with host-site neighborhoods, but only half of these connectors actually live in the neighborhood – again underscoring how the CV strategy is not simply a "grassroots" approach where informal place-based connections motivate participation; reaching people in high risk neighborhoods appears to work best when recruiters work through organizations and agencies that have a neighborhood presence and a connection to neighborhood issues and residents.

QUESTION 4: HOW EFFECTIVE IS COMMUNITY VOICE ON LONG-TERM OUTCOMES?

To assess the effectiveness of Community Voice on long-term outcomes, several indicators must be taken into account: community knowledge about the course and its content; positive behavioral changes in the population; increased utilization of first trimester prenatal care; and reduced low birth weight babies, prematurity, and infant mortality. Even at the end of the second year it is too early to assess progress on long term outcomes: birth data for 2007 and mortality data for 2008 has just now become available. In other words, our birth outcomes and risk factor data (see appendices W,X, and Y) is still very much baseline data.

Recommendations

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Curriculum			
Review expectations of topics to be covered and revise the curriculum design to ensure sufficient time to cover the entire curriculum.	The curriculum has been revised for the 2009 calendar year, and content from session one has been moved to session two to allow time for paperwork to be completed, but content often is still not covered in the allotted time.	Partially	
Develop time management strategies to ensure sufficient time to cover the entire curriculum.	Outreach Specialists are exhibiting better time management and continuing to exhibit enthusiasm in trainings. Because of this enthusiasm, Outreach Specialists should remain mindful of time management	Partially	1. Expand session one by 30 minutes to allow time for paper work; 2. Shift some of the content from session one to session two; 3. Hold group discussion until second session.
Review current role playing exercise design and develop consistent expectations regarding their inclusion.		Yes	
Review current strategies for addressing controversial topics such as Back to Sleep and breastfeeding and develop a consistent expectation for how to effectively address such topics.		Yes	
Consider shorter and more intensive training.		Yes	
The curriculum itself might include more information on the father's role in pregnancy and parenting, and the role of the male Lay Health Advisors in serving as mentors to other males when "taking it to the people." This curriculum revision should also include strategies/ expectations for how to effectively engage males during the training.	Although the curriculum does address sperm health and preconception health, more emphasis is needed on the role of men across the reproductive life span in the curriculum.	Partial	Emphasize the father's role across all stages of the reproductive lifespan in the curriculum. Create brochures targeted to men.
Consider adding listings for governmental and grassroots development organizations in the resource guide (e.g., environment court.)	The 2010 resource guide is being reviewed and additional resources/recommendations are being researched in detail for 2010 revisions .	No	
			Create a systematic way of training Outreach Specialists to address topics such as grief, domestic violence, mental health, and cultural awareness.

Recommendations

Previous Recommendations	Progress	Met?	Further/New Recommendations
Program Administration/ Implementation			
Clarify governance roles and responsibilities of the Community Voice project within the broader Infant Mortality Initiative.		Yes	
Clarify governance role and responsibilities of the Core Leadership group as they relate to the Community Voice project.		Yes	
Develop recruitment procedures (to include identifying/refining specific target organizations to be recruited and building recruitment partnerships with target organizations).		Yes	
Consider hiring full-time recruitment personnel as high priority.	Part-time recruiter has been hired.	Partially	
Reassess the incentive structure to assure that it aligns with program goals and expectations.		Yes	
			Hire second outreach specialist to increase training capacity to meet the demands of the program, and take burden of training off of non-OS staff.
			Evaluate roles and responsibilities of project coordinator, recruiter, and outreach specialists to ensure that all duties are being met, including following up with LHAs after trainings.
			Create resources for LHAs with pragmatic advice on handling situations related to domestic violence and grief.
			Expand the resource guide to provide referral networks, especially with respect to domestic violence and grief counseling.
			Expand the number of agencies that CV is working with and focus on those that connect to the key target demographic.
			Rather than targeting specific classes of high school students, consider trainings for high schools that are voluntary and after school groups and programs.
			Consider holding trainings at the Adolescent Parenting Program, an alternative school for pregnant teens.

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Dissemination/Penetration			
Continue to focus on recruitment strategies and encourage greater emphasis on the institutional and organizational strategies being developed.		Yes	
Strengthen the social marketing plan:		Partially	
1. Refine the community-based marketing strategy.	A Community Voice Facebook Page was created	Partially	Web page needs to be created and support materials should be more accessible.
2. Coordinate the marketing strategy with the broader Shelby County infant mortality initiative marketing plan.		Partially	Continue to partner with ABC to find opportunities to market Community Voice.
3. Develop a health promotion campaign related to infant mortality		No	This remains a community need that the Core Leadership Committee should discuss, however it is unrealistic for Community Voice to undertake this on its own.
			Provide the LHAs with more dissemination material, such as brochures and business cards with March of Dimes Community Voice contact information on the front and a pregnancy tip on the back.
			Provide the LHAs with access to supplemental materials such as videos.
			Use social networking opportunities more strategically (e.g., "Tip of the Day" on the Facebook page).

Recommendations

Previous Recommendations (CY2008 Annual Report)	Progress	Met?	Further/New Recommendations (based on CY 2009)
Long Term Outcomes			
The Infant Mortality Initiative is preparing to develop a long-term strategic plan. Such a plan would presumably articulate how the several Infant Mortality programs operating in Shelby County could leverage one another's resources and social networks. Community Voice would benefit from a stronger collaborative vision and supportive infrastructure that clarifies their role and responsibilities in the ongoing effort to reduce infant mortality in Shelby County.	ABC is expected to initiate strategic planning. Community Voice should play a role in ABC's strategic planning process.	Partially	This remains a community need that the Core Leadership Committee should pursue, however it is unrealistic for Community Voice to undertake this on its own.
			Provide refresher courses for long-term LHAs. Consider incorporating a mechanism that would allow LHAs to reach Outreach Specialist status.
			Review key material at the booster sessions.
			Focus on developing the Speaker's Bureau as a resource to expand visibility of CV in the community
			Capitalize on and support long-term, invested LHAs by keeping them informed, engaged, and supplied.
			Begin addressing sustainability, particularly with respect to funding.
			Develop a CV community advisory board.

Tables and Figures

Table 1: Host Site Zip Codes

Table 2: Participants Zip Codes

Table 3: Demographic Characteristics

Table 4: Participants' Individual and Family Situation

Table 5: Post Training Questionnaire Responses for All Participants and LHAs

Table 6: Participants' reactions to training

Figure 1: Topics Most Prepared to Discuss

Table 7: Pre and Post Knowledge Test

Table 8: Post-Post Knowledge Test

Table 9: Locations, Zip Codes, and Dates of Community Voice Training

Table 10: Source of information about Community Voice Training

Table 11: Participant's Interest in Telling Others about Community Voice and Perinatal Health/Infant Mortality

Figure 2: Expected Contact with Neighborhood Residents

Figure 3: Number of Participants People are Likely to Speak With about Community Voice

Table 12: Age Range of Contacts

Table 13: Reasons for Participating in Community Voice

Figure 4: Topics Discussed During Post Training Contacts

Figure 5: Topics Discussed By Gender

Figure 6: Context in Which Contact was Made

Figure 7: The Shelby County Zone Map

Appendices

A. Method

B. Evaluation Question by Method

C. Background Information Questionnaire

D. Pre/Post Knowledge Test

E. Post-Training Questionnaire

F. Contact Reporting Forms

G. Post-Post Knowledge Test

H. LHA Follow-Up Questionnaire

I. Non-Matriculate Phone Survey

J. Recruiter Interview Guide

K. Outreach Specialist Interview Guide

L. MOD, County and State Administrator Interview Guide

M. LHA Focus Group Interview Guide

N. Map Showing 2008, 2009 Community Voice Sites

O. Density Map: Mothers without High School Diploma

P. Density Map: 2007 Births Mothers in Poverty

Q. Density Map: 2007 Births Teen Mothers

R. Density Map: 2007 Low Birth Weight

S. 2007 Mothers without High School Diploma

T. 2007 Mothers in Poverty

U. 2007 Teen Moms

V. 2007 Low Birth Weighty

W. Death Rate Per 1000 Births by Zip Codes

X. Number of Infant Deaths by Zip Code for 2007 Births

Y. Infant Mortality Deaths by All Mothers and African American Mothers

Appendices

METHODOLOGY

The participant population for the Community Voice program and evaluation includes mostly adult women between the ages of 15 and 85. Participants have been recruited by the March of Dimes to participate in the Community Voice program to become Lay Health Advisors (LHAs). A few groups of participants have included high school students under the age of 18. All trainees are asked to participate in the evaluation and as of this reporting period, all who have participated in training also have participated in the evaluation. The goal of the program is to reduce infant mortality in African American communities and therefore most participants are African American. In addition, March of Dimes Community Voice is recruiting trainees in neighborhoods with higher rates of infant mortality and relying on churches and community-based agencies for recruitment contacts.

The methods used for the Community Voice evaluation are surveys, observations, interviews, focus groups, and pre- and post-knowledge tests. In addition, secondary data collected by the Tennessee Department of Health will be utilized as part of the evaluation. Following are descriptions of the methods and procedures used in this comprehensive evaluation.

Quantitative Methods

Surveys

Background Information Questionnaire. The first survey participants complete during training is a pre-training questionnaire, called the Background Information Questionnaire (BIQ). In 2009 this survey was modified from the original version by shortening the length of the questionnaire and rephrasing questions to limit confusion.

The BIQ gathers information including:

- how participants learned about and why they are participating in Community Voice
- if they are currently pregnant
- if they have children and/or if they are living with family members who are pregnant or have children
- whether they personally or know people who have experienced infant death
- if and how they will spread the word about Community Voice after training is complete
- demographic information

Pre/Post-Knowledge Tests. In addition to the surveys, participants complete a knowledge test at the beginning and at the end of the training. The knowledge test was originally developed by the Community Voice program in Lynchburg, and was slightly modified by Lynchburg at the end of calendar year 2008. This modified version was implemented locally in January 2009. The test includes multiple choice and True/False questions about topics such as:

- the Community Voice program
- prenatal care
- nutrition
- SIDS
- low birth weight
- Breastfeeding
- alcohol and drug use

Post-Training Questionnaire. The last survey participants complete during training is the Post-Training Questionnaire (PTQ). This survey was also modified in calendar year 2009 by shortening the questionnaire and rephrasing questions to limit confusion.

The PTQ gathers information about participants' reactions to the training including:

- the timing and organization of the sessions
- materials used for teaching
- the content and curricular activities
- the instructors' effectiveness
- participants' self-efficacy once they have completed the training

Contact Reporting Forms. Throughout the training, Lay Health Advisors (LHAs) are asked to take the information they learn and disseminate it into the local community. LHAs are asked to report on their interactions with people in the community to enable the evaluation team to track penetration of the intervention. LHAs are given Contact Reporting Forms (CRFs) to fill out for each contact they make, whether it is an individual or group. In calendar year 2009 the CRF was modified to add new types of contacts (e.g., email or internet). On this form, LHAs identify;

- number of and ages of the contacts
- how long they talked,
- topics they talked about with each contact
- what circumstances they made the contact

Non-Matriculate Follow-up Telephone Interviews. A telephone interview was created during the 2009 calendar year and used to better understand why those who originally signed up to receive training as a Lay Health Advisor did not participate in the training. In November 2009, evaluation team members attempted to contact 71 individuals who had signed up to participate in training but did not matriculate. Of those, 33 were interviewed about their experiences, for a response rate of 46.5%.

LHA Follow-up Telephone Interview. In calendar year 2009, a telephone interview

Appendices

was created to contact LHAs to discuss the process of returning the contact reporting forms and gain insight into ways to make it easier for LHAs to use and submit these forms, with the goal of increasing participation. Team members attempted to contact 458 LHAs during July and August of 2009. Of the 458 LHAs, 110 had telephone numbers that were disconnected or the person no longer lived there. Interviewers were able to obtain updated numbers for 20 LHAs, as well as 148 email addresses. A total of 185 telephone interviews were completed with LHAs, for a response rate of 40.4%.

Post-Post Knowledge Test. A short version of the knowledge test was administered during booster meetings and the Annual Community Voice Celebration during the 2009 calendar year. The purpose of this ten question survey is to evaluate the extent to which LHA's retain information from the trainings over the longer term..

Survey Procedures. The first component of the evaluation involves surveying individuals being trained to be LHAs. Following are the procedures for the five day, over five weeks, training sessions:

1. First Training Session
   a. Community Voice Staff welcomes participants and has them introduce themselves.
   b. A trained member of the Community Voice Evaluation team explains the purpose of the evaluation and confidentiality to trainees.
   c. A trained member of the Community Voice Evaluation team provides and obtains informed consent and the Background Information Questionnaire (BIQ).
   d. Trainees are asked to complete the BIQ.
   e. Community Voice Staff explains parental consent and collects parental consent forms if minors are in the training.
   f. Community Voice Staff explains and the trainees then complete the knowledge pre-test developed as part of the Community Voice program.
   g. Community Voice Staff conducts Session I. A trained member of the Community Voice Evaluation team observes the first session.
   h. Community Voice Staff forwards knowledge pre-tests to the Research Associate after grading tests and recording scores.
   i. The Research Associate removes the cover sheet on the BIQ that contains the names of each participant questionnaire and assigns each participant a unique identification number. An evaluation team member scans the BIQ data and stores original data securely in the office of the Center for Research on Women.
   j. The Research Associate enters the knowledge pre-test scores into the evaluation database, makes copies of the tests and stores them securely, and then forwards the pre -tests back to Community Voice Staff.
2. Second – Fourth Training Sessions
   a. A trained member of the Community Voice Evaluation team conducts at least one observation (see observation details below).
3. Fifth Training Session
   a. Community Voice Staff conducts Session 5.
   b. Community Voice Staff explains and trainees take the knowledge post-test developed as part of the Community Voice program.
   c. A trained member of the Community Voice Evaluation team briefly reviews informed consent and confidentiality.
   d. A member of the Community Voice Evaluation team explains the Post Training Questionnaire (PTQ) to participants.
   e. Trainees are asked to complete the PTQ.
   f. Upon completion of the PTQs, the Community Voice evaluation team member reviews the process for submitting Contact Reporting Forms (CRF) with LHAs. Each LHA is given a packet that contains an instruction letter, 10 Contact Reporting Forms (CRFs), a participant contact information sheet, and an envelope that is self-addressed and does not require postage so that participants may easily return forms to the CROW office. The team member then explains the process by which LHAs can report their contacts. LHAs are asked to complete a contact reporting form each time they speak to individuals or groups. The eam member also informs LHAs about the incentives for participating in this effort which include: certificates of appreciation; a $25 gift card to Kroger for the LHA who returns the most forms each month; recognition in a newsletter sent to all LHAs; and entrance into a monthly drawing for a $25 gift card.
   g. Outreach Specialist ends Session
   h. The Community Voice Outreach

Specialist scores each post-knowledge test and gives the tests to the Research Associate to record results. The Research Associate makes copies of the tests for the evaluation files, enters the data into the evaluation system, and returns the original knowledge tests to March of Dimes Community Voice staff.

i. The Research Associate removes the cover sheet on the PTQ that contains participant names and writes their unique identification number on the PTQ. An evaluation team member scans the PTQ data and stores original data securely in the office of the Center for Research on Women.

j. The Research Associate scans the knowledge post-tests and enters scores into the evaluation database. Copies of the tests are made and stored securely, and originals are forwarded back to Community Voice Staff.

k. As CRFs are received from participants, new packets containing more forms are sent to LHAs. CROW records CRF data and notifies LHAs if they win the LHA of the month honor, certificate, or drawing.

l. Several different formats were developed during the 2009 calendar year. These include 2 day trainings and 5 consecutive trainings in one week (versus 5 sessions over 5 weeks). Procedures at the beginning and the end of the sessions are the same. The 5 consecutive training sessions are observed the same way the 5 week sessions are observed (i.e., first and last sessions and one session in the middle are observed); however, for the 2 day trainings the trainings are typically observed in their entirety.

Secondary Data Analysis

In addition to the primary data collected by the team, secondary data from the Birth, Death and Hospital Discharge Data System datasets of Tennessee Department of Health will be analyzed using quantitative methods. The data includes records from all women who gave birth between 2006 (baseline) and 2010 (as the data become available) and their infants. Quantitative analysis will document risk factors, map their distribution by neighborhood in Memphis and Shelby County, and monitor for shifting associations and/or geographic patterns that might be attributable to Community Voice dissemination and penetration.

Qualitative Methods

In addition to quantitative methods utilized in the evaluation, qualitative methods also are included in order to produce a more comprehensive evaluation. Following are descriptions of the qualitative means by which the evaluation team has collected and will continue to collect, analyze, and report data.

Observations

A member of the CV Evaluation Team observed the first and last sessions, and one randomly selected session in between (second, third, or fourth) of the five CV training sessions offered by Community Voice March of Dimes. In the instance of a two-day training session, team members observed both sessions in their entirety. Participants and one outreach specialist (trainer) were observed during each session of CV training.

The evaluation team conducted systematic observations of 135 Community Voice training sessions during the 2009 calendar year. Observations documented curriculum fidelity, participant responses to course material, social cohesion among participants, and opportunities to strengthen the program. During observations, notes are written in a notebook, and observers transcribe their notes onto the Process Query (PQ) form. Elements observed are:

- room layout and seating arrangements
- dynamics of the training, including: visual indicators of engagement or disengagement of participants; visual indicators of comprehension or lack of comprehension of the curriculum; visual indicators of agreement (acceptance) or disagreement (rejection) with the curriculum
- time management of the trainers
- the materials disseminated, including: lay health guide, informational brochures (provided by March of Dimes), PowerPoint slides (provided by March of Dimes), and films (provided by March of Dimes)
- training sessions' fidelity to the Community Voice program

Team members looked at the relevant evaluation question, "How effective is the curriculum?" and determined salient aspects of the training to consider when coding notes for the purpose of examining the content and process of the training sessions. This included:

Appendices

- utilization of training materials
- participant comprehension and agreement with material presented
- participant engagement with curriculum
- Logistics
- interpersonal dynamics

For the purpose of this report, all observation notes from the training sessions from calendar year 2009 were coded. In addition, a sample of 15% of the observation notes were coded by three evaluation team members to assess whether all observations were coded in the same way by all coders. This process was conducted to ensure intracoder consistency and intercoder reliability. Through this process, the coders achieved a very high degree of accuracy and uniformity in the data coding process.

Interviews

The protocol to conduct interviews with professional staff associated with the Community Voice program was updated for the 2009 evaluation. Team members conducted nine interviews with professional staff associated with the Community Voice program including:

- One current outreach specialists who conducted the Community Voice training sessions
- Two former outreach specialists
- The recruitment coordinator for Community Voice (who also conducted training sessions)
- Project Director of Community Voice (who also conducted training sessions)
- March of Dimes State Director of Program Services
- Campaign Coordinator for All Babies Count
- Shelby County Infant Mortality Reduction Initiative Coordinator
- Director of Women's Health with the State of Tennessee Governor's Office of Child's Care Coordination

The purpose of the interviews was to learn about the effectiveness of the curriculum, recruitment and outreach, and administration of the program. Interviews took place from December 2009 through February 2010. These interviews serve as a benchmark for the evaluation and will be repeated annually to track the evolution of the program and to provide qualitative program data to document insights into the strengths and challenges faced by those implementing the Community Voice program. Interviews were conducted in person and notes were taken during each interview. Notes were reviewed and information relevant to effectiveness of the curriculum, recruitment and outreach, and administration of the program was summarized.

Focus Groups

The evaluation team made minor adjustments to the original focus group protocol for the 2009 calendar year. Following the protocol, team members conducted two focus groups in December 2009 with nearly 40 Lay Health Advisors (9% sample) from the Community Voice Education program. Evaluation team members recruited only those LHAs trained during the 2009 calendar year. The purpose of the focus groups was to learn about the effectiveness of the curriculum, the implementation of the training sessions, and the dissemination of information about infant mortality and perinatal health education. Subsequent focus groups are planned to take place every six months. Focus group discussions were audiotaped and transcribed. Transcriptions were reviewed and coded.

Content Analysis

Members of the evaluation team are reviewing the content of the CV guidebooks, brochures, handouts, and power point presentations. These will eventually be compared to ACOG guidelines for best practices.

Appendix B

Community Voice Evaluation Plan
Developed by University of Memphis Center for Research on Women

DRAFT CV - Evaluation Question by Method	Observations	Survey	Knowledge Test	Interviews	Focus Groups	MOD reports
Responsible PI	**RF**	**LS, RF**	**LS, RF**	**JC, RF**	**RF, JC**	**JC**
How Effective is the Curriculum?						
Effectiveness of materials (curriculum, PPT slides, fact sheets)	x	x	x	x	x	
Effectiveness of followup with LHA (booster, 6 month celebration)	x	x				
Effectiveness of educator	x	x	x	x	x	
Effectiveness of recruitment and outreach materials (website, newsletter, brochure, posters, other media)						
Fidelity to CV manual	x		x	x		
LHA knowledge of course content	x	x	x	x	x	
LHA confidence in ability to disseminate		x			x	
How Effective is the Administration of the Program?						
Staffing (hiring, training, supervision, cooperation, turnover)				x		x
Implementation of training	x			x	x	x
Implementation of tracking system				x		x
Implementation of follow up with LHAs				x		x
Implementation of Media Plan/Social Marketing				x		x
Fidelity to Contract Scope of Work				x		x
Troubleshooting/Problem solving				x		?
Partnerships among MOD, St. Paul's, CROW, Mayor's Offfice, Churches, Schools, Agencies, community collabora-	x			x		x
Implementation of recruitment						
Number and type of partnerships and level of commitment						
Proportion of prospective participants contacted vs. trained						
Effectiveness of tracking system						
CRFs returned						

Appendices

How Effective is Program Penetration/Dissemination?						
No of community hosts contacted (compared to assets)						x
Training Outputs (# trained, ave size, location, time, atten-		x				x
Background info on LHA's trained		x				
Barriers to retention; incentives for retention				x	x	
Barriers to making contacts					x	
Community awareness of issue					x	
Community awareness of program (source & perception)					x	
No of LHA contacts in the community (1-on-1 vs. grp)						
Topics covered by LHA during encounter					?	
Financial incentives – how important to LHA?					x	x
How Effective is CV on Long Term Outcomes?						
Community has some knowledge of course content			x (compare y1 to y4 pre)	x		x
Positive behavioral change in target population						
Increased utilization of first trimester prenatal care						
Reduced LBW births						
Reduced prematurity						
Reduced infant mortality						
Sustainability				x	x	
Scalability						x

LS= Lynda Sagrestano; RF= Ruthbeth Finerman; JC= Joy Clay; PB= Phyllis Betts

Appendix B

Community Voice Evaluation Plan
Developed by University of Memphis Center for Research on Women

DRAFT CV - Evaluation Question by Method	Recruitment Database	Contact logs	Birth Cer-tificate Data	TDH data	GIS maps	Media File	Content analysis	Comparison to ACOG Guidelines
Responsible PI	**LS, PB**	**PB**	**PB, RF**	**PB, RF**	**PB, RF**	**JC**	**JC, RF**	**LS, JC**
How Effective is the Curriculum?								
Effectiveness of materials (curriculum, PPT slides, fact sheets)							x	x
Effectiveness of followup with LHA (booster, 6 month celebration)	x						?	
Effectiveness of educator								
Effectiveness of recruitment and outreach materials (website, newsletter, brochure, posters, other media)							x	
Fidelity to CV manual								
LHA knowledge of course content								
LHA confidence in ability to disseminate		x						
How Effective is the Administration of the Program?								
Staffing (hiring, training, supervision, cooperation, turnover)								
Implementation of training	x				x			
Implementation of tracking system	x							
Implementation of follow up with LHAs							x	
Implementation of Media Plan/Social Marketing						x		
Fidelity to Contract Scope of Work								
Troubleshooting/Problem solving								
Partnerships among MOD, St. Paul's, CROW, Mayor's Offfice, Churches, Schools, Agencies, community collaborative board	x				x	x		
Implementation of recruitment	x	x						
Number and type of partnerships and level of com-mitment	x							
Proportion of prospective participants contacted vs. trained	x	x						
Effectiveness of tracking system	x	x						
CRFs returned		x						

Appendices

DRAFT CV - Evaluation Question by Method	Recruitment Database	Contact logs	Birth Certificate Data	TDH data	GIS maps	Media File	Content analysis	Comparison to ACOG Guidelines
How Effective is Program Penetration/Dissemination?								
No of community hosts contacted (compared to assets)	x				x			
Training Outputs (# trained, ave size, location, time, attendance)								
Background info on LHA's trained								
Barriers to retention; incentives for retention								
Barriers to making contacts								
Community awareness of issue		x				x		
Community awareness of program (source & perception)		x						
No of LHA contacts in the community (1-on-1 vs. grp)		x						
Topics covered by LHA during encounter		x						
Financial incentives – how important to LHA?								
How Effective is CV on Long Term Outcomes?								
Community has some knowledge of course content								
Positive behavioral change in target population				x	?			
Increased utilization of first trimester prenatal care				x	x			
Reduced LBW births				x	x			
Reduced prematurity				x	x			
Reduced infant mortality				x	x			
Sustainability		x						
Scalability	x							

LS= Lynda Sagrestano; RF= Ruthbeth Finerman; JC= Joy Clay; PB= Phyllis Betts

References

References

Chavkin, W. (2001). Cocaine and pregnancy: Time to look at the evidence. *Journal of the American Medical Association*, 285(12):1625.

Fergusson, D.M. & Woodward, L.J. (1999). Maternal age and educational and psychosocial outcomes in early adulthood. *Journal of Child Psychology and Psychiatry*; 40:479–89.

Fraser, A.M., Brockert, J.E., & Ward, R.H. (1995). Association of young maternal age with adverse reproductive outcomes. *New England Journal of Medicine*; 332:1113–17.

Gilbert, W. M., Jandial, D. Filed, N. T. Bigelow, P. & Danielson, B. (2004). Birth outcomes in teen pregnancies. *Journal of Maternal-Fetal and Neonatal Medicine*, 16, 265-270.

Scott, E. A, Wesley, K., Damus, K., Long, S. , & Jones, L. (2007). *Community voice: Taking it to the people.* Second edition, South Central Perinatal Council of Virginia.

Smith Madlock, Y. & Morrow, H. (2008). *Vital statistics report: 2002-2005*. Memphis and Shelby County Health Department.

Tennessee Department of Health: Infant mortality stats and facts. (2009). Retrieved March 4, 2009 from, http://health.state.tn.us/infantmortality/stats_facts.htm