Families Together Final Evaluation Report

LeCroy & Milligan Associates, Inc

Tuscon, AZ

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Table of Contents

List of Figures

Introduction/Background

The Families Together program is a home visitation program provided by the Horn of Africa, a community-based organization providing services to Somali and East African refugees who reside in the greater San Diego area. The program began in Spring 2006 and is based on the Healthy Families America home visitation model. The California Endowment and the Annie E. Casey Foundation jointly fund the program with the goal of providing support services to Somali refugee families.

Statement of Need

San Diego is a major resettlement site to individuals fleeing economic hardship or persecution for political and religious affiliation in their native countries. Immigrants from Somalia are among the most recent refugee groups to arrive in San Diego (St. Lukes Refugee Network, 2007). Over the last several years, the number of refugees settling in San Diego has grown to more than 20,000, creating the largest African community in California and the second largest in the nation (International Rescue Committee, 2007).

Data from the central region of San Diego illustrate the plight of African refugee families and the impact that lack of access to health care and unfamiliarity with the American health and education system is having on the well being of children and families. The following factors lead them to be considered an 'at-risk' group: limited knowledge of proper prenatal care and significant barriers to accessing health care services.

Although refugee resettlement agencies provide a variety of programs to assist refugees in accessing key services such as food stamps, housing, MediCal, and employment, health-specific assistance and education on navigating the U.S. health care and education systems are very limited and often not culturally relevant. Without a thorough introduction to these services, Somali refugee families are left without help to improve their families' health and education. In an effort to bridge the gaps to accessing services, the Horn of Africa, a non-profit community-based organization governed and staffed by Africans was started in 1995. In 2005, the Horn of Africa conducted focus groups that revealed that access to

culturally-responsive early health and education services was a priority and need among refugee families in order to provide infants and children with the appropriate health care, education, and support required to be healthy and succeed in school.

Program Development

The Horn of Africa partnered with the County of San Diego: Health and Human Services Agency, Women, Infants, and Children (WIC), Social Advocates for Youth (SAY) San Diego, Start Smart, and the City Heights Wellness Center. After a review of the literature, the Horn of Africa and their partnering agencies decided that a home visiting approach was essential to breaking down the cultural, language, and other barriers to access and education faced by refugee families. They felt that by visiting families in their homes, they could acknowledge and address their needs and build upon the families' existing strengths to address difficulties the refugee families experience. The partners agreed that the development of the Healthy Families America (HFA) home visitation program would be the most appropriate intervention to reach the target population of East African refugee families with young children ages birth through five. As a result, the Families Together (FT) program was founded in 2006 and uses the Healthy Families (HF) model to work exclusively with East African refugee families in the San Diego area.

The Families Together program provides support services to Somali families either expecting a child or with a child ages birth to five. Each new family is assigned to a Family Support Worker (FSW) who meets with them weekly to review a culturally-tailored curriculum of healthy behaviors for both the mother and the child. All four of the Family Support Workers are Somali themselves. In addition, the Family Support Worker links the family with appropriate services depending on the families' needs.

Program Advisory Board

The Families Together program receives regular oversight and programmatic guidance from an advisory board. The board representatives consist of physicians, nurses and other professionals from San Diego's leading health agencies and hospitals, as well as Somali community members. *Appendix A*

provides a complete listing of the board representation. Since spring of 2006, the board has met bimonthly and not only offers programmatic advice but also acts as a bridge to link participating families with appropriate and often much-needed health services.

Program Goals

The first year of program implementation focused more on the process and developing an infrastructure for measuring these outcomes. The overarching goals of the Families Together program include the following:

1. Reduce the incidence of child abuse and neglect
2. Enhance parents' abilities to create stable, nurturing home environments
3. Promote child health and development
4. Help develop positive parent-child interactions
5. Help ensure that families' social and medical needs are met
6. Ensure families are satisfied with program services.

First-Year Evaluation Plan

Families Together contracted with LeCroy & Milligan Associates, Inc. in October 2006 to provide evaluation services. Multiple process data and outcome indicators were gathered to assess the implementation and outcomes of this program. The goal of the evaluation is to provide an analysis of the following issues:

- Documentation of the program planning and development process, with a special emphasis on how the program was modified to be culturally relevant
- Program description
- Implementation of the program, including the challenges of adapting the program for this unique population
- Demographic data on numbers and characteristics of families served
- Participant satisfaction with the program
- Beginning to note the program's effectiveness in reaching outcomes.

Since the Families Together program is in its first year, the evaluation focuses primarily on process questions, successes and barriers of implementation, and characterizing the population served. Initial outcome data were collected and analyzed during this time as well.

The evaluation provided both qualitative and quantitative approaches to assessing the program's first year. The qualitative methods were in-depth interviews with program administration staff and Family Support Workers. The quantitative approach used screening tools, assessments of appropriate child development and parent-child interaction, immunization schedules, and satisfaction surveys. The measures selected were a culmination of those provided by Great Kids in the District of Columbia and Healthy Families Arizona. The first year examined how sensitive these tools were with this unique population.

Unique Challenge

One notable challenge was finding research-based measurement tools that worked with this unique population. The program development team clearly identified what they wanted to measure in the first year. The team researched and selected instruments that were validated with comparable populations to accurately measure their outcomes. However, the Somali refugee population has its own unique needs, and the team could locate no measurements that were validated with this specific population. This first year's data provided evidence for a need to either continue searching for culturally-relevant measurement tools or adapt the tools for this group.

Report Organization

The purpose of this report is to provide the first-year findings for the program through August 15, 2007. The report is organized into the following sections:

- *Data Collection Methods*: Includes a description of the qualitative and quantitative methods employed throughout the first year.
- *Results*: Highlights the findings from key-informant interviews at different times during the first year. It also provides a detailed description of the participant demographics, screening scores, intervention targets (e.g., prenatal care, immunizations, parent-child interactions), and satisfaction survey results.
- *Conclusions and Recommendations for Future Steps*: Summarizes the evaluation findings and provides suggestions for next steps for both the program and the evaluation.

Data Collection Methods

Qualitative

Qualitative methods were employed to record and analyze program development. In-depth interviews with program staff and administrators were conducted in March 2007 to get a sense of the development of the project. Follow-up interviews were conducted in August 2007 with Family Support Workers to better characterize the families served and the unique needs of this population. A summary is provided in the *Results* section and a full description is provided in *Appendix B*.

Quantitative

In addition to qualitative methods, quantitative measures were used to track participant progress and to begin to look at program outcomes. The screening tools used were the Kempe (Parent) Survey and the Center for Epidemologic Studies Depression Scale (CES-D). Developmental progress and the quality of home environment were assessed though the Ages & Stages Questionnaire and the Home Observation for Measurement of the Environment (HOME). General demographic information was gathered at baseline and a medical demographic profile was collected directly following the baby's birth (See *Appendix C* for the administration schedule of data collection forms). Self-reported immunization records were maintained on a regular basis and an in-person contact record was kept to capture parent-child interaction. Child Protective Services (CPS) and developmentally delayed (DD) cases were recorded through filing reports. In April 2007, the program administered participant satisfaction surveys to identify both attributes of the program and potential areas for improvement.

The program sent all evaluation-related data to LeCroy and Milligan Associates, Inc. for data entry and data analysis. A data collection training occurred in March 2007 to ensure all relevant data points were collected consistently and that a specified process was used to organize and send data to LeCroy & Milligan Associates, Inc. Program staff sent data regularly to ensure data flow and timely data monitoring, while quality assurance took place.

Results

Program Development and Implementation

The process evaluation documented the program development and implementation process for the Families Together program, with a special emphasis on documenting cultural issues. To provide this information, in-depth interviews were conducted with both program administrators and Family Support Workers in March 2007 and follow-up phone interviews were conducted in August 2007. Appendix B provides a full summary of the Family Support Worker interviews. These interviews provided a historical account of the program development, initial recruitment, and their perceptions of challenges and success stories.

The Families Together program began in March 2006 after staff received several weeks of training provided by the Mary's Center from the District of Columbia on the Healthy Families home visitation model. Collaborations with Marla Oros of the Mosaic Group helped with program development and evaluation consultation. Working with the Maternal, Child, and Family Health Services Branch of the County of San Diego Health and Human Services Agency and Social Advocates for Youth (SAY) San Diego, the program developed a curriculum culturally tailored for this population. Using the national Parents As Teachers curriculum, the program development team spent over 200 hours developing this curriculum. The Families Together curriculum provides detailed information on health topics such as women's health, child development, immunizations, as well as systems level help for those new to the United States. The curriculum has age-specific sections for appropriate development for children ages 0 to 3. Family Support Workers help families directly by teaching families this curriculum, providing referrals to needed resources, interpreting information, and supporting families throughout their participation.

Recruitment began in March 2006 and continued throughout the first year. Referrals to the program were received from WIC and other community centers via word of mouth. Since they work with a tight-knit community, many participating families had the same physician, which allowed program staff to develop relationships with a small group of health care providers. By August 2007, 50 families had enrolled in the program.

Family Support Workers provided examples of challenges their families face such as: not knowing English and requiring interpretation services, having difficulty navigating basic American systems, expensive and often inadequate housing, transportation challenges, needing economic support, and not using birth control. As a result, most families require more services than those typically provided by social service agencies. Family Support Workers help with interpreting (e.g., doctors' appointments, job interviews, etc.), talking with community members, navigating through American systems (e.g., education, housing applications, medical), and even staying with a mother through her delivery to translate and explain medical concepts. Gaining fathers' involvement was a key challenge for this program, but since March 2007 program staff felt they were making progress in this area.

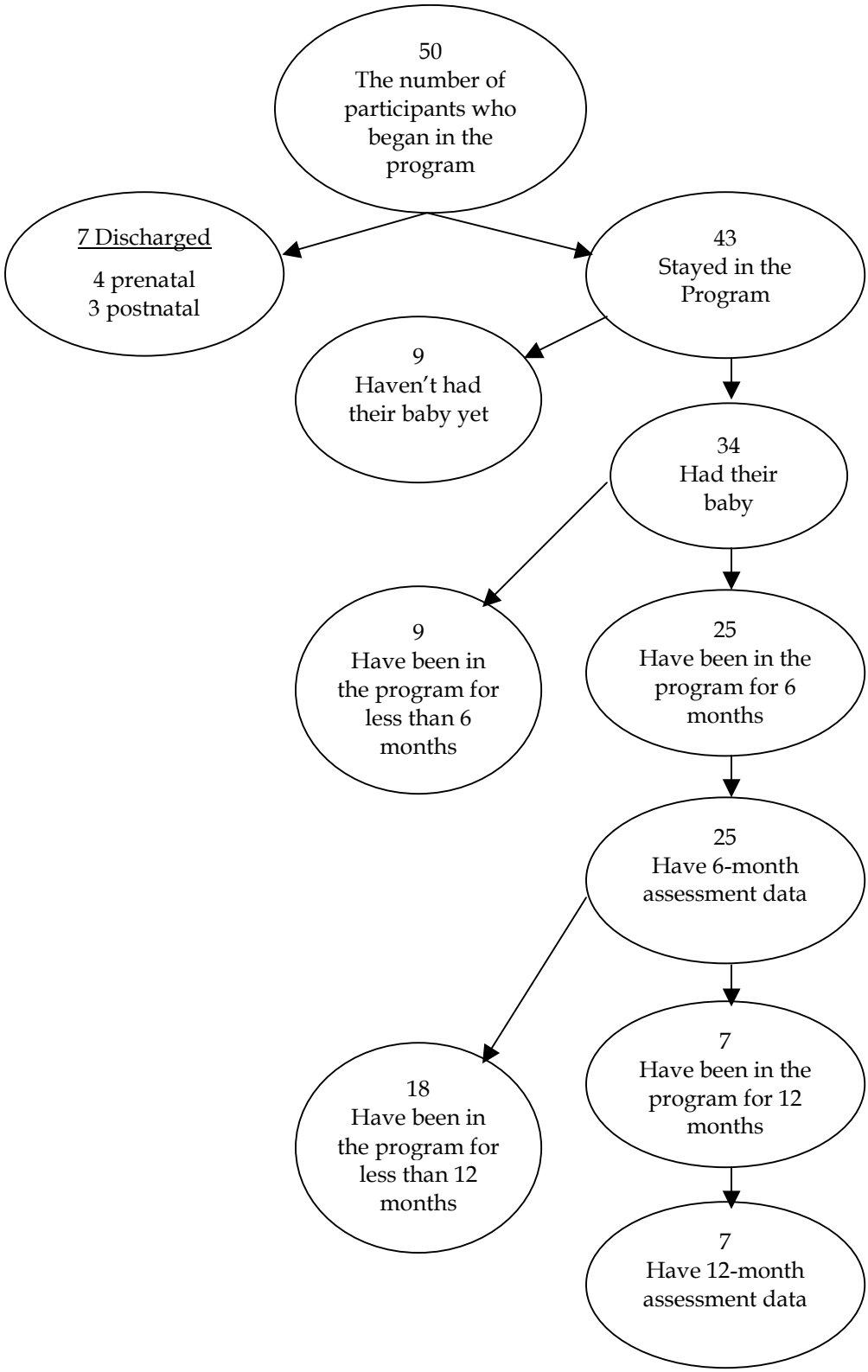
One of the program's most successful parts was the establishment of a monthly meeting with participating mothers to provide education seminars and facilitate connections with other families in the program. The meetings were an hour long and attendance was typically 15-20 participants per meeting. The program hosted guest speakers from community agencies and organizations throughout San Diego to present valuable information to the group and answer specific questions. A complete list of the program topics and guest speaker information is provided in *Appendix D*. The monthly group meetings continue to serve as an integral part of the program to connect participating families with both important services in the community and with other Somali refugee women.

Many individual families have had successful breakthroughs as well. For example, several families have obtained better, more suitable housing, have learned American systems, have overcome fears of caesarian section, and have seen noticeable increases in communication levels with their children. Overall, workers feel the program provides valuable services to an appreciative community in need of many fundamental services.

First-Year Program Outcomes

The following results include program data collected between May 2006 and August 2007. During this period, 50 families enrolled in program services with 68% (n=34) of families enrolled prenatally, and 32% (n=16) of families enrolled after the baby was born. Seven of the 50 families discharged, with three leaving within a month of enrollment. Three families discharged because they declined services, three moved away, and one said she did not have enough time to participate in the program. The following flowchart illustrates the flow of participants through the program.

Figure 1. Flowchart of Program Participants during the First Year



Demographics

Parent and Household Demographics

The following provides demographic information for the participants at baseline. Data were included for families who stayed in the program and did not discharge.

Figure 2. Demographic Profile for Participating Mothers and Fathers

	Mother 43 (100%)	**Father 42 (100%)**
Education		
Never Went to School	19 (48%)	11 (29%)
4th Grade or less	2 (5%)	1 (3%)
8th Grade or less	11 (28%)	0 (0%)
9th – 12th grade	7 (18%)	19 (50%)
Mental Retardation/Developmental Delays	0 (0%)	0 (0%)
Unknown	0 (0%)	7 (18%)
Education Credentialing		
None	27 (77%)	12 (31%)
High School Diploma	4 (11%)	18 (46%)
Associate's Degree	1 (3%)	0 (0%)
Some College	2 (6%)	0 (0%)
Bachelor's Degree	1 (3%)	2 (5%)
Unknown	0 (0%)	7 (18%)
Employment		
Employed Full-time	3 (9%)	14 (36%)
Employed Part-time	3 (9%)	13 (33%)
Unemployed Seeking Work	2 (6%)	2 (5%)
Unemployed Not Seeking Work	27 (76%)	6 (15%)
Unemployed – Seasonal	0 (0%)	1 (3%)
Unknown	0 (0%)	3 (8%)
Language		
Somali	40 (95%)	31 (98%)
Both Somali & English	2 (5%)	1 (2%)
Type of Health Insurance		
Medicaid	36 (90%)	
Private Insurance	1 (3%)	
None Yet, Have Applied	3 (7%)	
Marital Status		
Married/Common Law	34 (81%)	
Separated	7 (17%)	
Never Married	1 (3%)	
Age (median)	27.8	32.2

* Missing data were excluded from the percentages listed above.

Most participating mothers were currently unemployed and not seeking work, primarily spoke Somali, were married, and were currently receiving Medicaid support. Nearly 48% of all mothers had never attended school, and consequently, 77% did not have a high school diploma. However, eight mothers did obtain at least a high school diploma. The median age for mothers in the program was 28, while it was 32 for fathers. The demographic profile for fathers differed from the mothers in that only 31% had never attended school and 23% were unemployed.

Given the high unemployment and low education levels, the households had relatively large numbers of children under 18. The number of children ranged from 0 – 8, with 40% of the households caring for five or more children. Approximately 98% of families did not own their dwelling but shared an apartment or home with their family. Many families received supplemental income through TANF/Food Stamps (77%) and WIC (74%).

Infant Demographics and Delivery Information

The table below details information about the infant's birth and delivery. The infant's birth data were self-reported by the mother shortly after the birth. Thirty-four mothers provided information about their baby's birth.

Figure 3. Medical Demographic Data

Birth Indicators*	**Number (%)**
Gender of Baby	
Male	17 (50%)
Female	17 (50%)
Type of Delivery	
Vaginal	20 (74%)
C-Section	7 (26%)
Birthweight	
Very Low Birthweight (<1500 grams)	2 (6%)
Low Birthweight (1500-2500 grams)	2 (6%)
Normal Birthweight (2500-4000 grams)	26 (76%)
High Birthweight (>4000 grams)	4 (12%)
Prenatal Care Began (Week in Pregnancy)	
1st Trimester (1-12 weeks)	26 (81%)

Birth Indicators*	Number (%)
2nd Trimester (13-26 weeks)	6 (19%)
3rd Trimester (27-42 weeks)	0 (0%)
Complications during Labor/Delivery for Baby	
Yes	6 (18%)
No	28 (82%)
Complications during Labor/Delivery for Mother	
Yes	9 (27%)
No	25 (73%)

**No mother reported using birth control before getting pregnant.*

Seventy-four percent of the births were vaginal and 26% were by c-section. Family Support Workers continue to teach families about c-section births to reduce the women's fear associated with that delivery method. Babies' birthweights for this group are slightly more at risk than the birth trends in the United States. According to recent CDC's Pediatric Nutrition Surveillance data (2007), 9% of infants had low birthweights (<2500 grams) and 7% had high birthweights (>4000 grams). In the Families Together program, 12% of infants were low birthweight and 12% were high birthweight.[1] All of the families with low birthweight infants enrolled in the program postnatally. Future reporting of evaluation results should divide the families into prenatal and postnatal families. Given the relatively small number of families participating in this year's evaluation, the results were combined into one table.

While birthweights were slightly more at risk, 81% of mothers began prenatal care during their first trimester. Eighteen percent of families had complications for the baby during labor and delivery, and 27% had complications for the mother. This percentage is low compared to national CDC data (2007) that report 43% of women experienced some type of complication or morbidity during their delivery hospitalization.

[1] Due to the small number of births, these percentages may not be fully representative of this group.

Screenings and Assessments

Intake Screening

The Parent Survey assesses each participant's level of risk and need for the program at intake. Overall, 56% of the mothers enrolled screened as being high-risk (i.e., having a score 25 or greater). When broken down by whether mothers entered prenatally or after their baby was born, a greater percentage (67%) of the postnatal mothers screened as high-risk. Program coordinators were initially trained to administer this tool in March 2006 with an additional in-depth training that occurred in July 2006. The second training intended to teach Family Assessment Workers to more accurately identify high-risk families. Looking at families screened after July 2006, 60% of all mothers screened as being high-risk, which is slightly up from the 56% for all mothers screened over the entire program.

Figure 4. Parent Survey Administered during Families' Intake

Parent Survey*	% (n) Above High Risk Score (25 or Greater)
All Mothers (n=43)	**56% (n=24)**
▪ Prenatal Mothers (n=28)	50% (n=14)
▪ Postnatal Mothers (n=15)	67% (n=10)

** For the prenatal Parent Survey scores for the father, 23 of the 28 collected (82%) were incomplete. For the postnatal Parent Survey scores for the father, 19 of the 23 (83%) collected were incomplete.*

Maternal Depression Screening

The program uses the Center for Epidemologic Studies Depression Scale (CES-D) to assess the mother's depression prenatally or two months after the baby's birth, and at eight months. This tool has been used with many populations but it has not been used with Somali refugee groups, in particular. Initially, program administrators questioned the sensitivity of this tool for this population and also wondered whether different concepts (e.g., trauma) should be measured given the unique refugee experience. However, they wanted to test how sensitive the CES-D was with their population. To date, no families received high-risk scores (scores greater than 10) for any of the three time periods. There are several possible explanations for this outcome. This instrument might not be sensitive to identifying depression within this particular population. In which case, if depression continues to be

an outcome the program wants to track, then program administrators might consider alternative tools to measure maternal depression within this group. However, this group may not be clinically depressed, in which case, the program might consider using a broader outcome measure which includes depression as a subscale.

Ages & Stages Questionnaire Assessment

The Ages & Stages Questionnaire (ASQ) is used by the Family Support Worker to assess the child on a variety of physical and social indicators. The subscale categories include communication, gross motor, fine motor, problem solving, and personal/social. For each item under the subscale, the child is assessed using a scale of Yes/Sometimes/Not Yet to determine their development stage. A normal score indicates that the child does consistently exhibit developmentally-appropriate behaviors. High-risk scores are those subscales less than 25 for the six-month administration. High-risk scores for the 12-month administration vary per subscale.

Figure 5. High-risk scores for the 12-month ASQ administration

ASQ Subscale	**12-month High-risk Scores**
Communication	Below 20
Gross motor	Below 30
Fine motor	Below 30
Problem solving	Below 30
Personal/social	Below 25

Of the 34 participants with a baby, 25 participants were enrolled for six months or more and seven participants were enrolled for 12 months or more. For the six-month enrollment, 100% received the ASQ and all seven participants received the 12-month assessment. The following tables provide a description of the results for each assessment time. These findings should be interpreted with caution, given the small number of participants.

Figure 6. ASQ Results for 6-Month and 12-Month Assessments

Admin Time (n)	% (n) Above High Risk Score by Subscale
6 months (n=25)	0% (n=0)
12 months (n=7)	0% (n=0)

No participating families received high-risk subscale scores for the ASQ at either six or 12 months and in turn, were considered on-track developmentally.

Home Observation for Measurement of the Environment Inventory

The Home Observation for Measurement of the Environment (HOME) inventory is used during home visits at six and twelve months to examine the home environment and parent and child interactions. The Family Support Worker indicates whether they observe specific behaviors during the assessment period. The behaviors measured include those one would expect to see in a nurturing home environment: emotional & verbal responsivity, acceptance of child's behavior, organization of environment, provision of play materials, parental involvement with child, and opportunities for variety. A total score is generated with scores less than 25 being considered 'high-risk.' The following table describes the scores at six and 12 months. Again, the findings should be interpreted with caution, given the small number of participants.

Figure 7. HOME Results for 6-Month and 12-Month Assessments

Admin Time (n)	Mean Score (Range)	% (n) with High Risk Score
6 months (n=25)	36 (26-39)	0% (n=0)
12 months (n=7)	33 (31-42)	0% (n=0)

No participating families received a high-risk score for the HOME assessment. The program had no families considered at high risk at six months. The Family Support Workers use both the program curriculum and their own monitoring to encourage communication between the parent and child and other social development skills. Consequently, no developmental delay reports had been made at the time of this report.

Parent/Child Interaction

Parent/Child interactions are measured through both the HOME assessment and on the In-person Contact Record. One section of the HOME consists of six behaviors focused on parental involvement with the child. These behaviors include holding, conversing with, praising, and showing affection toward the child. At the first administration (6 months), 29% (n=7) of families demonstrated three of the six behaviors, which is considered to be a potentially high-risk score.

Another indicator of successful parent-child interaction is the In-person Contact Record. The interactions captured include: communication cues, holding, expression/eye contact, empathy, environment, rhythmicity/reciprocity, and smiling. While this tool is used during every contact with the family, the evaluation uses the information provided within the first week of the third, sixth, and twelfth month. The table below outlines the percentage of families demonstrating parent-child interactions. Most families exemplified these interactions at all three time intervals.

Figure 8. Parent Child Interactions Noted on the In-Person Contact Record

Administration Time	At least six of the seven Parent Child interactions	Five or fewer of the Parent Child interactions
Third Month (n=34)	94% (n=32)	6% (n=2)
Sixth Month (n=24)	96% (n=23)	4% (n=1)
Twelve Month (n=7)*	86% (n=6)	14% (n=1)

* Due to a small sample size, these numbers should be interpreted with caution.

Prenatal Checkups

Initially, the program collected information about prenatal visits through self-report data gained through their home visits. The program recognized the need to have a more formal instrument to collect this information and began using a prenatal checklist in March 2007. The checklist used identified the number of prenatal visits per month of pregnancy. To date, the program tracked all eligible mothers (n=14) on their prenatal care visits.

Figure 9. Prenatal Visits by Trimester Enrolled in Program

Trimester	# Enrolled	% Who Had a Prenatal Visit during This Trimester (n)
1st	3	67% (n=2)
2nd	6	100% (n=6)
3rd	4	100% (n=4)

All but one participating mother who enrolled during a given trimester also received prenatal care during that trimester. For mothers who enrolled, 93% (n=13) began prenatal care within one month of starting services. Once these 13 mothers began prenatal visits, all attended the visits regularly and missed no more than one visit during their pregnancy.

Well Baby Visits and Immunizations

The Well Baby schedule involves the family meeting with a physician regularly during the baby's first year (at two weeks, two months, six months, nine months, and 12 months). These visits include an overall check-up and all visits except the two-week and nine-month visits provide immunizations. At the time of this report, 100% of 25 eligible families had followed their well baby check-up schedule through six months.

During these doctor's visits, scheduled immunizations are given. At two and four months, the immunizations include Hepatitis B, Rota, DTP, Polio, HIB, and PCV. The six-month immunization includes everything except the Hepatitis B. At the time of this report, 100% (n=25) of program participants reported they had immunized their child through six months. Similarly, 100% of children eligible for their two-month (n=29) and four-month (n=26) immunizations received them.

Child Protective Services Reports

As reported by program staff, no substantiated Child Protective Services were submitted at six or 12 months. While two participants had confirmed CPS status at enrollment, none proceeded to have a CPS report filed to date.

Satisfaction Survey Results

In April 2007, 18 participants completed a satisfaction survey for the Families Together program. All participants were invited to take the survey, which was administered during the program's monthly meeting. Due to language barriers and to make the process as anonymous as possible, a Somali woman not associated with the program facilitated the session. Selected questions from the satisfaction survey were interpreted for the group, and each respondent selected her response. Since the survey was administered at one point in time, participants' involvement with the program varied from one month to 12 months.

Key findings revealed that participants had positive feelings about their Family Support Worker. Most respondents felt the FSW was knowledgeable (94%), understanding (94%), helpful (89%), respectful (89%), and supportive (89%). However, some respondents also reported that their FSW was firm (67%), smothering (56%), and scattered (22%).

Eighty-nine percent of respondents felt that as a result of participating in the Families Together program, they knew more about their baby's growth and development, taking care of their baby, well-baby visits, and immunizations. Respondents also felt they knew more about talking to other parents with young babies (83%), coping with problems and stress in their daily lives (78%), resources in the community (78%), and parenting information (72%).

Overall, 100% of respondents were very satisfied with the program. The most cited aspects of the program respondents liked best were home visits (89%), parent groups (83%), and the cultural sensitivity of the program (78%). Respondents cited the information gained which included how to take care of their babies (n=3), labor and delivery (n=2), immunization (n=2), and nutrition for their babies (n=2). When asked what could be added to the program, one respondent mentioned she needed more education and toys.

Figure 10. Program Objectives and Status

Program Objective	Indicator Status
1. 95% of families enrolled in FT will not receive a CPS referral during participation.	100% did not receive a CPS referral during participation.
2. Within 18 months of initiating services, 80% of FT parents demonstrating a need will show improvement in parent-child interaction (HOME).	Not enough data to assess 18 month progress. At six or 12 months, no participants had a high-risk score.
3. 90% of families participating in FT will develop a service plan with their FSW within the first ninety days of continuous service.	100% of participating families enrolled completed a service plan within 90 days.
4. 95% of infants enrolled in FT will be linked to a medical provider within three months of service initiation (self-report).	100% of infants were linked to a medical provider within three months of service initiation.
5. 90% of infants enrolled in FT will be fully immunized by age two (immunization records).	Not enough data to assess immunizations by age two. However, 100% of infants (n=25) enrolled received their scheduled immunizations through 6 months.
6. 90% of children enrolled in FT for six months or longer will be in full compliance with Well Baby Checks per EPSDT standards or equivalent (self-report).	100% of eligible families (n=25) had followed their well baby check-up schedule through six months.
7. 90% of children will be screened for potential developmental delays at regular intervals (ASQ).	100% of families (n=25) eligible for the ASQ at six months were screened.
8. 90% of parents will be given ongoing information on child growth and development (ASQ).	100% families (n=25) eligible for the ASQ at six months were screened.
9. 100% of children who evidence potential developmental delays will be referred for developmental assessment and early intervention services per parental consent (Developmental Delay Form).	No Developmental Delays were identified for referral.

Program Objective	Indicator Status
10. 90% of prenatal families receiving FT services will report having a child with a normal birthweight (greater than 2,500 grams).	100% of prenatal respondents had a child with a birthweight greater than 2,500 grams. Two prenatal families had high birthweight babies (greater than 4,000 grams).[2]
11. 95% of parents in FT will be linked to a medical provider within three months of service initiation (self-report).	100% of mothers were connected to a medical provider within three months of service initiation.
12. 95% of families receiving FT services will report an overall satisfaction with services received (satisfaction survey).	100% of respondents reported being 'very satisfied' with their FT services.

[2] One of the families joined the program the month before the baby was born, which minimized the potential impact on the mother's prenatal care.

Conclusions

Over the first year, the program learned a great deal about adapting a home visitation model for this population. Establishing and building trust within this community was key to having families be receptive to the program. The program developed the curriculum specifically for a Somali audience, which aided this process. Through using assessments from other home visitation programs, Families Together learned that particular assessments were more sensitive than others for this group. The Parent Survey and CES-D were not especially sensitive measures within this population and in future years, the program might consider using measures that are either more culturally relevant or measure a different concept. The program also gained a better understanding of what families need from home visitation programs and what types of services are most useful to Somali refugee families. Most families received the services and assessments projected for the first year and were satisfied with those services.

During this time, program staff learned several key lessons about administrating this program. As with any program development, early planning proved critical in guiding the process. Comparably, developing trusting relationships with both community members and other agency providers was considered key to success. During the implementation phase, staff felt that a six-month follow-up training to the core training session would have helped address challenges and provide clarification earlier on. Furthermore, it was recommended that the data collection forms and instruments be closely scrutinized during program planning. Overall, staff felt like the first year of implementation provided families with necessary home-visitation services.

Recommendations for Future Steps

Further examine the implementation and sensitivity of the initial screening measure.

After the first year, 56% of participants screened as being 'high risk' and therefore, in need of services. The program should continue to monitor its implementation and sensitivity of this intake assessment. Program administrators received additional training in July 2006 but still screened and accepted families below the threshold. With the program near capacity, program administrators should consider only accepting families who receive 'high risk' scores.

Consider another measure for maternal depression.

Similarly, no families were identified as at risk for maternal depression through the CES-D. Since program administrators were concerned about the sensitivity of this instrument, they should consider locating one that is more sensitive for this population. Or, the program might consider a broader instrument for measuring outcomes that includes a maternal depression scale. An instrument that covers a larger spectrum of mental health and parenting stress could help the program continue to identify pressing issues for this population.

Continue to gather information on key indicators.

Most data were collected and reported in a timely and complete manner. As the program progresses, the quantity of data will increase and produce meaningful insights into the program's process and success. Continued monitoring of the data collection procedures and processes would help ensure consistency in the information collected. Follow-up data collection trainings are recommended as a means of ensuring quality.

Include staff follow-up trainings

The Maternal, Child and Family Health Services staff with the County of San Diego Health and Human Services staff provided an 18-hour follow-up training on the program curriculum at six months. This training was informative, and staff felt a comparable training on the Healthy Families program would have been useful. It is recommended that all future family support workers receive a follow-up Healthy Families training to review key concepts and address any real case issues early in the process.

References

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Appendix A. Families Together Advisory Board

As of August 2007, the Families Together Advisory Board consisted of members from the following organizations:

- County of San Diego, Health and Human Services: Maternal, Child, and Family Health Department
- County of San Diego, Health and Human Services: Central region public health center
- University of California San Diego Hospital
- A private OB/GYN doctor
- The City Heights Wellness Center
- American Red Cross Women, Infants, and Children (WIC)
- Start Smart, SAY San Diego
- Somali community members

Appendix B. Family Support Worker Interview Summary

The FSW phone interviews took place on 8/22/07 and 8/24/07. The four FSWs interviewed were Rukiya Mahad, Hafsa Cheik, Ardo Mohamed, & Falis Budul. Each interview took approximately 25 minutes, and participants were encouraged to share their input. Participants were told the information shared would be written up for the program evaluation and shared back with them to ensure it was representative of their experiences.

1. Tell me about a typical family you see. (Prompt: What services do they receive? What are their needs?)

The FSWs typically see large families with two-parent households and several children (often 5-6 children). Most families face the following challenges:

- They do not know English and need interpretation services for everything from basic living (mail, medical documents, and school documents) to more complex issues (job interviews, and negotiating housing).
- Most have trouble navigating basic American systems (education, medical, welfare, etc) and need help learning American culture.
- Housing is a pervasive problem with most families living in space that is too small and too expensive for their family's size.
- Transportation is an issue since most do not have cars or find the San Diego bus system inadequate or confusing to navigate.
- Most need economic support through social services, WIC, etc.
- Many families are not using birth control and are having more children.

2. Tell me about a family that needed extra services. (Prompt: What are examples of those services? What extra work did you have to do to help? How much extra time did you spend with them? How often do families need extra services?)

There were many examples of families that required extra services even within this high-need group. The following examples were the most telling:

- One family had a husband who left after he got a decent-paying job. The wife was left to take care of the children, did not speak English, and received $700 per month from welfare. With her

families' needs, the money received from welfare was insufficient. Her caseworker helped with the landlord and talked with elders in the community to get the husband to contribute. Through the caseworker's help, the husband began contributing and continues to help for the time being.

- One mother went into labor and her caseworker stayed with her for 15 hours to translate and provide support and understanding about the American medical system. During this process, the caseworker helped calm the mother's fears about having a cesarean section. The mother eventually agreed to the necessary procedure, which prevented other birth complications.
- There were many examples of interpretation services and time spent navigating through American systems. Some examples include: working with medical providers to reschedule when appointments were missed, translating mail and professional correspondence, navigating automated phone systems, helping with the educational system, reminding families when to take prescription medicines and helping them with diabetes care, interpreting during a job interview, etc. All of these services take significant amounts of the caseworker's time.

3. Please tell me about a family you worked with who had a successful break through (Prompt: What support did you give that family? Did you do anything special with them?)

Despite these challenges, many families have breakthrough moments where they exhibit what they have learned. The following examples were provided:

- After going into labor, one woman overcame her instinct to call '911' and called a designated friend, instead. Her caseworker had worked with her to only use '911' for emergency services.
- Another breakthrough came when a woman in labor overcame her fears about having a caesarian section and had the procedure done to help her child.
- Many families have inadequate housing or housing that does not provide enough space for the size of the family. Many breakthroughs were described when families were able to obtain bigger, better, and more affordable housing for their families.
- One breakthrough described was helping a family who had many challenges then watching them make plans to start their own business.

- A caseworker encouraged a mother to talk with her children more. The mother increased her communication with her children and saw noticeable results. She said that the children she talked to more were better off than her other children.

4. On the flipside, please tell me about what you think are the most pressing challenges facing the families you work with. (Prompt: What types of difficulties do they encounter? Do you spend your time helping with certain kinds of problems?)

According to the FSWs, the most pressing issues for the families are: language barriers, inadequate & expensive housing, transportation challenges (poor bus systems, long waiting times), and learning the U.S. systems (takes time, missing important deadlines).

5. Is there anything else you would like to add about your work?

- The FSWs sometimes work non-traditional hours when helping their families. They feel that these families often do not have other forms of support and that it is there responsibility to help them. One FSW caseworker said she became like one of the family.

- Several FSWs mentioned that it is important to build trust among the families and the men in the community. Through developing relationships, the FSW caseworkers can better help the families with critical issues.

- One FSW mentioned that when the program began, families were unsure at first. Now, the community knows about the program and what the program does for participants. Parents are coming to them, which is a wonderful outcome. The challenge of this overwhelming response is letting them know the program is full.

One FSW suggested that the program get a van to transport participants to their destinations. She said it would help save time for both the families and the FSW caseworkers.

Appendix C. Families Together Data Collection Schedule

Data Collection Schedule by Administration Period

Data Collection Forms	Birth – 3 mths	6 mths	12 mths	18 mths	24 mths	36 mths	48 mths	60 mths
FT Family Demographics	X							
FT Family Demographics Update			X		X	X	X	X
FT Medical Demographics	X							
FT Growth & Progress Record I		X	X	X	X			
FT In-person Contact Record (1st page)	X	X	X		X	X	X	X
FT Participant Satisfaction Survey*			X		X	X	X	X
FT Parent Survey (Kempe) - Coversheet	X							
Ages & Stages Questionnaire (ASQ) - Coversheet		X	X	X	X	X	X	X
HOME - Coversheet		X	X	X	X	X	X	X
CES-D (Prenatal/Intake & 8 mths) - Coversheet	X		X					
FT Individual Family Support Plan - Coversheet	X							
Prenatal Check-up (if applicable)	X							
*Developmental Delay Tracking Form (if applicable)***		X	X	X	X	X	X	X
CPS Referral Report (if applicable)		X	X	X	X	X	X	X

* The FT Participant Satisfaction Survey will be distributed each March to families currently enrolled in the program. Forms should be sent by the end of April to LeCroy & Milligan Associates.

** This form will be completed if a developmental delay is identified through the ASQ screen. A doctor's visit, childcare or other referral can also prompt this form to be used.

Appendix D. Participants' Monthly Meeting Presentation Schedule

Families Together program monthly meeting schedule:

Date	Topic	Presenting Agency
November 17, 2006	Networking and support group	N/A
December 28, 2006	Discipline	Families Together Program
January 26, 2007	Developmental screening	First 5 Commission of San Diego
March 23, 2007	Immunization	San Diego County Immunization Branch
April 27, 2007	C-section and child birth	Grossmant Hospital
May 25, 2007	Childcare license	Union of Pan Asian Community
June 29, 2007	Women's health & family planning	▪ County of San Diego, Health and Human Services: Maternal, Child, and Family Health Department ▪ Central Region Public Health Center
August 3, 2007	Nutrition	American Red Cross Women, Infants, and Children (WIC)
August 31, 2007	Early childhood literacy	Start Smart, SAY San Diego