Our Community Grants Program

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Community Grants

The North Carolina Healthy Start Foundation's Community Grants Program has always been one of the essential components of the Foundation's efforts to address the problems of poor birth outcomes and high infant mortality in the state. The grants program originally dovetailed the Foundation's comprehensive initiatives and legislative agenda delineated by the Governor's Commission on Reduction of Infant Mortality.

As originally conceived, the Community Grants Program was a natural extension of the Foundation's efforts to stimulate local coalitions and community groups to unite and address infant mortality reduction at the local level. The guiding force behind the grants program was a philosophy shared with the earlier Governor's Commission on Reduction of Infant Mortality: infant mortality is a community problem and reduction efforts must begin, but certainly not end, on the local level.

Many of the funded programs had similar objectives—yet each program offered its own approach to the problem, based on the local resources and needs of the community it served. All the programs funded by the Foundation provided an action-oriented approach to the issues affecting infant mortality and morbidity. All related directly to one or more of the Foundation's objectives and all reflected some level of collaboration with the local community aimed directly at solving one or more clearly identified problems.

The Foundation supported the Community Grants Program with the intent to:

- Stimulate ownership of the problems of low birthweight (LBW) and infant mortality, and commitment to finding solutions at the local level
- Impart autonomy to local groups to design and implement interventions uniquely suited to needs of the community
- Encourage local agency collaboration to combine resources/fill gaps in local services
- Fund a diverse range of strategies for preventing LBW and infant mortality

From 1990 to 2002 the Foundation invested nearly $4 million of private and public funds in 265 community grants across the state. In the first phase, FYs 1991-95, 129 projects were funded in 85 counties with more than $2.3 million in grants. Grants during this period averaged $25,000 and focused on six primary strategies:

- Adolescent pregnancy (31.5%)
- Service linkage and agency coordination (28.8%)
- Community development (17.4%)
- Mentoring programs (9.1%)
- Substance use prevention (6.7%)
- Program incentives (6.5%)

With the end of the five-year Governor's Commission on Reduction of Infant Mortality in late 1995, the Community Grants Program was suspended until FY 1996-97. Grants awarded from 1997 to 2002 are described on the following pages in greater detail.

Much of the value gained has been in the lessons learned about program design and community response ... aspects that continue to benefit families well into the future.

Administration and Advisors

In 1996, administration of the North Carolina Healthy Start Foundation's Community Grants Program was contracted to the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill. The Sheps Center collaborated with many statewide groups to accomplish its goals for the program. Utilization of the established public health infrastructure in North Carolina provided staff with avenues for comprehensive outreach to target populations. Advisors to the Community Grants Program were invaluable. They included:

- N.C. Division of Public Health, Women's and Children's Health Section
- N.C. Office of Minority Health and Health Disparities
- N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse
- N.C. Farmworker Program
- N.C. Office of Rural Health
- N.C. Child Advocacy Institute
- Local Infant Mortality Coalitions
- March of Dimes, N.C. Chapter
- Healthy Carolinians
- Telamon Corporation
- UNC Department of Ob/Gyn
- UNC School of Public Health

FYs 1997-99 Funding Priorities

In FY 1997 Sheps Center program staff identified 10 topical program areas that would have the greatest impact on improving healthy birth outcomes and that could be administered through community-based programs with the help of modest funding ($25,000-35,000). Those 10 program areas were:

- Service coordination
- Transportation and improved access to services
- Pregnancy prevention for high-risk women
- STDs and reproductive tract infections
- Workplace-based services
- Local coalitions for the reduction of infant mortality
- Minority focus on disparities
- Substance abuse
- Smoking cessation
- Year-one wellness

These funding categories were aimed at programs that could augment activities and services at local health departments, nonprofit organizations, community coalitions, faith-based organizations and other local groups interested in administering initiatives to prevent infant deaths. With funding levels set at a $35,000 maximum, most proposals encompassed either a mid-level clinic or outreach staff position and some ancillary support for the work. However, if no staff support was requested then the nature of the work centered more on augmenting existing programs such as adding an incentive program, transportation or child care to enable use of services, or adding a component such as smoking cessation to an existing clinical care service, or taking traditional services to a non-traditional setting such as a worksite.

In FYs 1997-99 applicants were encouraged to submit proposals that would address one or more of the following objectives:

- Target counties with the highest numbers of infant deaths (at the time, 10 counties in North Carolina accounted for 43.3% of the state's total infant deaths)
- Target counties having high rates of infant death (exceeding 15 deaths per 1,000 live births)
- Emphasize public health (e.g., non-medical interventions and shifting efforts to outreach), not just medical interventions
- Continue to expand access to services
- Focus funding on specific prevention efforts promoting health behavior change for substance abuse, tobacco use, family planning, birth spacing, adequate prenatal diet or weight gain

FY 1999-00 Funding Priorities

For FY 1999-00 the emphasis on teens was reassessed and shifted to the older 20 to 34 age group where data indicated a higher probability of risk. An explicit focus on minority groups also was shifted away from Hispanics to an overall emphasis on African American women, for the same data-driven reason. Priority again was given to counties with high rates and or numbers of infant morbidity or mortality; and applications were encouraged from these counties.

To help ensure that all eligible applicants had an equitable chance of being selected, the application process also was revised to include pre-application technical assistance. After releasing the Call for Proposals, the Sheps Center sponsored three one-day workshops to explain the new direction of the grants program and provide assistance with program plan development. Attendance was not

mandatory, but strongly recommended. Applicants were encouraged to collaborate with other community agencies and leave with a draft program plan. Letters of intent outlining proposed projects and budget needs were due three weeks later. After reviewing the program plans, finalists were invited to submit full proposals.

FYs 2000-02 Funding Priorities

During 1999, the Sheps Center staff reviewed risk factors and associated behaviors to identify key areas of prevention likely to have a substantial impact on pregnancy outcomes in the state. Research yielded the following three areas: timing and spacing of pregnancies; smoking cessation; and sexually transmitted diseases and reproductive tract infections. As a result, the focus of the Community Grants Program was reduced to those three priorities in FY 2000-01.

Two additional changes in the Community Grants Program funding strategy were the decisions to support fewer projects at a higher level of funding and to extend the funding period to two years. Previous experience with grantees had shown how difficult it was to develop, implement and evaluate a project with minimal funds on a one-year grant cycle. The Foundation therefore made a shift from supporting 10-15 small grant projects with up to $25,000 to supporting five projects with up to $75,000 per year over a two-year period.

The FYs 2000-02 funding cycle priorities included:

- Demonstration projects modeled after projects shown to be effective
- Projects that could be replicated in other parts of North Carolina
- Projects that demonstrated how a relatively small investment in prevention or intervention can reap significant savings in the future (cost-benefit evaluation)

The goals within each priority topic area were:

- Smoking Cessation: innovative approaches to help preconceptional, pregnant and post-partum women and their household members quit smoking or reduce use of tobacco products
- Improved Timing and Spacing of Pregnancies: improved access to services to promote healthy birth intervals—optimally 24 months—combined with education about the risks of childbearing "too young, too old, too close, too soon"; use of mentoring models, care coordination and community outreach workers to reach those at highest risk
- Sexually Transmitted Diseases/Reproductive Tract Infections: improved screening, diagnosis and treatment of STDs and RTIs in high-risk women; reduction of prematurity and improved birth outcomes through identifying and appropriately managing reproductive tract infections in pregnancy

Evaluation

The FYs 2000-02 grant cycle focused specifically on enhancing and improving the health of pregnant women to decrease the risk of premature, low birthweight babies. This grant cycle concentrated resources on areas, topics and programs that would optimize the chances of reaching those at highest risk and focused on services that would be most likely to make a difference in birth outcomes.

We know what each project cost to implement and because of local program tracking efforts, we know how many women were screened, enrolled or referred for service, received care and, in most cases, what resulted (treated for STD infection, reduced or quit tobacco use or adopted effective contraception).

We know that collectively, across these five projects, 5,004 women were screened and identified as being "at risk" and eligible for program services. Of those, 2,926 were enrolled and received counseling, and 1,009 received treatment for the targeted and specific risks based on best practice standards. If half of these women had delivered a low birthweight or premature baby, the costs would have exceeded the $475,000 awarded to these grantees.

While knowing the exact cost savings may provide more precise evidence for the success of such community-based efforts, the reality is that such an analysis would necessitate sophisticated and involved calculations and tracking, require substantial resources to conduct, and limit the availability of funds and personnel for the actual interventions—a frequent dilemma in program evaluation. In this instance we tried to strike a practical balance between the design of evaluation components (thus the costs and logistics required) and the availability of useful information to monitor success and provide accountability.

From FYs 2000-02, smoking cessation was the most frequently targeted of the three topic categories. This may, in part, be due to the wide publicity about the harmful effects of smoking during pregnancy as well as the

promotion of the Smoke-Free Families' evidence-based, best practice model for perinatal smoking cessation. There were fewer applicants in the areas of inter-conceptional care or identification and treatment of STDs, possibly because the models for addressing these areas of service are less well-developed and harder to implement.

Throughout the five years of funding, equipment and community education events were the least funded program elements. Only three grantees applied funding toward equipment which usually included program-related computers or in one case a second-hand ultrasound machine for a satellite clinic. As part of its multi-pronged approach to reduce the risk of fetal exposure to tobacco products, Wake County used radio, television and print media to educate community members. It also conducted workshops for parents of at-risk adolescent females. More than 40% of grantees funded patient education efforts, and 35% funded the development of community networks. These community networks were frequently comprised of public-private partnerships with the goal of improving local perinatal networks and referral systems.

FY 2000-01 Rapid Response Minigrants

With its new commitment to funding fewer, closely focused projects that had greater chances of success, the North Carolina Healthy Start Foundation realized that many high-quality, local programs would have greater difficulty obtaining funding to start or sustain activities. As a result, a "Rapid Response Minigrant Fund" was set up by the Foundation for nonprofit and governmental agencies to obtain immediate funding up to $2,000.

The concept and logistics of the minigrant program were simple. Applications were accepted on a monthly basis and funding decisions were made by the end of each month from August 2000 through July 2001. The two-page applications were reviewed and approved by a representative of the Sheps Center and the Foundation's executive director. Funds could be used for a variety of projects on behalf of pregnant women, babies or women of childbearing age. Examples of appropriate uses included: staff training, special incentives, travel, expenses related to providing or receiving technical assistance, purchase of clinical or educational supplies, local coalition development or activities, conferences or other one-time educational events. On occasion, purchase of computer or electronic equipment was allowed. Priority was given to first-time applicants.

Minigrant Funding Allocation

A total of $62,814 was allocated for 83 minigrants averaging just under $760 each in FY 2000. However, no funds were available to repeat the minigrants in FY 2001. While 58 counties were documented as being served through the minigrants, some minigrants were implemented on a statewide basis. Therefore, all 100 North Carolina counties were potentially affected or served by the Foundation's Minigrants Program.

Not unlike the regular grantees funded from FYs 1997-02, the greatest proportion of FY 2000-01minigrantees allocated funding to incentives (46%), patient education (39%) and service coordination and training (36%). Incentives included items that would encourage both enrollment in programs, but also and probably most important, promoted retention and continued participation, once enrolled. Items such as cameras and photo albums for expectant moms were given away once they had successfully completed and fully participated in the offered program. Patient education efforts included Orange County's development of materials to encourage families with infants in the Neonatal Intensive Care Unit and special care units to eliminate secondhand smoke at home. Five grantees allocated funding for technical assistance—most of which was provided to outreach worker/lay health advisor personnel to improve their knowledge of risk factors and associated information related to the prevention of poor pregnancy outcomes. Fewer than 25% of the 83 grantees allocated funding to either transportation and improved access or equipment. Grantees who did fund these priorities used several creative strategies for reaching clients, such as combining vouchers and incentives for attending clinics that together helped to remove barriers to use of services.

Funded Minigrants Applicants

Over half (53%) of the minigrantees were local nonprofit agencies which offered a wide range of services, such as job training, life skills training including parenting, job development, women's health services and indigent emergency care. Over a quarter (28%) of minigrantees were county health departments, reflecting all regions of the state. Community/university partnerships accounted for 11% and faith organizations 8% of the grantees. Although no local coalitions applied for minigrant funds, the Healthy Mothers, Healthy Babies Coalition of Chatham County was started using minigrant funds.

Grants Program Summary

Funding

Since its inception in 1990, the North Carolina Healthy Start Foundation has worked with its statewide partners to invest millions of dollars in the prevention of low birthweight and infant mortality. The total amount of Foundation funding for the five fiscal years 1997-02 was $1,509,355 for 49 grantees.

From FY 1997-98, 14 one-year award amounts averaged $23,571. From FY 1998-99, 17 one-year awards averaged $23,035. From FY 1999-00, the 13 awards were slightly smaller, averaging $21,366 each. The FY 2000-01 funding cycle represented the first of two years of fewer yet larger awards. Therefore, from FYs 2000-02, a total of five awards averaged more than $56,000.

An additional $62,814 was allocated for 83 minigrants averaging just under $760 each in FY 2000-01 as shown in the table below. No funds were available to repeat the minigrants.

Making a Difference

Most grantees provided some matching funds that were frequently in-kind dedication of staff, office space and equipment. Given the budgets of the community grants in the initial phases (FYs 1997-99), these matching resources made the difference in assuring the ability of the local agency to provide the extra services within the community. The Foundation funds often made the difference for getting people to health care services, through use of incentives or actual transportation, but the local agencies ensured that once in care, services

Community Grants Funding

	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02
Total # Regular Grants	14	17	13	5	4 *
Total # Minigrants	—	—	—	83	—
Total # Grants	14	17	13	88	4
Total # Counties Funded Including Minigrants	15	14	12	47	4
Total Funding Including Minigrants	$330,000	$391,600	$277,755	$347,814	$225,000
Regular Grants					
Counties Funded	15	14	12	6	4
Counties Served	23	21	20	15	14
Funding Range	$10,000-$33,500	$10,000-$30,000	$1,700-$29,500	$25,000-$75,000	$25,000-$75,000
Total Funding	$330,000	$391,600	$277,755	$285,000	$225,000
Average Funding	$23,571	$23,035	$21,366	$57,000	$56,250
Minigrants					
Counties Funded	—	—	—	41	—
Counties Served	—	—	—	58	—
Funding Range	—	—	—	$260-$1,975	—
Total Funding	—	—	—	$62,814	—
Average Funding	—	—	—	$756.79	—

** year 2 funding*

could be provided. Often local groups had never before received grant funding and were learning the requirements of program tracking and fiscal accountability. Very few problems were encountered, despite the novice level of many grantees.

Categories Funded

There were eight broad categories across all of the projects and the range of program areas that describe how the funds were allocated by grantees in implementing their work:

- Community Education Events
- Community Networks
- Equipment
- Incentives
- Patient Education
- Service Coordination and Provider Training
- Transportation for Improved Access
- Technical Assistance

From FYs 1997-99, the majority of grantees used funds to provide incentives. More than half of grantees also used funds to enhance service coordination and training. These strategies ranged from providing transportation and child care for maternity clinic patients to holding continuing education workshops for local staff on topics related to risk factors leading to poor birth outcomes.

From FYs 2000-02, service coordination/training and patient education were implemented by most of the five grantees. Non-traditional community locations and strategies were utilized by some grantees. Other programs expanded the network of trained providers in order to serve an increased number of women.

Many grantees targeted multiple priority areas simultaneously, such as enhanced care coordination for minority women, transportation and use of incentives.

Use of Funds 1997-02

Categories	Grants	Minigrants
Incentives	35	32
Service Coordination/ Training	35	25
Patient Education	26	27
Community Network	22	0
Transportation/ Improved Access	19	9
Technical Assistance	11	5
Equipment	3	10
Community Education Events	7	0

Topic Summary

Many of the target population were Medicaid-eligible and enrolled in the Baby Love program, and for whom support ended at the 60-day post-partum period; thus, initiatives like the Foundation's community grants program provided much needed support to continue services to these women and their families during their first year post-partum.

Topic Areas 1997-02

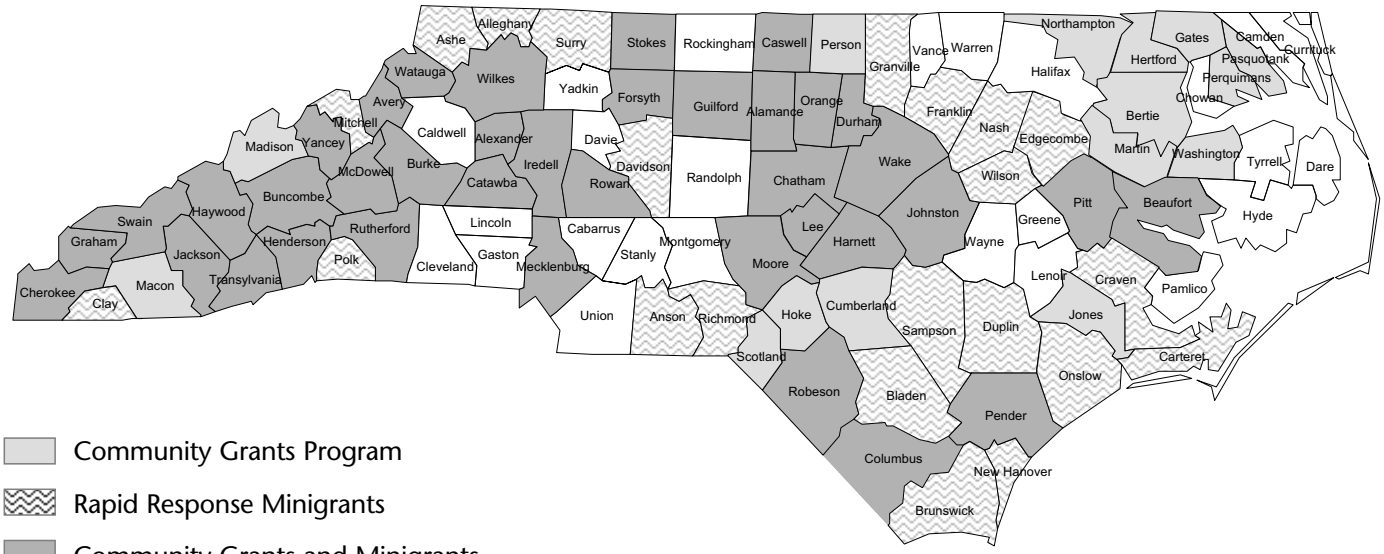
Topic Area	Grants	Minigrants
Enhanced Perinatal Services	22	35
Year-One Wellness	21	9
Local Coalition/ Community Development	18	9
High-risk Pregnancy Prevention	16	8
Smoking	10	1
STDs/Reproductive Tract Infections	6	1
Adolescent Health	6	17
Worksite Wellness	5	0
Substance Abuse	3	2

Geographic Distribution Summary

The vast majority of counties in the state were funded over five fiscal years (1997-02). From FYs 1997-02, the Foundation funded 132 projects in 75 counties, which includes minigrants. An average of 25 counties were served by the Community Grants and Minigrants Programs each year.

There were 25 counties that were neither funded nor reported served through the program as shown in the map below. Most of these counties had either very few women at risk of poor birth outcomes or they did not respond to the Foundation's call for proposals.

Community Grants Participation FY 1997-02



- Community Grants Program
- Rapid Response Minigrants
- Community Grants and Minigrants
  - From 1991-1995 the 129 grants = $2,300,000
  - From 1997-2002 the 49 grants = $1,509,355
    and the 83 minigrants = $62,814
    combined value = $1,572,169
  - In total, the North Carolina Healthy Start Foundation awarded 265 grants and minigrants totaling $3,872,169

Grants To Promote Smoking Cessation

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Looking at county-level data on women who smoke during pregnancy, it is pretty clear that this is a serious problem in western North Carolina. The North Carolina Healthy Start Foundation's Community Grants Program funded two organizations to encourage a regional effort in the West to address the problem.

While the impetus for the two funded projects was based on the common goal of reducing the prevalence of prenatal smoking, their programmatic structure differed significantly. The Appalachian Health District Families in Smoke-Free Homes (FISH) project was health department-based and designed to establish effective perinatal smoking cessation services. Conversely, the Mission St. Joseph's Smoke-Free Families Project was hospital-based and designed to enhance existing smoking cessation components in an established Preterm Prevention Program.

Each site used the Smoke-Free Families guidelines, a standard smoking cessation protocol based on a best practices model funded by the Robert Wood Johnson Foundation and endorsed by the U.S. Public Health Service. The protocol ensures a comprehensive approach to prenatal smoking cessation assistance as a routine part of prenatal care. Smoke-Free Families is an evidence-based intervention for obstetricians, gynecologists, certified nurse midwives and other health care providers who face the challenge of facilitating smoking cessation among pregnant women. It is based on five steps, also referred to as "the Five A's," which are:

- Ask patients about their smoking status
- Advise patients about the benefits of quitting if they smoke and the effects of smoking versus quitting on the woman and the fetus
- Assess the willingness of the patient to make a quit attempt within the next 30 days
- Assist patients with ways to quit by providing pregnancy-specific, self-help smoking materials; suggesting problem-solving methods and skills for quitting; providing social support as part of the treatment; and helping to arrange social support for the woman among family, friends and co-workers
- Arrange follow-up visits to track the progress of the patient's attempt to quit smoking

This cost-effective intervention for clinicians to use with pregnant smokers has been shown to reduce smoking rates for light to moderate smokers in pregnant women from 30% to 70%.

Mission St. Joseph's Healthcare Foundation, Inc.

The Smoke-Free Families Project was primarily focused in five areas (Buncombe, Madison, Henderson, Toe River and Polk). The population targeted was those women who were referred to Mission St. Joseph's existing prematurity prevention program who self-identified as being smokers. The services provided included screening, counseling and referrals for prenatal smoking cessation per the U.S. Public Health Service/Smoke-Free Families guidelines. Additionally, an important component was the training of local obstetric providers in surrounding clinics where women first presented for prenatal services.

The importance of involving local staff and allowing for the need to adapt to local unique set-ups was key to success.

Outcomes

This project was unique in that it operated at a tertiary level, through a hospital-based program aimed at women already identified as being at high risk for preterm delivery, instead of being based at a health department or at a primary level in the community. With North Carolina Healthy Start Foundation funding, Mission St. Joseph's was able to provide an enhanced smoking cessation component for its existing Preterm Prevention Program, expanding the program into four new counties (to a total of nine) and engaging a total of 22 public and private practices that were not previously doing prenatal smoking cessation.

This program exemplifies how Foundation funds augmented an already successful preterm prevention model by incorporating an additional intervention (smoking cessation) for a targeted high-risk group of women. It also used some of the lessons learned in the Fetal and Infant Tobacco Exposure Reduction (FITER) project in Watauga County regarding the importance of incentives and training a range of healthcare providers to maximize opportunities for reaching women after they leave the hospital.

Of the 603 high-risk pregnant women who were referred to the Mission St. Joseph's Preterm Prevention Program from FYs 2000-02, 483 (60%) completed the program. Unfortunately, more than 70% of women who did not complete the program were smokers and very little information was obtained for them. Anecdotal reports from the staff indicate that a majority of these women were African American, and may have been uncomfortable participating in the program due to incompatibilities with staff. In FY 2000-01, 50 of the 184 active clients were smokers at their first program visit: 10 (20%) quit smoking and 21 (42%) reduced the number of cigarettes smoked by their last program contact. In 2001-2002, 33 of the 130 active clients were smokers at their first program visit, 16 (48%) quit smoking and 11 (33%) reduced the number of cigarettes smoked by their last program contact. This represents an overall quit rate of 31% (26 of 83 clients) and a 39% reduction rate (32 of 83 clients) for an overall effect of 70% among program clients. At their last program contact, most smokers reported smoking more than 10 cigarettes per day. Due to unforeseeable data management problems, individual outcomes data were not finalized in the course of this program cycle. Therefore, birthweight and gestational age outcomes stratified for smokers and non-smokers were not available.

State and private foundation funding diminished after 2002, but staff remained committed to blending the counseling efforts for smoking cessation into existing job responsibilities within the Prematurity Prevention Program. The most noticeable change in long-term maintenance of this project was the lack of support for participant incentives—a component identified as very important to the integrity and popularity of the program.

Appalachian Health District

The Families in Smoke-Free Homes (FISH) Project served six western counties (Avery, Burke, Haywood, McDowell, Transylvania and Wilkes) and focused exclusively on primary clients who went to local health departments or partners of local health departments for prenatal and obstetrical care. The project involved pregnant and post-partum women ages 14 to 47 years. The services provided included screening, counseling and referrals for prenatal smoking cessation per the U.S. Public Health Service/Smoke-Free Families guidelines as well as provider training for health department staff in individual or group trainings in the Smoke-Free Families Five A's protocol. FISH is an outgrowth of another North Carolina Healthy Start Foundation grant—the Watauga County FITER project.

Outcomes

The Appalachian Health District project successfully involved six of the highest need counties using interventions based on best practices established through the national Smoke-Free Families and Centers for Disease Control and Prevention models as well as those lessons learned locally through the previously established FITER program. All six health departments adopted the standardized program model and developed locally based protocols for implementation.

Three health departments received technical assistance in establishing their local program from a mentor in a neighboring health department that had experience in implementing smoking cessation programs. This was a key component of this program and one of the basic elements contributing to its success. Additionally, N.C. Department of Health and Human Services consultants provided ongoing consultation and project oversight to ensure that local program staff had the support needed to be successful. Quarterly team meetings afforded local staff the opportunity to discuss issues and share ideas for addressing barriers and creative strategies for the use of incentives and program implementation.

More than half (62%) of the 1,504 women screened in the FISH project were reached in the first trimester of pregnancy: 1,325 (88%) enrolled in FISH. Of the 605 current smokers enrolled in FISH, one-fourth quit smoking and more than 60% reduced the number of cigarettes smoked during pregnancy, from an average of 13 to 6 per day.

As was anticipated, birth outcomes for women who smoked during pregnancy were significantly worse than for the non-smokers: 13.7% of births were low birthweight among women who reported smoking at their initial prenatal care visit versus 6.4% of births among non-smokers. Birthweight was not shown to be statistically associated with participation in the FISH program. However, women who had more than one program visit had fewer low birthweight births (12.7%) than women with only one visit (18.5%). An unexpected outcome of this project was that the FISH project's unique, simultaneous outreach to providers resulted in smoking cessation among several of them. Another unique feature was enrolling nonsmoking pregnant women in the program. FISH understood the need to go beyond the woman and look at her tobacco exposure at her home or with friends.

Prior to the end of this grant period, short-term private foundation funding was secured to carry on project activities and the project coordinator's salary was supplied in-kind by the Appalachian District Health Department. Staff hope to secure additional sources of funding for continuation of the project and expansion into additional counties.

Program Comparisons

The combined efforts of the two programs in a total of 16 counties established a strong presence in the Western part of the state. The FISH project successfully implemented a standardized protocol even though each site's structure was different (e.g., staffing, service delivery and record keeping components). Data collection and tracking and monitoring were done locally for the FISH project sites. Mission St. Joseph's administered its program from the hospital with a statistician dedicated to receive standardized encounter sheets—part of a formal tracking system that facilitated permanent integration of smoking cessation protocol into clinical practice.

One problem identified by both projects was high staff turnover in the local clinics among those who provided counseling and smoking cessation services. To reduce staff turnover, the FISH project included ongoing and frequent provider training and incentives for the providers and patients interested in participating in the program. Mission St. Joseph's also implemented ongoing training with existing sites and for new practice sites. No centralized program manager was appointed in the FISH project; a network of mentors and referral offices was established among the participating counties (and health departments). This approach was probably the most feasible given the geographic and logistical constraints of the region. A centralized program manager for Mission St. Joseph's made in-person visits to participating provider and health department offices every two weeks, and hand-delivered incentives and maintained regular contact with local staff. During these visits, the program manager provided feedback regarding the significance of the effort, expressed appreciation to providers and answered questions. In addition to visits to participating providers, weekly phone calls from the nursing health managers in the existing Preterm Prevention Program were placed to all participating clients.

FISH Project	Mission St. Joseph's Program
1,504 Maternity clients screened	603 High-risk women identified
1,325 Enrolled	314 Enrolled
605 Smokers	88 Smokers
25% Quit	30% Quit
60% Reduced	36% Reduced

Lessons Learned

The final reports of the Appalachian Health District's Families in Smoke-Free Homes and Mission St. Joseph's Healthcare Foundation's Smoke-Free Families project yielded pragmatic lessons learned. Those lessons can benefit other health departments and agencies interested in administering a community-based smoking cessation program.

- Training: Frequent in-service training of providers (e.g., quarterly) is essential because staff turnover is often a factor. Collaborative group learning for training sessions was found to be most effective for facilitating discussion and questions. Because the Five A's are often divided up among multiple

providers the effectiveness of the comprehensive protocol would be affected if all providers involved are not trained. Staff responsible for maintaining medical records should also be trained in a standardized tracking method for the smoking cessation services provided.

- Staff turnover: At the project management level staff turnover affected the whole project. Back-up staffing plans should be part of the original program plan. Staff vacancies disrupted the implementation and continuity of each program.

- Management: Centralized management of a regional project is most effective for maintaining provider commitment and participation and for ensuring consistency of service provision and tracking.

- Communication and Marketing: An electronic listserv combined with a project Web site is an economical and efficient way to provide program updates and other information to participating clinic sites (and their respective providers and staff) in a regional program. The Web site can market the components and successes of a project to state health departments, the state legislature and other stakeholders.

- Marketing to Healthcare Providers: Marketing to providers is as pivotal an activity as marketing to consumers. Having full staff endorsement is a major determinant of the degree of success and sustaining service. It also is important to market smoking cessation programs to staff/providers as a way to encourage them to quit and increase their effectiveness with their patients. In some cases it was possible to involve private providers by building on an existing program versus initiating a new one.

- Initiatives: Smoking cessation clients respond favorably to material incentives (e.g., water bottles, stress kits, cameras, photo albums and diaper bags). However, no one should underestimate the power of personal follow-up and verbal incentives such as praise and encouragement.

- Challenges: Clients who present the greatest challenge are long-term smokers (e.g., have smoked five years or more), second-time mothers who smoked with their first pregnancy, adolescents, clients who want to quit but have minimal family support and may live with smokers, and clients who refuse to quit or even reduce the number of cigarettes smoked. The best strategy for clients who refuse to quit is education about secondhand smoke and maintaining a smoke-free home and car. If necessary, extend counseling and support efforts to the family members of clients who smoke.

- Collaboration: The success of community grants can always be bolstered by collaboration with existing services at the state level. For example, Mission St. Joseph's and FISH project staff both worked with Perinatal/Neonatal Outreach Educators, Medicaid's Baby Love Program; Maternal Outreach Workers; community nonprofit agencies and others.

In sum, while an evidence-based model existed for smoking cessation, it became evident that the model requires substantial retrofitting to the local setting and infrastructure. While having a strong, regional effort made a big difference in the momentum and support for these projects, the importance of involving local staff and allowing the projects to address local unique needs was key to success.

Grants To Improve Pregnancy Timing/Spacing

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Infants born to mothers who give birth within less than a two-year interval have a greater risk of poor health. Close to half of all pregnancies in North Carolina are unintended, with approximately 75% of those births among women less than 20 years of age. In 2001, 11% of births to white women and nearly 14% of births to women of other races occurred within less than a two-year interval (state average is 12.7%). Unintended pregnancy is associated with increased morbidity and mortality for the mother and infant. Lifestyle factors such as smoking, alcohol consumption, unsafe sex practices, poor nutrition, late entry into prenatal care and inadequate nutrient intake (including folic acid for the prevention of neural tube defects) pose serious health hazards to the mother and fetus, and are more common among women with unintended pregnancies.

The period between pregnancies is an opportune time to intervene on risk factors including folic acid supplementation, smoking cessation, stress management, improvement in overall health status and treatment of chronic diseases. Access to services that promote optimum spacing of pregnancies, combined with education about the increased risks involved in mistimed childbearing, are critical to improving birth outcomes. With the exception of family planning programs, most of our state's current initiatives focus on helping women access health care services after they are pregnant. One of the largest gaps is the absence of sufficient initiatives to improve a woman's health before or between pregnancies.

Prenatal care has enhanced pregnancy outcomes in many ways. However, it has not been shown to have a beneficial effect on the incidence of premature birth, a major cause of infant mortality. The most likely reason for such a failure is that the causes of prematurity are predominately related to a woman's general health, social, environmental and emotional circumstances prior to her becoming pregnant. In order to reduce the incidence of prematurity, it is necessary to address those circumstances before as well as during pregnancy.

One of the greatest factors that can improve the likelihood of a healthy pregnancy is having a planned, healthy birth interval. Short birth intervals and lack of access to health services in the year or two post-partum are major contributors to repeated poor pregnancy outcomes. Unfortunately, expanded Medicaid coverage in North Carolina extends only to 60 days postpartum. Many women, therefore, lose access to family planning and other health services at a time when repeat pregnancies are particularly dangerous both to the mother's and her future child's health. Expanding Medicaid coverage to working parents with incomes below 200% of the federal poverty guidelines would allow more women to access perinatal health services. If done for at least two years post-partum it would help improve the health of mothers between pregnancies and enable the mothers to more effectively care for their newborns.

Recognizing this potential, the Foundation established the interconceptional period for high-risk families in defined populations as a grant priority. The management team worked with several agencies which were interested in expanding existing models and establishing demonstration projects with features that could be replicated statewide. The Foundation funded two programs with services to be provided by local public health departments. Both groups appreciated the complexity of the issues involved and were aware that the work involved new strategies never before developed.

One of the largest gaps is the absence of sufficient initiatives that focus on improving a woman's health before she becomes pregnant.

Pender County Partnership for Children

This program was designed to extend the Maternity Care Coordination (MCC) model provided by the local health department to the highest risk families who had been enrolled in MCC during pregnancy. The new program was to introduce a Family Care Coordination (FCC) model that would extend the services of the health department's care coordination team to 24 months. The model focused on interconceptional health for the mother at the same time that the infant received needed specialized care for the first year of life. Under contract with the Pender County Partnership for Children, the Pender County Health Department developed a tracking system and mechanism for Family Care Coordinators (FCCs) to follow the target families and address health issues including but not limited to pregnancy spacing, STDs, infant care, breastfeeding and other related issues. A reimbursement mechanism built into the grant also served as a tracking mechanism to document the number of women served, services provided and outcome measures including length of pregnancy intervals. Unfortunately the health department discontinued the project after six months due to administrative constraints and hiring difficulties.

Outcomes

Prior to the start of this program, there were only limited studies to document the effectiveness of post-partum case management for women and families identified at risk for infant mortality. The intended contribution of this project was to provide the necessary documentation to show the success of extended support to high-risk women beyond the 60-day post-partum period. A model to provide needed services was to be incorporated into existing maternity care coordination and child services coordination to expand the opportunity to impact on issues related to infant mortality such as breastfeeding and pregnancy spacing as well as attend to critical psychosocial needs that do not have short-term solutions. The model was designed to build upon a program generic to every local public health maternity care coordination system, and allow billing for specific encounters and services. These activities were designed with a specific tracking form that would have summarized costs and outcomes in a single system of paperwork.

Despite the truncated grant period (six months of a two-year contract), this project succeeded in accomplishing several important things. Two nurses were hired and trained as Family Service Coordinators. A tracking system for women at risk that incorporates collection of necessary data as part of the reimbursement mechanism was developed and tested. Seventeen families received services after discharge from maternity care coordination over the six-month program period. Training in smoking cessation for community providers was initiated. The forthright manner in which funds were returned allowed monies to be used by other projects.

Rowan County Health Department Optimal Birth Interval (OBI) Project

This program built upon the community-based Health Link project (originally funded in 1998) which effectively utilized lay outreach workers to link high-risk families to needed maternity services. The extension of this work into the post-partum and interconceptional period was a natural progression, and there was very strong leadership interested in developing the model for wider application.

The overall goal of the OBI project was to help at-risk families prevent short inter-pregnancy intervals while enhancing the capacity of mothers to provide a better life for their children. Staff partnered with the Adolescent and Family Enrichment Council to provide program training to 10 Health Link Advisor volunteers. The 14 hours of training covered advising, infant mortality, family planning, pre-conceptional and prenatal health, STDs and HIV, communication skills, community resources and advocacy. College interns assisted with outreach and follow-up.

The OBI project served women in one of the poorest predominantly African American neighborhoods in East Spencer, Salisbury. The target group was defined as underserved, hard to reach and at high risk for short birth intervals (and 18 years of age or older with a child 15 months or younger). The project provided services to improve access to contraceptives and information about birth control and optimal birth intervals, through intensive case management, education and support from outreach workers. Clients also received job assistance.

The OBI program included numerous, creative incentives for clients including: lunches with Health Link Advisors, phone cards for families without telephone service, wall and pocket calendars for meeting/appointment reminders, thank you notes and birthday cards for parents and children, free transportation to appointments and other family support services, grocery store gift cards and in special circumstances GED and community college tuition. Incentives were well received by clients.

To establish a sense of commitment and responsibility among clients, program staff developed an agreement form for new enrollees. In return, Health Link Advisors reciprocated the commitment by being on call (clients had advisors' home phone numbers) and maintaining in-person contact.

Outcomes

Health Link Advisors visited 24 families identified from birth certificate data as high risk for a short birth interval. All families received an average of four contacts, and 10 of those families enrolled in the OBI program. OBI clients and their children were given priority access to coordinated health department services along with intensive, personal follow-up of OBI Health Link Advisors. This approach provided a structure of care that was tailored to individual needs and fostered a higher likelihood of success.

Two OBI clients made significant life changes as a result of program participation. A single mother successfully began course work to pursue her GED, and a mother of three with a bachelor's degree found a better paying, professional job and learned how to better manage family finances. These exceptional outcomes and the 90% success rate of the program in preventing short birth intervals among enrolled families are a tribute to the diligent efforts of program staff and volunteer Health Link Advisors.

Those efforts require numerous hours and other resources. However, the resource-intensive efforts had a significant impact on the lives of clients. One client reported, "The program has helped me become more confident in myself. And I want to further my education. I think this program is the best one ever 'cause it gives you a woman or health link advisor that cares about you and that's what some single moms need sometimes and in the future I feel this program will be of benefit to more single mothers. I'm very grateful for this program."

The project received funding from three sources to expand the program for FY 2002-2003. The program will continue to use a volunteer-based approach to minimize costs and maintain its grass-roots structure.

Lessons Learned

The Optimal Birth Interval and the Pender County projects were successful in their contribution to the development of an interconceptional model for services to at-risk women during their infant's first year of life. They yielded lessons learned that might be particularly useful for other groups wanting to focus in this area.

The billing process developed as part of the Pender County project can be used as a model for a viable reimbursement process by the state. The factors that led to discontinuation of the Pender County project provided insight into the critical need for adequate and committed staff for such a project.

The Rowan County Project exposed the difficulties in developing a mechanism to identify women at risk using birth certificate data, necessitating a more creative effort to locate this population. The program also noted the difficulties of working with volunteer staff that had little training in dealing with the complex psychosocial conditions of the women they served.

The future success of programs such as these will be determined by implementation of multiple strategies for creating effective relationships between the partners involved: volunteers and clients, staff across agency programs (MCC and Child Service Coordinator), and most important between program personnel and clients and their families.

Applications for Related Projects

- A "non-event" such as achieving an optimal birth interval is not as concrete as modifying a specific health behavior (such as smoking cessation, treatment for a reproductive tract infection), or event (such as an existing pregnancy). Clients may not be able to grasp the importance of, or see the value in, planning now for an event that is optimally two or more years in the future. Because prevention of a short birth interval involves many complex issues including a woman's sense of confidence, empowerment and ambitions, many services outside the public health domain may need to be provided. These include job programs and educational assistance.

- Identification and location of potential clients with birth certificate data was more difficult than expected because certificates often lacked complete contact information. When the program implemented a process for referrals from WIC, additional clients enrolled. The benefits of the new approach included: identifying clients who are or who may be more receptive to additional services;

WIC staff referred those they believed would benefit most from the program; and strong communication and close proximity between the WIC and Health Link Directors.

- It is difficult to initially identify clients who will comply with program requirements and take full advantage of support services offered. Even when staff make time-intensive efforts to identify and locate potential clients, there is no guarantee that these women will enroll in the program. Staff are still struggling to determine how much effort (both time and resources) should be expended on potential clients who are reluctant to participate.

- Clients must be responsible for following through on their commitments; failure to do so may lead to removal from the program. Staff should provide assistance, but foster the client's decision-making abilities and responsibilities.

- Finding and keeping volunteers willing to make a commitment to supporting underserved clients is challenging. Volunteers become disenchanted when clients do not seem to appreciate their support, fail to show for appointments or fail to return telephone calls.

- Using lay health volunteers can be problematic because of their training needs, potential lack of credibility with subject matter (as compared to professional providers) and skills for discussing the sensitive topics related to optimal birth intervals. These challenges can be ameliorated via comprehensive, ongoing training for volunteers, and standardized forms for client intake and subsequent visits (e.g., short and requiring as little writing as possible).

A Grant To Identify/Treat Sexually Transmitted Diseases/Reproductive Tract Infections

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Sexually transmitted diseases (STDs) can be transferred from mother to infant, possibly resulting in fetal death, premature births and severe long-term problems. The United States has the highest rates of STDs in the developed world. In North Carolina teen and adult STD rates are disproportionately higher for minorities, especially for gonorrhea cases. In 1998, African American teens accounted for 76% of all HIV/AIDS cases in North Carolina. Congenital syphilis has declined over the last five years; there were only 22 cases in 1998, however nearly three-quarters of these cases were African Americans.

Reproductive tract infections (RTIs) such as bacterial vaginosis have been associated with preterm birth. In one recent cohort study, bacterial vaginosis was detected in 16% of 10,397 pregnant women. The presence of bacterial vaginosis among those women was associated with a 40% increase in the risk of delivery of a premature infant. Studies are underway to determine optimal management of bacterial vaginosis in pregnancy to reduce the risk of preterm birth.

New Life Women's Leadership Project

New Life Women's Leadership Project is a small, grass-roots, nonprofit agency in Eastern North Carolina with experience in HIV/AIDS outreach. Community Grant funding from the North Carolina Healthy Start Foundation was used to add other sexually transmitted diseases and reproductive tract infections to its program and to establish much needed alternative screening clinics. Existing clinics were not perceived as user-friendly by the client population, resulting in undiagnosed and untreated infections.

The project targeted two counties (Martin and Washington) along the I-95 corridor where there is high prevalence of STDs and RTIs. The short-term goal was to engage women of childbearing age in a community health education and outreach program for identification and treatment of sexually transmitted infections. The long-term goal was to reduce the rate of infant mortality via a decrease in the prevalence of STDs and RTIs among sexually active women of reproductive age. The program served women of childbearing age residing in public housing, trailer parks, crime-dense and outlying communities. The project staff went to unorthodox places that might have frightened traditional providers away. They also went to local food banks, storefront offices and local neighborhoods.

The existing HIV/AIDS peer educators expanded their training to include prenatal issues and recruited new peer educators. Staff developed a training manual for outreach workers and peer educators on causes of infant mortality, Sudden Infant Death Syndrome risks, and STD and RTI screening. They also developed patient education packets and conducted support group meetings to encourage women to limit their personal risk factors and to engage participants in exercises that would lead to behavior change. The peer counselors found that personal vignettes (story telling) was both a popular and an effective way to educate.

An alternative outreach approach using trained volunteers from the communities in which the target population lives may be most effective among high-risk populations.

Other Components

- Incentives: The New Life program effectively implemented numerous client and staff incentives and awards to maintain good morale and participation. A monetary incentive awarded for each appointment kept was a popular $5 grocery store voucher—thanks to a partnership with a local grocery store. Handouts on discussion topics and inspirational poems and books were provided at support group meetings. Verbal incentives were delivered via one-on-one contacts and follow-up phone calls. Frequent, personal contact was found to be as important as incentives in gaining trust. Incentives also were used with the peer educators. On a quarterly basis, an outstanding peer educator was recognized for outreach efforts.

- Support services: To reduce barriers to health care access, the program provided child care, elder care and transportation to appointments. The provision of child care and transportation became problematic until the program purchased a van. This item was identified as a budgetary priority with data collected from clients at the inception of the program (30% of women stated that they did not keep their appointments because of lack of child care and 10% reported problems with transportation).

- Client tracking: Program staff developed and implemented a detailed tracking system to document client enrollment, participation in education sessions and support groups, staff development workshops and peer educator trainings. The system included staff log sheets, client encounter forms and a computer database. Staff members and peer counselors were responsible for maintaining accurate program records in direct relation to their roles on the project. Program staff also monitored program efforts (continuous quality improvement) to ensure that support group meetings were well planned and successful. After each meeting, staff held 30-minute review sessions.

- Service access: The program increased access to screening, diagnosis and treatment of STDs by providing clinics in non-traditional settings. They created a food bank at their facility to attract women in greatest need of support in the community who were often equally at risk for STDs.

- Partnerships: New relationships were forged with local midwives, the local hospital and health departments. A provider network was created to facilitate access to patient care. Both the East Carolina University (ECU) Department of Health and Human Promotion and the East Carolina School of Medicine, Department of Family Medicine provided clinical services in non-traditional settings.

Outcomes

This project demonstrated the efficacy of building on a single-issue organization (HIV outreach and counseling), and expanding its grass-roots linkages to incorporate other health issues and services for the women being served. Providing screening services in non-traditional settings increased access and use. This project was a success on several levels.

The New Life staff documented their ability to identify, refer and follow women at risk for STDs using creative incentives and outreach workers. Program staff used educational sessions, house parties, and one-on-one support and group meetings to reach and educate 2,833 high-risk women. More than 1,000 were referred for healthcare, 767 of those women made appointments (72%) and 76% kept their appointments. Over half of them (56%) were diagnosed with an RTI of which 100% received treatment. Follow-up with those women who did not keep appointments expressed problems with child care and finding transportation. While the mere number of women educated and screened is impressive, the number of cases identified by the project confirms that the targeted population was at high risk for sexually transmitted diseases and in need of the services provided by the project.

More than 30 peer educators were trained to serve Martin and Washington Counties. Many exceeded the expectations of program staff by enrolling in additional training. Because outreach workers encountered a variety of health issues in the community, New Life arranged for supplemental in-service trainings. These included workshops on diabetes, hypertension, lupus, stress and a breast and cervical cancer screening training sponsored by the N.C. Breast Cancer Screening Program. Equipped with new knowledge and skills, peer counselors adeptly referred 31 women for mammograms.

The project revealed that a lot of the women had very complex multifactoral problems (such as trading sex for drugs or food) that surfaced in peer support meetings and one on one. Some of the outreach workers found they were not prepared for or able to effectively address the clients' many personal issues and emotions. Subsequently, the pro bono services of a psychiatrist were enlisted to screen women and get them into other treatment.

Clinics will continue after the funding period because of the dedication of staff, interns from ECU, peer educators and volunteers. Grant writing, documentation and evaluation skills acquired via the technical assistance provided by Sheps Center staff will enable program staff to apply for additional funding. Staff currently is exploring additional funding opportunities to continue and expand their activities to include other risk factors such as smoking. The East Carolina University Department of Family Medicine is working with them to provide alternative clinics using the services of rural family practice fellows.

Lessons Learned

- Trust: The most difficult challenge was gaining trust of the client. Clients with a history of substance abuse and lack of family support were reluctant to trust the outreach worker. Yet, once a relationship began, many of the women served became dependent on the outreach workers for other forms of support; this was a burden that volunteers were not emotionally and/or professionally trained to manage.

- Partnerships take time: It is time-intensive to develop a networking team of agencies and constituents prior to program implementation. And the best of plans were often delayed when clinic directors changed (it happened four times in two years). It also took time to overcome the objections of and challenge to the community's medical structure in establishing screening clinics organized by low-income women.

- Local advantage: There are advantages to administering a program from a nonprofit agency versus a local health department. The differences in bureaucracy allow for greater flexibility and quicker responses to mid-stream programmatic structure change in the nonprofit setting.

  When implementing a county-level program, it is advantageous to approach local collaborators (versus state-level) who know the area and indigenous populations. Furthermore, program staff can encourage the local women to visit project administrators and state legislators to speak out regarding the success of the project and funding justification.

- Outreach: An alternative outreach approach using trained volunteers from the communities in which the target population lives may be most effective among high-risk populations.

- Staffing: Although the project budget did not allow for hiring more individuals with professional expertise, the midterm program evaluation indicated that at least one of the key staff members should have been a professional health educator.

  Future programs should consider including a professional to oversee a triage process for referrals of clients to counseling and other services or support systems. Alternatively, peer educators could be trained regarding the ancillary services available and how to refer/link their clients to those services.

- Transportation: A larger budget for transportation of clients and provision of child care would have alleviated barriers to effective program implementation and provision of services.

Lessons Learned

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The typical one-time, one-year grant provided by the North Carolina Healthy Start Foundation was never expected to impact infant mortality long-term, nor did the limited funding allow for a rigorous evaluation of the programs. Over the years, however, much was learned through close contact with grant recipients. The Foundation continually modified its community grants program as it strived to increase its impact.

The following is offered in the hopes that others, who may be in the position of funding local community initiatives in the future, can learn from our experience.

- Be clear and precise about the purpose of your grants program, what you want to accomplish and who you want to reach.
- Counties with the highest need may not be in the applicant pool at grant review time. Promote the availability of the community grants in a wide variety of settings and to a diverse group of agencies—not just the usual and visible ones. Give yourself time to acquire mailing lists and set up electronic communication.
- Utilize a simplified grant application process that allows community-based organizations with limited grantwriting experience to successfully compete. Be prepared to provide technical assistance during the grantwriting process.
- Host pre-application workshops to provide local organizations an opportunity to learn more about the issues, to identify the critical needs in their community, and to address the most salient problems with relevant solutions.
- Encourage grants with strong community partnerships. This is essential for linking key networks at the local level, building on past community experiences, maximizing resources, building on other local efforts, developing pride and local ownership of the project and ensuring project sustainability.
- Convene an interagency review team with expertise in the topic area as well as knowledge of the research, model programs and the capability of the local organizations that may apply for funding.
- Know what different levels of funding can accomplish.

Small grants (under $15,000) play a definite role in ensuring the success of larger efforts through stop-gap funding or providing flexible funds for items or services that are difficult or impossible to fund through routine mechanisms. These include items like vouchers for transportation or incentives to encourage enrollment or retention in programs, or funding for staff development. Seemingly insignificant, these small grants were very much appreciated by local agencies which often were faced with shortfalls in their budgets and would have been at a loss in terms of continuing special services or items.

Medium size grants ($20,000-$35,000) typically fund program growth or provide seed money. Part-time staff might be added to an existing maternity program to coordinate services into new neighborhoods, increase clinic access or train ancillary lay-health promoters to provide linkages between the community and health services. These grants also tend to provide early financial support for demonstration projects that have potential to evolve into models for other counties. They also are used to secure leverage funds from other community

The efforts of the Foundation led to ownership of factors that locally contributed to high rates of infant death and disparities in birth outcomes.

groups to expand or extend services past the grant period. This size grant is limited in its ability to have measurable impact on indicators related to infant mortality, *per se*.

Larger grants ($40,000-$75,000) allow for a slightly wider range of creative strategies. While this level of funding increased the scope and depth of what projects could endeavor to do, there were definite limitations as to what realistically could be expected in terms of impact at a community level for affecting rates of infant death. Projects at this level of funding were still focused on services and improving systems of care across agencies; there were very few available dollars dedicated to evaluation or implementing formal tracking mechanisms.

Multiyear grants provided a clear advantage for the grantees. Most projects required several months (as many as six) to process contracts, set up accounts with awarded funds, identify/hire and train staff, and organize the infrastructure for implementing the program. The majority of the first year was spent establishing the program. But with two-year funding, most grantees entered the second year with well established activities and were able to track the number of services provided. These projects were also able to develop strong coordination with local agencies, better develop their objectives and target risk groups more appropriately.

Evaluation

The Foundation's Community Grants Program was not a study project or a research program; funds were dedicated to the services and residents of local communities at risk of poor birth outcomes. In many cases, local program managers and staff were not trained nor familiar with evaluation techniques or the necessary items that would need to be tracked in order to make statements at the end of the project period about program success. In almost every case, there was keen interest and appreciation of this effort; however, relative to the goal of providing services, the evaluation and tracking activities were necessarily secondary.

Each of the grantees funded for a two-year period had dedicated staff time and made a considerable effort to set up and utilize tracking mechanisms. However, without comparison groups or information about the complete maternity population served in a clinic, health department or hospital program, it is difficult to draw conclusions about the relative efficacy or significance of the efforts.

Seed Money

The grants program in the early 1990s gave community groups a funding source for seed money to support new ideas or new ventures among local partners. Many of the coalitions initiated through this work evolved as viable 501(c)(3) nonprofit agencies and sustained their efforts through locally derived support and public-private ventures that involved businesses, industry and the faith communities. The FYs 1997-2002 cycles of the grants program continued to support several of these groups (for example in Lee and Forsyth counties), identified new groups that had the potential to develop these kinds of interagency relationships (Chatham, Pasquotank, Martin and Moore counties) and worked in tandem with other state groups who were mounting community grants programs (March of Dimes, Minority Infant Mortality Reduction Project, Targeted Infant Mortality Reduction Project, Healthy Start Baby Love Plus).

In this way, the Community Grants program succeeded in fostering the original ties established through the Governor's Commission on the Reduction of Infant Mortality and strengthening efforts through shared resources (review teams, application forms, site visits, funding mechanisms, pre-application workshops) that administer the programs.

Local Ownership: Innovation

Foundation funds were effectively used to "bring the issues home" and establish greater emphasis, in existing and new programs, on ways to reduce prematurity and low birthweight. The efforts of the Foundation led to fostering local ownership of infant mortality issues and helped to raise awareness about local factors that contributed most substantially to high rates of infant death and disparities in birth outcomes. A number of innovative projects were implemented, especially to increase access to care and target areas of highest risk. And several groups shifted their focus to add components for outreach, referral and treatment of risk factors as well as to focus on reproductive tract infections, improved birth spacing and smoking cessation, as a result of their involvement with the Foundation's grant program.