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Practice Summary & Implementation Guidance

Grassroots Maternal and Child Health Initiative: Faith-based MCH Promotion

The Faith-Based MCH program is grounded in the utilization of partnerships with, and the capacity-building of faith-based organizations to advance maternal and child health outcomes.

Cutting-Edge → Emerging → Promising → Best

Location	Topic Area	Setting
Indiana	Health Promotion & Communication	Community

Population Focus	Date Added
Women & Maternal Health	November 2024

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Section 1: Practice Summary

PRACTICE DESCRIPTION

Adverse birth outcomes, such as infant mortality and morbidity, preterm birth, low birth weight, and maternal mortality and morbidity, result from a complex interaction of biological, social, economic, psychological, and environmental factors (Office of Disease Prevention and Health Promotion 2021). Many interventions that promote positive birth outcomes focus on the direct medical causes of these birth outcomes and maternal behaviors, choices, and practices (World Health Organization 2022). While impressive advancements in biomedical care and innovative home visiting programs help reduce adverse birth outcomes, sustaining and making further improvements requires the activation of community members and organizations to help address the inequitable social, economic, cultural, and environmental factors that lead to adverse birth outcomes (Office of Disease Prevention and Health Promotion 2021).

Collaborations between public health entities and faith-based organizations (FBOs) have resulted in positive behavioral and physical health outcomes in traditionally marginalized communities (Barnes and Curtis 2009; Cutts and Gunderson 2018; Goldmon and Roberson 2004; Zahner and Corrado 2004; Ammerman et al. 2003; Ghouri 2005; Jeffries et al. 2017). Faith-public health partnerships working to improve vaccination rates and physical health and nutrition are common. There is a need to develop frameworks that systematically promote faith-public health partnerships to sustainably reduce adverse birth outcomes in communities with high rates of infant mortality. To this end, we developed an adaptable framework grounded in organizational theory to help build the capacity of FBOs in communities with high infant mortality rates to improve their MCH outcomes.

Past initiatives used various frameworks to engage FBOs in health promotion activities, including but not limited to, the Consolidated Framework for Implementation Research (Islam and Patel 2018), Himmelman's Partnership Model (Barnes and Curtis 2009) and the Community Based Participatory Research Method (Goldmon et al. 2008). We developed the 5-pillars of action by modifying actions implemented within the National Cancer Institute's Body and Soul Program. This program successfully partnered with African American churches to drive dietary change in African American congregations/communities (National Cancer Institute 2020).

CORE COMPONENTS & PRACTICE ACTIVITES

Project staff within our MCH initiative were guided by organizational change theory, a process theory that outlines the stages community participants will go through to make a change in health outcomes at the community level (Batras et al. 2016). These stages include awareness, adoption, implementation, and Institutionalization.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Awareness	Bring awareness to the infant and maternal mortality problem within the congregation's local community (zip code data). Bring awareness to the role faith-public health partnerships have played in advancing other public health initiatives because of the mission/ministerial work by Faith organizations.	Project staff provided an initial 30-minute presentation to the congregation/ community team. Project staff led the congregation/ community team in a discussion to highlight the role that congregations serve in relation to both individuals and their community and how focusing on MCH activities melded with their mission and current strengths/activities. Cohort set a weekly virtual meeting schedule to implement and sustain the work.
Adoption	Adopted 5-pillars of action to build the capacity of faith organizations to promote maternal and child health within the local community.	Project staff explained five pillars of action to help the congregation/community team guide and organize their efforts for MCH promotion. Our five pillars of action include: - developing positive MCH communication strategies, - developing MCH programming within the congregation that impacts congregants across the lifespan, - equip and strengthen a MCH infrastructure, - honor the MCH stories of congregants, - build local MCH resource networks. After reviewing the five pillars, congregation/community team members listed existing activities, ministries and resources that aligned or could be adapted to include MCH information and interventions. Once these opportunities were identified, team members prioritized the opportunities to start with using a prioritization matrix (Hessing 2021). Each team member used a scale from one (lowest) to ten (highest) to rate the potential impact and potential feasibility of each identified opportunity. Project staff took the

		responses and calculated the mean for impact and the mean for feasibility for each opportunity and plotted the numbers on the chart. Teams discussed the ratings, made any adjustments, and then chose the opportunities with the highest feasibility and impact.
Implementation	Implementation of the chosen opportunities with the highest feasibility and impact ratings.	Once the prioritization of activities was completed, cohort members volunteered to lead the implementation efforts for the selected activities. Leaders were charged with the task of developing a workgroup of other community and church volunteers with the social capital to plan and implement the work. Workgroups met weekly to plan until implementation occurred. Project staff collaborated with workgroups by taking notes and keeping track of responsibilities to assist the workgroup leader. Project staff assisted with evaluation efforts across pillars of action. Process and outcome evaluations were performed through the weekly team meetings. Each meeting allowed the teams to report out on activities accomplished, successes, surprises, barriers, and what changes would be made for improved implementation. accountability. The workgroup had the final decision-making power about implementation strategies and took responsibility for implementing the work.
Institutionalization	Institutionalizing MCH promotion within faith organizations everyday mission/ministerial work.	By embedding MCH activities within the five pillars of action, building or pivoting on existing strengths and resources, and choosing high-impact and high-feasibility activities, we aimed to increase the likelihood that activities would become an ongoing part of the church structure. Our faith based MCH initiative also built leadership capacity by training and supporting designated MCH leaders within the FBO congregation/community.

HEALTH EQUITY

Although this framework does not address these issues directly, faith organizations remove obstacles and barriers to health because these organizations are trusted pillars of support within communities, particularly marginalized and underrepresented communities. Many of the faith organizations we worked with served immigrant communities, impoverished communities, black communities, and provided programming to support persons returning home from incarceration. These populations have a long standing history of a lack of trust with not only healthcare systems, but adverse experiences with housing, employment, education, and overall safe environments often brought on by structural racism because of one's skin color, national origin, income status, or past criminal history. As trusted organizations within these communities, faith organizations often act as liaisons by identifying and building relationships with other community partners and organizations who operate to bring comprehensive solutions to populations facing structural racism. As liaisons, faith organizations become the approved, trusted voice to underrepresented and marginalized communities on what organizations they can go to for help and can trust to have their needs met. This is important because many populations that suffer from adverse experiences will opt to forgo engaging with organizations who may be able to help due to past experience of mistreatment and fear that this experience will reoccur. Faith organizations may remove barriers faced due to structural racism by identifying culturally competent and trauma informed services, building relationships with these organizations that provide the services, and referring people to these organizations or hosting events that invites the organization into the community to build trust and allow community members to be properly served. In 2023, our framework for faith-based MCH promotion was published in the Journal for Public Health (Wynns et al, 2023).

EVIDENCE OF EFFECTIVENESS

We evaluated the success of the project based on the activities that faith organizations were able to implement under each pillar of action.

Pillar 1: Developing Positive MCH Communication Strategies

One congregation developed a communications workgroup that collaborated with project staff to develop MCH content to distribute through existing email, social media, and newsletters channels that reached both congregation and community members. The email and newsletter outreach targeted over 500 people weekly. Social media outlets reached 1300 regularly. The MCH communication content included data about local infant mortality rates and church zip code infant mortality data.

Additional content focused on the racial disparities in infant deaths, the importance and best practices of infant safe sleep, and the church's summer farmer's market to address local food insecurity. These three issues are major local concerns associated with infant mortality and other poor birth outcomes. Once congregation used their own Facebook page and YouTube channel to have conversations about infant mortality and the importance of infant safe sleep. This team invited pediatricians, mental health professionals, mothers, and grandmothers from the community to participate in the conversations held. Approximately 260 individuals viewed these conversations. Two different pastors used their leadership roles to develop MCH messages in their sermons through scripture. Two different congregations prioritized the use of art to present positive MCH communications. Artwork was commissioned from two artists associated with FBOs, both have had showings of this artwork across the community to start conversations about improving communities to support MCH with a wide array of stakeholders. For example, one was invited to display their large murals depicting African American motherhood in our statehouse.

One of our mosque partners, which primarily serves West African immigrants had us host a MCH booth at their Eid festival at the end of Ramadan. We coordinated with WIC so that a WIC bus was present during the festival to sign up families for WIC services.

Pillar 2: Develop Life Span MCH Programming
Two congregations selected to dedicate May (when American's celebrate Mother's Day) to raise awareness about MCH issues within their congregation. The Pastor from one FBO used May Sunday services to invite special guests to speak about MCH topics. Another chose to provide opportunities for mothers to come together after church service every Sunday in May for MCH learning discussions. Each event lasted about two-three hours and had separate themes to support MCH promotion. Food and games were provided to facilitate fellowship and help attendees become familiar with one another.

Congregations provide an opportunity, through their central office, for congregants to share names and contact information of women in need of infant/maternal care supplies. Congregations have come together to provide community baby showers for low-income women within their community, and to provide baby showers for participants in our HRSA funded Healthy Beginnings at Home intervention, which provides housing, rental assistance and case management for pregnant women experiencing housing insecurity. Pregnant women and their families can attend and receive safe sleep supplies and instruction, infant care supplies, and have fellowship over lunch and listen to programming about maternal mental and physical health, and parenting tips. Pregnant women are provided opportunities to provide insight about local needs. We have seen one church now offer infant CPR classes for parents in the community. Once church learned of the need for a mother's support group within the community and partnered with program staff to develop a curriculum and implementation plan to launch a peer support program for new mothers. In a mosque we partner with, they worked with us to develop MCH learning tools in French, English and Arabic to promote knowledge across their members. In addition, we worked to get three years of funding for them to support the growth of their early childhood education program for families.

Pillar 3: Equip and Strengthen MCH Infrastructure
Building capacity within FBO's infrastructure to carry out MCH promotion activities ensures that these organizations will remain agents of change in this area of public health. Three organizations we partnered with referred us to women within their organization to receive our Grassroots MCH Leadership training. This curriculum trains women who live in communities with high infant mortality to become leaders with knowledge of adverse and inequitable birth outcomes, negative health outcome from chronic stress, and develop skills to have protective power over the community (Skinner et al., 2019; Irby et al., 2023; Mintus et al., 2024). We now have five women from faith-based organizations trained so that they can help support MCH efforts in their respective organizations. One such leader increased the social capital of the local community by training 15 congregation members as safe sleep ambassadors utilizing the Safe Sleep Ambassador Training from Cribs For Kids (Cribs For Kids 2021). These safe sleep ambassadors are trained to educate families about safe sleep and guide them towards resources they may need at home. The leader also wrote an op-ed piece for the local paper about inequitable housing and participated in a panel discussion on evictions in her city. Two leaders helped organize a legal clinic for immigrants in their parish.

Pillar 4: Honor MCH Stories
During programs and events, mothers often shared about their experiences while pregnant. The community/congregation teams established opportunities for pregnant and postpartum women within the congregation or community to share their MCH stories as a means of collecting the stories and sharing them to motivate people to action. Women who participate in these opportunities can decide if they do or do not want their stories shared (in an anonymous manner) to help advance MCH advocacy. Stories were collected at booths set up during the farmer's market, during community walks to meet neighbors, and while providing ministry. Stories have subsequently been shared through podcasts and social media platforms to encourage people to

think about ways they can be of support to pregnant women and new moms. Each team also prayed over the stories to provide spiritual support to the families.

Pillar 5: Build Local MCH Resource Networks

Project staff provide FBOs with information about existing county and state-level resources about programs, organizations, and telecommunication services that serve both moms and babies. These resources include, but are not limited to, information on local milk and diaper banks, posters and signs promoting safe sleep practices, information about how to refer to home visiting programs like Healthy Families and Nurse-Family Partnership, and information for hotline services to support improved MCH outcomes.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
Riley Children's Foundation (RCF)	RCF provided funding, there were not directly involved in any decision making for the project.	As a funder	Riley Children's Hospital serves the populations from these areas.
Faith organizations/ membership	Faith organizations were directly involved by developing the community/ congregational team and choosing what activities they wanted to focus on implementing for MCH promotion.	Project staff partners with the community/ congregational team to facilitate discussions and guide the team through the process of awareness, adoption, implementation, and institutionalization.	The faith organizations are located within the community in which we aimed to serve based on high infant and mortality rates. Leaders and members of the congregation lived in the community as well. These congregation members were often from the population aimed to be served or personally experienced an adverse birth outcome, or someone in their family had.
Community leaders/Families (mothers and infants)	Community members were directly involved by being a part of the community/ congregational team that made decisions on activities to focus on and implementation of those activities.	Project staff partners with the community/ congregational team to facilitate discussions and guide the team through the process of awareness, adoption, implementation, and institutionalization	Community leaders were important because they may not be members of the congregation, but they are known and trusted voices in the community who could speak to the need of the community, areas that needed the most focus, and could be the representative

			of the community by bringing the community voice to the table and uplift stories of adverse experiences from people in the community.These community leaders were either mothers, fathers, or youth who were interested in making a community impact where they lived.

REPLICATION

The project is replicated within FBO's located in predominately marginalized and underrepresented communities (i.e. African American or immigrant communities). These communities are considered priority communities due to poor maternal and child health outcomes that exist within these demographics. Furthermore, research shows that FBOs have an established trusted relationship within these particular communities who often distrust systems due to mistreatment and other poor experiences, or a fear of deportation from seeking help to improve their quality of life. We specifically started the pilot within a predominately African American community and replicated the project in a Spanish speaking community and an immigrant Muslim community whose population consisted of Northern and Western African countries.

The main modification to replicate this project across different cultural populations was focused on the type of team members who made up the community-congregation team. For example, the Muslim culture takes strong advice and direction from the Imam. Additionally, since the project had a strong maternal and child health focus, we needed to deliberately engage with the women leadership of the Mosque to engage with other women in the Mosque because interaction among members at the Mosque are often separated by gender. With these factors in mind, the Muslim community-congregation team was made up of the Imam, the second leader in command of the Mosque who was female, and two Muslim women who were trained as GMCH leaders. As the community-congregation team started to plan activities, additional Mosque members were identified to help support the implementation of these projected activities. In a partnership with another FBO, the community-congregation team consisted of only two members who were a part of church leadership, who based on their connections to the community, were able to convey the needs and issue areas to focus on. Each FBO came up with different activities to implement based on the guidance of the community-congregation team.

The modifications made were based on cultural practices within these different populations that we needed to account for to engage the community in a collaborative partnership. By honoring cultural and religious practices, project staff developed trusting relationships and a strong rapport with both the FBO and surrounding community. The foundational success of this project rests on building trusted relationships and strong rapports with these communities because, as mentioned, this project is meant to be a collaborative partnership. Project staff focused on bringing data, tools, and resources for the community-congregation team to utilize, and helped facilitate team meetings by setting agendas and guiding conversations and strategic efforts. The community-congregation team was charged with identifying issue areas to focus on that are of most importance to the community and related to maternal and child health. Once these issue areas were identified, the team picked two or three areas to focus on by creating strategies to address those issues and developed an implementation plan to follow when it came time to implement the activities.

A lesson we learned was that community-congregation teams needed guidance and support in developing and implementing an evaluation plan that would help the team track impact and outcomes of the implemented activities. Project staff collected most of this information, but in order for the community to track the impact and outcomes that came from implementing activities, the team needs to know how to collect this information without the support of project staff and implement a strategy to share with the community the results from evaluations to determine if these activities are adequate or if they need to be adapted or abandoned.

INTERNAL CAPACITY

- One university Project Manager (project staff) was assigned to support the community-congregation team by providing necessary resources and tools to support activity implementation. This person also facilitated team meetings when necessary because of their training in community organizing and collaboration.

- FBO Leadership is necessary to be a part of the team to sign off on and support the implementation plan where needed.

- 1-2 team members who are active members of the FBO who often participate in/help with FBO activities are recommended. These people make good candidates to train as GMCH leaders.

- 1-2 team members who are from the community and have experienced an adverse MCH outcome or someone from the community who is considered an active leader are recommended. These people make good candidates to train as GMCH leaders.

To develop personal capacity in each team member, we often trained 1-2 community-congregation team members to become GMCH leaders. These Leaders were trained in leadership, advocacy, community organization, and storytelling which are areas that scientifically support improving MCH outcomes by driving systemic change.

Although organizational structures were different for each FBO, our focus was not to change the structure. The structure of the FBO that provides the avenues to conduct mission and ministerial work were structures we aimed to partner with and work alongside. Our goal was to meet each FBO where they were, understand their organizational structure, and allow the community-congregation team to identify areas within the structure they could work with to implement the planned activities. To honor the organizational structures, it was important to engage FBO leadership because they have the power to allow or stop FBO activities. FBO leaders also have the foresight to recommend where in the organizational structure activities could be implemented.

Before choosing which FBO's to work with, research their organizational structures to determine the type of capacity the organization may have to carry out the work. Some FBO's have such limited resources that it is a challenge for them to carry out their planned activities without hands on help from project staff. The goal of project staff is to be involved as little as possible in the planning and implementation because the activities should be created and implemented by those who live, work, learn, play, or worship within that community. They are the experts of the community and understand the needs better than any outsider. We recommend encouraging smaller FBO's with limited resources to collaborate with other FBO's from the community looking to engage in similar activities who may have a stronger organizational structure and more resources to support the work. Eventually, the goal is for the FBO and community to sustain this work without the help, guidance, or presence of project staff.

PRACTICE TIMELINE

Each community-congregation team, as experts of their community and understanding the needs, developed the activities to be implemented. As a guiding tool to help teams make these determinations, project staff categorized these activities into five areas: Developing Positive MCH Communication Strategies, Develop Life Span MCH Programming, Equip and Strengthen MCH Infrastructure, honor MCH stories, and Build Local MCH Resource Networks. Depending on the proposed activity and the resources of the FBO, the community-congregation team determined the time needed to implement the proposed activity and identified the appropriate person or persons who needed to be involved in order to carry out the implementation. As you may see, the activity, timing of implementation, and persons involved were all determined by the community-congregation team who understand the organizational structure of the FBO, the needs of the community, and the correct people who needed to be involved.

It should also be noted that depending on the proposed activity, persons who needed to be involved may not have been members of the core team. Depending on the FBO, some teams created subcommittees of additional people who needed to be involved to implement the activity. Some teams added members to the community team on an as-needed basis to address the implementation of an activity. These added members sometimes became permanent or were only utilized depending on the activity to be implemented.

One key support project staff provided to community-congregation teams were strategies for creating reasonable timelines for implementation. To reiterate, this planning came from the team, however, project staff stepped in at times to help the team think of a more practical timeline, if the team wanted to implement an activity too fast. The issue here was often that the team needed to identify additional outside resources or engage other community organizations (with the help of project staff) to appropriately implement the activity. We often helped teams set goals for when they wanted to have certain outreach completed and once those moving pieces were in place, the team could set a more practical timeline to implement the activity.

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Train Community-Congregation Teams as MCH Leaders	6 weeks of training (approximately 2 hours weekly)	Project Staff
Engage FBO Leadership who can support efforts by obtaining funding to pay and support the work of the Community-Congregation Teams	Depends – this should be the first step in engaging an FBO before creating the full Community-Congregation Team because FBO leadership may assist in identifying members internally from the FBO. FBO Leaders have demanding schedules. It also depends on	Project Staff

	their availability and willingness to participate.	
Train Community-Congregation Teams in meeting facilitation and begin to designate different team members to create meeting plans and agendas to run the meetings	3 months: - 1st month: project staff leading meetings by example - 2nd month: project staff begin to designate team members to create meeting materials and agendas, and leading the meetings with the assistance of project staff as facilitators where necessary - 3rd month: Team members lead meetings without the facilitation of project staff	Project Staff and Community-Congregation Teams

PRACTICE COST

Project staff were paid through the University to support this work and this was a salary set by the University based on the position description of project staff ($50,000).

As stated, activities were directed by the community-congregation teams. A lot of the activities proposed were based on bringing in additional resources already available to the community from other community organizations (i.e. WIC mobile buses, HealthyStart programs from local departments of health, setting up a pro-bono legal clinic, etc.). This was due to the fact that many of the communities we worked with did not want to leave the comfort of their communities to find resources, they were not aware of the resources available, or there was fear with accessing these resources due to issues with citizenship. There was a big push to bring free resources to the community in order for the community to build trusted relationships with these other organizations through the FBO. The FBO and the community-congregation teams often acted as liaisons to bridge and build relationships between these outside organizations and communities with the goal that community members would begin to trust these systems and willingly access them without using the team members or the FBO as an intermediary.

Since the activities were identified and implemented by the community-congregation teams, sometimes those ideas required funds, however, providing a budget is challenging because this is on a case by case basis dependent upon the team and activity proposed. The only funding provided was for the University to support project staff to go out and build these relationships and guide the community-congregation teams. Moving forward, if one were to implement this project, it is highly recommended that the project staff come to the table with grant funding to support the FBO's with the type of work they want to do, or inform local funders of the work of the FBO's to encourage those funders to support specific activities of the FBO that align with the mission and vision of the funding organization. In some cases, FBOs had grant writers, therefore, project staff would help

those writers identify where to find the appropriate grant funding and the writers would complete the writing and submission process for the grant.

LESSONS LEARNED

We learned that getting faith organizations to partner with one another in their efforts to institutionalize change is more impactful than each organization doing individualized work. Faith organizations at times serve the same areas and some are more robust in their activities and community support than others. Through collaborative efforts of these organizations, members of each FBO and throughout the community may utilize this web of faith partners to find the services and support they need to find the right service provided and improve their overall quality of life.

No two faith organizations are the same. Each are dealing with their own set of challenges and focus areas based on the needs of their members and surrounding community. It takes an individualized approach with each organization and depending on the size, some faith organizations are able to sustain and institutionalize the work better than others. For example, the faith organizations with big populations and many volunteers because self-sufficient and needed little support from project staff than smaller congregations that heavily relied on program staff to do most of the work.

We started to connect smaller faith organizations who had less man-power with the bigger, more robust organizations if they were willing to collaborate and if their missions aligned. Many faith organizations are located in the same geographic areas. If we were to implement this practice differently, we could create faith-based cohorts who are in the same geographic area to help reach more of the community and institutionalize MCH promotion within the entire geographic area, as opposed to the individualized approach of working with one faith organization at a time. This will also help keep engaged the smaller or less robust faith organizations because they have other reliable faith-based partners who are sharing the work load.

NEXT STEPS

We continue to identify and build relationships with faith organizations working on social justice issues. In doing so, we have moved from our individualized practice to creating bigger spaces for faith organizations and other community organizations to come together, discuss what they are working on, and discuss plans for collaborations to expand the impact of the social justice work and MCH promotion.

We have already expanded our support to these organizations by connecting them to pro bono attorneys who can assist them in understanding their rights and how to claim their rights when they face adversity, because chances are the adversity faced is a human rights violation, and there may be legal remedies to mitigate the issue. For example, many of our faith partners are working towards fighting for more equitable, affordable, safe, and healthy housing within their community. By connecting them to attorneys in the housing space, faith organizations were able to move from scrambling to find housing for people to holding slum-landlords accountable for deplorable housing conditions within their community. Additionally, faith organizations are using their community spaces to host eviction sealing clinics that help anyone from the community to come in, speak with an attorney, look at their eviction record, and attempt to seal as many eligible past evictions from their record as possible, in order to remove the barrier to housing that evictions create. We would like to build on this by moving from addressing housing issues to addressing other issues that create barriers to positive health promotion (i.e. immigration, employment, healthcare and connection to doula services, etc.)

RESOURCES PROVIDED

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Project Webpage: https://medicine.iu.edu/pediatrics/specialties/health-services/grassroots-maternal-child-health/faith-based