Stronger Together: Aligning Public Health and Faith Communities’ Capacity to Protect Our Communities

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July 2014
National Public Health Information Coalition Call
Presentation Objectives

• Provide background on faith-based and public health partnerships – history and characteristics of likely partners

• Describe project activities and accomplishments – the context of “the model practices” reach to vulnerable, at-risk, and minority populations

• Describe the Model Practices Framework key practices that increase reach to “sub-populations”
“Lack of trust can cause health programs to fail with harmful consequences. Measles outbreaks in the United Kingdom and the United States and the spread of polio across Africa from Northern Nigeria underscore the importance of building – and maintaining – public trust in health interventions and in the authorities who provide them.

**Trust relationships must be built over time so that they become the social framework in which health interventions – and positive health outcomes – can thrive.**”

[Heyman & Larson, JAMA, 2010, pg. 272]
Rationale for FBO Partnerships

1. “Pervasive social structures and institutions in communities – congregations, FBOs, health care, education, etc.

2. Hold a kind of **trust** that makes possible a unique access to particular populations

3. Values and commitments that align with and can contribute to achieving public health goals
Background and History

Eliminating Health Disparities

- Interfaith Health Program formed – 1992 The Carter Center
- Coalition for Healthy Cities and Communities – 1995
- *Engaging Faith Communities as Partners in Improving Community Health* – 1997 CDC and the Interfaith Health Program
- *Strong Partners: Realigning Religious Health Assets for Community Health* – 1997 Interfaith Health Program and the CDC
- Interfaith Health Program, PHLS, and NACCHO at Fetzer Institute - 2000
    - Team-based leadership development - 78 teams from 24 states
Project Goal and History 2009 - Present

Build and mobilize capacity within networks of faith-based and community organizations to expand reach to vulnerable, at-risk, and minority populations for prevention and treatment of influenza.

Built on:

- CDC with IHP/Emory (‘01 to ‘07) trained 78 teams of religious and public health leaders in 24 states to collaborate on eliminating health disparities.

- HHS’ Center for Faith-Based and Neighborhood Partnerships work with IHP/Emory and 9 sites during 2009 H1N1
Ten Unique Multi-Sector Sites

• Chicago, IL
  Center for Faith and Community Health Transformation (Advocate Health Care and UIC)

• Colorado Springs, CO
  Penrose-St. Francis Health Mission

• Detroit, MI
  United Health Organization Outreach

• Los Angeles, CA
  Buddhist Tzu Chi Medical Foundation

• Lowell, MA
  Lowell Community Health Center

• Memphis, TN
  Methodist LeBonheur Center of Excellence in Faith and Health

• Minnesota
  Minnesota Immunization Networking Initiative (MINI)

• New York City, NY
  South Brooklyn Interfaith Coalition (Lutheran Health Care)

• Pennsylvania
  Schuylkill County’s VISION

• St. Louis, MO
  Nurses for Newborns Foundation
Likely Partners: *Intermediaries*

- **Individual Community Leaders**
  - Persons of faith with a health commitment
  - Persons of health with a faith commitment
  - “Boundary Leaders”

- **Organizations**
  - Community outreach programs – institutional mission, community health workers, coalition building
  - Community health, health of the “public” commitments
**Likely Partners**

*Diversity of U.S. Religious Landscape*

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<th>Level</th>
<th>Organizational/Structural Examples</th>
<th>Possible Health Program Links and Points of Partnership</th>
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| National Associations| National Association of Evangelicals, Islamic Society of America, World Union for Progressive Judaism, National Council of Churches | • May have an office for health programming that is connected across related denominations  
• May have religious leaders who are champions of particular national or global issues |
| National Religious Bodies | Christian (Catholic, Southern Baptist, United Methodist, National Baptist Convention, Assemblies of God, etc.), Islamic branches (Shia and Sunni are the largest), Judaism (most within 4 branches or movements), Buddhism movements or schools (many within 3 major divisions) | • May have health program offices  
• Connectional identity and structures that reach local congregations vary greatly  
• May have little and unpredictable “trickle down” dissemination impact  
• However policy positions and resources from the structure can support and reinforce local actions |
| Middle judicatory | Named synods, conferences, districts, dioceses, archdioceses, councils, provinces, presbyteries, conventions, unions, societies, etc. | • Organizational structures that more closely link congregations and faith based organizations – clusters of states, a state, large metro area, or portion of state.  
• May also have a health program office and staff  
• Key determinant of public health partnership is leadership with a vision for an institutional role in the health of communities – discovered not created from the outside. |
| Local Congregations | Just over 300,000 worshipping congregations of all faiths in the U.S. (actually a small portion of religious institutions) | • Majority have less than 200 members  
• Some have health ministry programs  
• Estimated > 10k Faith community nurses  
• Not all congregations are linked to a denominational structure (trend away from that)  
• Varied orientations to civic/public engagement  
• Some have spun off community outreach service organizations |
## Likely Partners

### Diversity of U.S. Religious Landscape

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| Local Ecumenical or Interfaith Agencies | Regional or State Councils of Churches, Ministerial Alliances, Interfaith AIDS Networks, Council of Islamic Organizations of Greater Chicago, Jewish Community Relations Council of New York | • May have a health program and/or health partners, also may have a champion leader who is an advocate for a health issue  
• May have special interests in certain groups or issues – children, violence, prisons, interfaith dialogue |
| Parachurch Organizations              | Habitat for Humanity, Bread for the World, Heifer International, World Vision, YM/WCA, Aga Khan Foundation | • Many are focused on global reach  
• All are linked in different ways to congregations for resource support |
| Charitable Aid Organizations          | Catholic Charities, Lutheran Social Services, Islamic Relief, Church World Service, Salvation Army, American Jewish World Service, Jewish Social Service Agencies, Buddhist Tzu Chi Medical Foundation | • Many combine domestic and global program work  
• All reach those beyond those of their tradition to serve those in need  
• Are ideal public health partners when interests intersect |
| Seminaries and Higher Education       | ATS is a membership organization of more than 270 graduate schools (post-baccalaureate professional and academic degree programs) Numerous other rabbinical and bible schools | • Several seminaries have participated in IHP’s Faith Health Consortium  
• A number have programs that address seminarian/future clergy health |
Project Activities & Accomplishments

• Selected and established formal agreements with 10 diverse multi-sector sites in the U.S. for outreach to vulnerable populations for influenza prevention and treatment.

• Coordinated capacity building events, community outreach, and dissemination activities with partner organizations and new adopters.

• Strengthened evaluation methods to capture population reach achievements and to describe model practices for recommendations to guide replication and successful future outreach endeavors.
The “Reach:”
Cumulative Vaccination Impact

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<tr>
<td>Vaccination Reach</td>
<td>78,708</td>
<td>13,686</td>
<td>15,103</td>
<td>16,381</td>
<td>19,430</td>
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<tr>
<td>(persons)</td>
<td>(with partners)</td>
<td></td>
<td></td>
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<td>138 events</td>
<td>108 events</td>
<td>227 events</td>
<td>268 events</td>
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Populations Reached: 
*Education and Vaccination Outreach*

- **Places:** churches, temples, mosques, community centers, migrant farmworker camps, senior housing, shopping malls, homeless shelters, crisis centers (food pantries, soup kitchens)
- **People:** low-income (uninsured, underinsured, homeless), minorities, geographically isolated, different religious traditions, migrant farm workers, cultural and ethnic groups, immigrants and refugees
- **Partners:** Schools, health systems, fire departments, community centers, FQHCs, health departments (state and city/county), Walgreens, EMS, immunization coalitions, religious leader alliances
Memphis – Congregations with Preparedness Capacity
Chicago – Congregations with Preparedness Capacity
Model Practice Framework Development - *Methodology*

A *practice based discovery* process using a modified Delphi technique to synthesize distinctive elements from across 10 sites.

- Document review and thematic analysis
- In-person inductive identification of key elements of practice (4 of 10 sites)
- On-line survey to validate key elements and characteristics (16 respondents across 10 sites)
- Multi-site in-person meeting to define and describe operational components of the practices
Model Practices Framework:

Leadership Anchors the Work
Volunteers as Groundwork
Circle of Core Partners
Network Connections
Multisectoral Collaboration
The Toolkit!

Introduction
Purpose
Who is the Guide For?
How Can the Guide Be Used?

Faith-Based Organizations
What are FBOs?
Diversity of the U.S. Religious Landscape
Types of Faith-Based Organizations

Faith-Based Partners
Likely Partners in the Public Sphere
Why FBOs as Partners?
Government and FBO Partnerships

The Model Practices
How Was the Model Practices Framework Developed?
The Network
The Fourteen Practices
Model Practices Framework:

- Leadership Anchors the Work
- Volunteers as Groundwork
- Circle of Core Partners
- Network Connections
- Multisectoral Collaboration

Leadership Anchors the Work
Volunteers as Groundwork
Circle of Core Partners
Network Connections
Multisectoral Collaboration

Marry Stories with Data
Keep Relationships and Presence Paramount
Build and Maintain Trust
Faith Mission as Core Driver
Inclusivity
Compassion Driven Flexibility
Trust in Community

Identify Trusted Leaders
Collaboration That Endures
Faith Mission as Core Driver

Definition: The work is grounded in beliefs and principles that sustain energy, motivation, and commitment to serving the collective good.

How does one recognize and build this?

- The values of sacred calling and meaning in the work are made explicit in the organizational and collaborative environment – prayer, devotion, mission made visible, etc.
- There is a demonstrated recognition and embracing of diverse religious traditions and intentional identification of a mutually held commitment to caring for all people.
- Caring for all people means an explicit and shared commitment to seeing and knowing the most vulnerable and those on the margins and acting on their behalf.
Case Example: Center for Faith and Community Health Transformation in Chicago

Our strong and large partnership network has a unique communication capacity with trusted messengers and translated, accessible, health information for the whole person. We collaborated with one of our partners, the Council of Islamic Organizations of Greater Chicago, on the development of a flu prevention message that is framed by the commitments and theological perspectives of their faith tradition. It was distributed through their e-newsletter that has a reach of over 9,000 readers.

Faithfully Prevent the Flu
Purity and cleanliness is central to Islam. During each flu season, the vulnerabilities to great suffering, including potential hospitalization and death, remind us that our spiritual journeys demand attention to the messy world around us. Vast disparities in health condition and access to health care resources result in vulnerable populations’ disproportionate suffering.
Identify Trusted Leaders

*Definition:* Identify and make connections to leaders who -- share commitments, can articulate a common mission, represent different voices and parts of the community, contribute to the deep bench of trust, and support each other in getting the work done.

*How does one recognize and build this?*

The leaders engaged …

- Are known to be motivated by the work itself – the needs of the community, ministry, purpose, call, and/or faith commitments.
- Know other trusted leaders and are able and willing to transfer and leverage that trust to and on behalf of others.
- Have relationships with one another and their community through formal and informal networks and serve as trusted messengers with influence in those communities.
- Represent different sectors, levels of community leadership (grassroots and up) and can serve at different times and in different capacities as part of the collaborative work.
Case Example: Methodist LeBonheur Health Care’s Center of Excellence in Faith and Health in Memphis

From day one, the health care system partners have taken seriously and act upon what the religious leaders consider priorities for the community. These leaders developed the founding covenant that guided the relationship between the congregations and the health care system through the Congregational Health Network. Community priorities drive the work and the congregations understand they are an integral part of the community health system. Clergy were vaccinated first during 2009 H1N1 and named “First Responders” which represented their true role in the community.
Summary Points

• Partnerships are increasingly important to achieving public health goals

• Local faith and community-based organizations can play a vital role in building *trust* and extending the reach of public health efforts

• Successful engagement requires *time* and *structures* for ongoing communication and partnership *relationship* building
Thank You

Toolkit and more information available at: www.ihpemory.org

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