

ISSUE BRIEF

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TRENDS IN PUBLIC HEALTH

Healthy Start: Health Education Plays a Key Role in Local Efforts

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Healthy Start began as a demonstration in 1991, before becoming a fully operational program in 1998. This brief is based on Mathematica's evaluation of the demonstration, conducted for the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The analysis is based on data collected from 1994 to 1997, including two rounds of site visits to 15 Healthy Start projects across the U.S. and several rounds of telephone follow-up interviews, as well as a special set of interviews with local health education staff. It also draws on data collected in a cross-sectional survey of about 3,000 postpartum women living in the Healthy Start project areas. In the survey, equal numbers of participants and eligible nonparticipants were interviewed.

Building Awareness and Educating the Community

Healthy Start was about more than reducing high infant death rates. It also sought to improve other maternal and infant health outcomes through interventions targeting women, infants, families, and communities. To accomplish these goals, projects used health education to pass on health-related information and skills to individuals and families.

Community education, which complemented targeted, one-on-one efforts focused on individuals, had three goals: (1) to educate communities about the problem of infant mortality and key factors that influence infant deaths, (2) to encourage healthy

behaviors in communities, and (3) to increase awareness and utilization of Healthy Start services. Most efforts were aimed at entire communities, but some were focused on specific groups, such as health care providers or pregnant and postpartum women.

Some projects contracted with public relations firms to fulfill these goals; others employed full-time staff to design and implement their communitywide campaigns. HRSA also hired Vanguard Communications to assist in directing a national Healthy Start education campaign and provide technical assistance to projects. The national campaign promoted Healthy Start through television and radio spots, posters, and billboards. A toll-free number connected callers with state and local agencies that provided referrals to programs and services.

TABLE 1

HEALTH EDUCATION TOPICS OFFERED

Topic	Number of Projects Addressing
Family planning	15
Nutrition	15
Alcohol and drug use/abuse	15
Smoking cessation	15
Childbirth preparation	15
Parenting	14
Sexually transmitted diseases (including HIV/AIDS)	14
Infant and child development (including safety and immunizations)	13
Domestic and community violence	12
Breastfeeding	10
Stress management	8
Life skills	7
Male/father involvement	5
Literacy/employment skills	5
Abstinence	3
Fetal alcohol syndrome or effects	1
Lead poisoning	1

Source: Mathematica survey.

Projects sought to educate community members about lifestyle and health issues affecting infant mortality (see Table 1). In designing their strategies, projects gathered input from staff and community members, including each project's community-based consortium, focus groups, and infant mortality review committees. Various media were used to reach communities; most projects used a multifaceted approach (see Table 2).

Component	Number of Projects Using
Brochures, fliers	15
Logos, slogans	15
Newsletters	15
Health fairs and other events	15
Radio (ads, PSAs, talk shows)	14
Promotional products/items	14
Fact sheets	14
Posters	14
TV or cable (ads, PSAs, talk shows)	13
Newspaper (ads, articles)	11
Local hotline/helpline	10
Billboards	9
Press conferences/press releases	9
Media kit	8
Public transportation posters, cards	8
Calendar of events	6
Phone book ad	1
Direct/target mail	1

Source: Mathematica survey.

By far, the most effective method of reaching potential clients was through family members, friends, providers, and other members of the community. Roughly 86 percent of clients said they had heard about Healthy Start through word-of-mouth (see Table 3). This finding has important implications, because spreading the word in this way is likely to be less costly than television, radio, or billboards. This finding also underscores the importance of having campaigns up and running early on, given the time needed to engage clients and promote a program through word-of-mouth.

According to Healthy Start staff, using multiple approaches (print, broadcast, and face-to-face contact) is crucial to the success of community education. They also learned that slogans or jingles, simple fliers

Source	Percentage of Clients
Word-of-Mouth/One-on-One Contact	
— Friend/relative	26
— Doctor	21
— Outreach worker	14
— Hospital	11
— WIC office	6
— Other service agency	6
— School	1
— Church	1
Radio/TV	10
Posters/fliers/cards	8
Billboards	2
Promotional items	1
Health fair or community event	1
Hotline	1

Source: Mathematica survey.

and posters, ads posted on buses or subways, and radio spots are especially effective. The majority had much less success with tear-off cards placed in buses or subway cars, or with newspaper ads and articles. Many projects found television to be effective, although expensive. To conserve resources, some projects opted for public service announcements (PSAs) and other donated time slots, but this less costly air time typically occurred during off hours. Newsletters were effective for educating providers and existing clients, but not for attracting new clients.

On the Mark: Targeted Education

Projects developed topics for health education classes and one-on-one contacts using input from local infant mortality review committees, discussions with community members, available statistical data, and staff's perceptions of client needs. In a number of sites, the local Healthy Start consortium or one of its committees helped design health education programs. All projects focused on pregnant women and women of childbearing age; two-thirds also targeted adolescents and male partners; and a third worked with health care providers.

Nearly all Healthy Start clients received some form of health education. Clients were more than twice as likely to receive one-on-one health education than to participate in group instruction. Roughly 83 percent received one-on-one education in at least one topic, with most learning about breastfeeding, STDs, or

nutrition. More than half learned about family planning, parenting, alcohol and drug use/abuse, childbirth preparation, smoking cessation, and infant and child development. About half as many clients (41 percent) participated in formal classes, most often in parenting, childbirth preparation, infant and child development, breastfeeding, and nutrition.

Clients seemed most interested in and comfortable with concrete and relevant subjects related to daily life, with an emphasis on positive behaviors, such as nutrition, parenting, and child development. Classes were more useful for providing general information, and staff thought one-on-one education was better for developing personal strategies and addressing sensitive topics. Overall, some approaches worked well for certain groups but not for others, reinforcing the value of using multiple strategies.

Participation in classes improved when support services, such as transportation and child care, were available. Incentives also improved consistency of participation. All projects used some type of incentive for attendance, either formally awarding points that could be redeemed for health products or informally offering small rewards. Other factors that improved participation included convenient class times, high-quality presenters, interesting topics, refreshments, and good advertising. As with communitywide campaigns, word-of-mouth was especially effective in boosting attendance.

Staffing for health education initiatives varied by project. About half used central health education coordinators; others relied on a more decentralized approach, with multiple health educators and case managers. Case managers—often lay workers without college degrees—provided extensive health education during one-on-one interactions, using protocols developed by health education staff.

Overall, maintaining consistency and quality control over health education was difficult, especially since so much was delivered one-on-one by lay case managers. Projects using a more centralized approach tended to have more control over quality.

Sustaining the Momentum

As federal funding tapered off, projects had to find other funding sources. Because they lacked strong evidence of how health education could improve birth outcomes, projects found it difficult to demonstrate the value of their programs to potential funders.

At the end of the demonstration, most projects had tentative plans for sustaining targeted health education. Health education was thoroughly integrated into case management services, so projects were able to sustain some targeted health education in this manner. Many projects also were planning to continue other types of health education through partnerships with community organizations such as the March of Dimes, state and local health departments, and universities. Others sought funding from foundations, national health agencies, and managed care organizations.

Keeping communitywide health education afloat proved even more challenging. The impact of a communitywide campaign is difficult to quantify, and it is hard to demonstrate direct benefits for any one funder. Despite this obstacle, most projects were able to continue at least part of their community education program. They relied on relationships with community organizations, with funding from foundations, local hospitals, and/or businesses. State and local agencies also supported local Healthy Start hotlines. Some projects received free airtime or discounted rates from television or radio stations, as well as space from billboard companies. Other free publicity came from print and broadcast news coverage of Healthy Start events.

Adding It Up

Healthy Start projects overcame a number of challenges to develop relevant, creative health education initiatives that reached a large number of people in the target areas. With a focus on the community and a goal of changing entire systems of care, Healthy Start's health education efforts drew on a wide range of expertise at the state and local levels. The following lessons may help other communities with a similar mission help improve systems of care for vulnerable women and children:

- Involving community members in planning and testing health education programs helps ensure that topics, messages, and format are appropriate.
- Communitywide promotional campaigns are most valuable early on. Later, after a program has an image, word-of-mouth is the best publicity. Getting the word out early to providers helps build awareness and stimulate word-of-mouth advertising, as does making promotional messages consistent.

- Despite extensive advertising, most participants learned about Healthy Start from family, friends, doctors, and other personal contacts. Promotional campaigns should focus on organizing small events and forums that give potential clients, staff, providers, and other community members an opportunity to interact.
- Classes worked well for some topics and some populations, but most health education was provided one-on-one during case management contacts. This more decentralized approach can be very effective, but it is also challenging to maintain quality across encounters.
- Although set in different communities and given wide latitude in program design, projects focused on the same set of core education topics and identified many of the same education needs. Rather than beginning anew, future efforts could use Healthy Start resources and materials as a starting point for developing health education initiatives.
- Projects lacked the resources and expertise to conduct rigorous evaluations of their targeted and communitywide health education efforts. Although some held focus groups and used pre- and post-tests to assess certain components, most projects relied on anecdotal evidence when deciding how to improve or refine their efforts. The lack of solid

evaluation findings made it difficult for projects to demonstrate the benefits of health education to potential funders.

To Find Out More

For the full report, *Using Health Education to Reduce Infant Mortality: The Healthy Start Experience*, visit Mathematica's web site at www.mathematica-mpr.com. A variety of other publications, including additional copies of this issue brief, can be ordered or downloaded from the site.

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