Phase II Implementation

It Takes a Village: Giving our babies the best chance

Report on efforts to address birth outcomes disparities in Utah's Native Hawaiian/Pacific Islander communities (May 2017 - March 2018)

UTAH DEPARTMENT OF HEALTH
Office of Health Disparities

Utah Office of Health Disparities

Organizational description

Guiding Principle

Health equity is the principle underlying our commitment to reduce and, ultimately, eliminate health disparities by addressing its determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those communities at greatest risk for health disparities.

Health disparities are differences in health outcomes that are closely linked to economic, socio-cultural, environmental, and geographic disadvantage.

Mission

Our mission is to advance health equity and reduce health disparities in Utah.

Vision

Our vision is for all people to have a fair opportunity at reaching their highest health potential given that health is crucial for well-being, longevity, and economic and social mobility.

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Phase II Implementation

It Takes a Village: Giving our babies the best chance

Introduction

After disaggregating data for Asians and Native Hawaiians/Pacific Islanders, the Utah Department of Health (UDOH), Office of Health Disparities (OHD) detected a higher rate of infant mortality among Utah's Native Hawaiian/Pacific Islander (NHPI) communities compared with Utah overall. This health disparity was accompanied by other birth outcomes disparities including higher rates of maternal obesity, gestational diabetes, and unintended pregnancy as well as poor rates of folic acid consumption, continued breastfeeding, birth spacing, and early prenatal care.[1]

Project overview

In spring 2015, OHD in collaboration with the MAHINA (Maternal Health & Infant Advocates) Task Force conducted a pilot project, consisting of six workshops for 23 members of NHPI communities to raise awareness about birth outcomes disparities.

After evaluating the pilot project, OHD created a Native Hawaiian/Pacific Islander (NHPI) Birth Outcomes Advisory Committee to revise and expand the pilot project and create a video production. In spring 2016, phase I of *It Takes a Village: Giving our babies the best chance* (ITAV) project was implemented in NHPI communities along the Wasatch Front.

After phase I, OHD focused on developing a promising practice, by conducting focus groups and a quantitative analysis of vital records to inform final revisions of the curriculum. OHD also hired a project assistant from the NHPI community to help ground the curriculum in NHPI culture and tradition. Between May 2017 and March 2018, OHD conducted the second implementation and evaluation of the ITAV project.

Report overview

This report describes the activities and outcomes of the second phase of the ITAV project. Included in the report are updates on activities, outcomes, successes and barriers encountered, and plans for moving forward.

Project Activities

Curriculum development

Between January 2017 and May 2017, OHD and the NHPI Birth Outcomes Advisory Committee worked on revising the curriculum from phase I. This included condensing the project into four 90-minute workshops: (1) The Village, (2) Before Pregnancy, (3) During and After Pregnancy, and (4) A Healthy Village. The basic outline of the curriculum remained the same with a project overview, project objectives, weekly lesson outlines, and a list of materials and resources needed. However, the curriculum was newly designed to bond participants as members of a village tasked to address village issues. The redesigned workshops focused on educating participants about infant mortality and preterm birth, preconception health, prenatal care, and birth spacing. New activities were created to improve communication, navigate resources, and disseminate information. Cultural concepts were also selected and added to help participants internalize and connect with the information. Videos were selected to complement the curriculum and the PowerPoint presentations were revised. A participant workbook was also created to help guide participants through the project. This version of the project was designed to be delivered by two trained community facilitators to a group of 6-12 individuals over four meetings within a two-week period.

Facilitator training

OHD revised the facilitator training with the advisory committee between January 2017 and May 2017. The training was modeled after the four workshops in the new curriculum with an added outline of facilitator roles and responsibilities, a thorough review of the curriculum, demonstrations, and time for practice and questions. OHD's project assistant recruited facilitators. Two separate trainings were held between May and September 2017. OHD provided ongoing training and support to the facilitators throughout the implementation.

Project implementation

Between May and November 2017, OHD implemented the ITAV project among three cohorts. Cohort I took place between May and June 2017, with four groups completing the ITAV project. Three of the groups were hosted by the same pair of facilitators and the fourth group was hosted by a different pair

of facilitators. A total of 26 participants completed the workshops. The four groups chose village names: Triple B Tribe (Breeding Breathing Babies), Motenui, Tafiti, and La' Fou which means new leaf. Cohort II took place in September 2017, with three groups completing the project. Two of the groups were hosted by the same pair of facilitators and the third group was hosted by another pair of facilitators. A total of 30 participants completed the workshops. The three groups chose village names: Ihmw Enjela, a combination of Marshallese and Pohnpeian meaning house of knowledge; He Umeke Ka'eo referencing the Native Hawaiian family gourds; and Malie Toa which means great warriors. Cohort III took place in November 2017, with one group completing the project. OHD staff acted as the facilitators. Seven participants completed the workshops. The group chose the village name Kafa Taha, meaning woven together as one.

Three-month follow-up survey

OHD created a three-month follow-up survey to send to all participants who completed all workshops during phase II. The surveys were created on SurveyMonkey using the post-assessment survey with added questions regarding the village project, impact, barriers encountered, and perceived success. OHD used the email addresses collected on the attendance rolls to contact participants. The surveys were sent at least three months after the last workshop of each of the cohorts in October 2017, January 2018, and February 2018. The survey opened on a Monday and closed the following Sunday. Three automated reminder emails were sent and participants were notified that those who completed the survey would be entered into a drawing for a gift card. OHD aimed to have at least 40% of participants from each group complete the survey. OHD monitored the survey during open access and the project assistant and facilitators reached out by phone or text to remind participants to complete the survey.

Project Outcomes

Facilitator training results

A total of 12 facilitators were trained. OHD conducted a post-training survey to evaluate the facilitator training, details are provided below.

Facilitator training survey results (N=12)

	Min	Max	Mean
The rating for each section was based on the following criteria:			
5=excellent 4=good 3=average 2=fair 1=poor			
1. The usefulness of the information received in the training.	4	5	4.92
2. The structure of the training session(s).	4	5	4.83
3. The pace of the training session(s).	3	5	4.58
4. The convenience of the training schedule.	3	5	4.75
5. The convenience of the training location.	2	5	4.42
6. The usefulness of the training materials.	5	5	5.00
7. The usefulness of the training activities.	4	5	4.92
	Yes	**No**	
8. Was this training culturally appropriate for PI/HN communities?	12 (100%)	0 (0%)	
9. Was this training appropriate for your level of experience in this area?	10 (83.3%)	2 (16.7%)	
Explanations: • I haven't gone through this stage. • I did not know anything about this topic.			
10. Do you think this training could be improved?	8 (66.7%)	4 (33.3%)	

Explanations:

- Maybe if possible cutting the amount of days.
- Have a little longer break.
- *Fono* 4 seems lacking in substance and not as clearly explained as the other *fono*.
- The videos (or at least one of the videos) did NOT coincide with the message of the fono message being discussed. Also, the discussion following the PowerPoints needs to be more engaging.
- See after the next cohort.
- There is always room for improvement but it's a good start.
- Always room for improvement. Learn as we go.
- Just more energy in presenting material and not so monotone slows the pace down!

Project implementation survey and follow-up survey results

OHD collected pre- and post-project data through questionnaire surveys. Surveys were collected before the first workshop and after all four workshops. Overall, 70 participants completed the pre-questionnaire and 63 completed all questionnaires. Only those who completed all questionnaires are included in the analysis.

Out of 61 participants contacted for the three-month follow-up survey, 31 individuals initiated the survey and 30 completed survey (48% of total participants). All cohorts and all groups were represented.

A table of total results is included below. Percentages are rounded to the nearest tenth and are subject to rounding errors when totaling to 100 percent. Categories with missing data specify the missing data. Questions not asked in both questionnaires are marked with a hyphen (-).

Demographic results

	Pre-questionnaire (n=63)	Three-month follow-up (n=30)
Gender		
Male	15 (24%)	9 (30%)
Female	48 (76%)	21 (70%)
Age		
Min.	18	22
Max	67	67
Mean	35	35
Marital status		
Single	17 (27%)	5 (17%)
Married	40 (64%)	22 (73%)
Divorced	5 (8%)	3 (10%)
Other	1 (2%)	0% (0)
Race/ethnicity		
Micronesian	8 (31%)	3 (10%)
Native Hawaiian	7 (11%)	1 (3%)
Samoan	21 (33%)	11 (37%)
Tongan	25 (40%)	16 (53%)

Other Pacific Islander	6 (10%)	1 (3%)
Other race/ethnicity	11 (18%)	6 (20%)
Highest level of education		
Less than high school	4 (6%)	2 (7%)
High School diploma/GED	22 (35%)	10 (33%)
Some college	21 (33%)	8 (27%)
Associate degree	9 (14%)	5 (17%)
Bachelor degree	6 (10%)	4 (13%)
Master/Doctoral degree	1 (2%)	1 (3%)

Stages of behavior change results

	Pre-questionnaire (n=63)	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
Check the box that best represents what you think …			
The Pacific Islander/Native Hawaiian (PI/NH) communities have many health problems, but infant mortality **IS NOT** one of those problems.	16 (25%)	1 (2%)	0 (0%)
The PI/NH have many health problems, and infant mortality **IS** one of those problems.	22 (35%)	10 (16%)	11 (37%)
Infant mortality is a problem among PI/NH communities, and I would like to do something about it, but I do not know what to do.	24 (38%)	5 (8%)	1 (3%)
Infant mortality is a problem among PI/NH communities, and I have the tools to do something about it.	1 (2%)	47 (75%)	18 (60%)
Progress		**Pre to Post**	**Post to Follow Up**
Stayed the same		11 (18%)	19 (63%)
Backward		2 (3%)	9 (30%)
Forward		50 (80%)	2 (7%)

Knowledge results

	Pre-questionnaire (n=63)	Post workshop 1 (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
Infant mortality refers to:				
Death of a fetus before birth	7 (11%)	0 (0%)	0 (0%)	0 (0%)
Death of a baby before his or her first birthday	13 (21%)	59 (94%)	62 (98%)	26 (87%)
Death of a toddler (1-3 years of age)	0 (0%)	2 (3%)	1 (2%)	0 (0%
All of the above	31 (49%)	2 (3%)	0 (0%)	4 (13%)
Not sure/Don't know	12 (19%)	0 (0%)	0 (0%)	0 (0%)
Progress		**Pre to PW1**	**PW1 to Post**	**Post to Follow Up**
Same right answer		12 (19%)	58 (92%)	26 (87%)
Still wrong answer		3 (5%)	0 (0%)	0 (0%)
Backward		1 (2%)	1 (2%)	4 (13%)
Forward		47 (75%)	4 (6%)	0 (0%)

	Pre-questionnaire (n=63)	Post workshop 1 (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
According to what you know, check THE TWO racial/ethnic groups with the highest infant mortality in Utah.				
Pacific Islander/ Native Hawaiian	34 (54%)	62 (98%)	63 (100%)	30 (100%)
Black/African American	21 (33%)	62 (98%)	63 (100%)	26 (87%)
Not sure/Don't know	20 (32%)	0 (0%)	0 (0%)	0 (0%)
Progress		**Pre to PW1**	**PW1 to Post**	**Post to Follow Up**
Same right answer		16 (25%)	61 (97%)	26 (87%)
Still wrong answer		2 (3%)	0 (0%)	0 (0%)
Backward		0 (0%)	0 (0%)	4 (13%)
Forward		45 (71%)	2 (3%)	0 (0%)

	Pre-questionnaire (n=63)	POST WORKSHOP 1 (N=63)	Post-questionnaire (n=63)	THREE-month follow-up (n=30)
Preterm birth refers to:				
A premature baby	1 (2%)	0 (0%)	0 (0%)	0% (0)
A premature birth	13 (21%)	0 (0%)	4 (6%)	0% (0)
When a baby is born too early, before 37 weeks of pregnancy have been completed	12 (19%)	34 (54%)	12 (19%)	8 (27%)
All of the above	30 (48%)	29 (46%)	47 (75%)	21 (70%)
Not sure/Don't know	7 (11%)	0 (0%)	0 (0%)	1 (3%)
Progress		**Pre to PW1**	**PW1 to Post**	**Post to Follow Up**
Same right answer		16 (25%)	24 (38%)	15 (50%)
Still wrong answer		20 (32%)	11 (18%)	3 (10%)
Backward		14 (22%)	5 (8%)	6 (20%)
Forward		13 (21%)	23 (37%)	6 (20%)

	Pre-questionnaire (n=63)	Post workshop 1 (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
What is the leading cause of infant mortality among PI/NH?				
Injuries and accidents	2 (3%)	2 (3%)	1 (2%)	0% (0)
Preterm birth	3 (5%)	43 (68%)	52 (83%)	23 (77%)
Sudden Infant Death Syndrome	7 (11%)	0% (0)	0% (0)	1 (3%)
All of the above	25 (40%)	16 (25%)	10 (16%)	6 (20%)
Not sure/Don't know	26 (41%)	2 (3%)	0 (0%)	0 (0%)
Progress		**Pre to PW1**	**PW1 to Post**	**Post to Follow Up**
Same right answer		3 (5%)	41 (65%)	20 (66%)
Still wrong answer		20 (32%)	9 (14%)	3 (10%)
Backward		0 (0%)	2 (3%)	4 (13%)
Forward		40 (64%)	11 (18%)	3 (10%)

	Pre-questionnaire (n=63)	Post workshop 2 (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
Preconception health refers to:				
A woman's health before she becomes pregnant	15 (24%)	7 (11%)	21 (33%)	5 (17%)
Promoting the health of women of reproductive age before conception	2 (3%)	0% (0)	2 (3%)	0 (0%)
Taking steps to get healthy before pregnancy	8 (13%)	5 (8%)	1 (2%)	1 (3%)
All of the above	26 (41%)	51 (81%)	39 (62%)	24 (80%)
Not sure/Don't know	12 (19%)	0 (0%)	0 (0%)	0 (0%)
Progress		**Pre to PW2**	**PW2 to Post**	**Post to Follow Up**
Same right answer		25 (40%)	36 (57%)	17 (57%)
Still wrong answer		11 (18%)	9 (14%)	5 (17%)
Backward		1 (2%)	15 (24%)	1 (3%)
Forward		26 (41%)	3 (5%)	7 (23%)

	Pre-questionnaire (n=63)	Post workshop 3 (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
Prenatal care refers to:				
Health care that a baby receives after s/he is born	1 (2%)	1 (2%)	0 (0%)	1 (3%)
Health care that a pregnant woman receives during pregnancy	45 (71%)	51 (81%)	59 (94%)	24 (80%)
Health care that a pregnant woman receives after the baby is born	1 (2%)	1 (2%)	1 (2%)	1 (3%)
All of the above	11 (18%)	10 (16%)	3 (5%)	4 (13%)
Not sure/Don't know	5 (8%)	0 (0%)	0 (0%)	0 (0%)
Progress		**Pre to PW3**	**PW3 to Post**	**Post to Follow Up**
Same right answer		40 (64%)	49 (78%)	23 (77%)

Still wrong answer	7 (11%)	2 (3%)	1 (3%)
Backward	5 (8%)	2 (3%)	5 (17%)
Forward	11 (18%)	10 (16%)	1 (3%)

	Pre-questionnaire (n=63)	**Post workshop 3 (n=63)**	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
When should a woman initiate or start prenatal care?				
During the second trimester of pregnancy	0 (0%)	2 (3%)	0 (0%)	0 (0%)
During the third trimester of pregnancy	1 (2%)	0 (0%)	0 (0%)	0 (0%)
As soon as she finds out she is pregnant	55 (87%)	61 (97%)	63 (100%)	30 (100%)
Not sure/Don't know	7 (11%)	0 (0%)	0 (0%)	0 (0%)

Progress	**Pre to PW3**	**PW3 to Post**	**Post to Follow Up**
Same right answer	54 (86%)	61 (97%)	30 (100%)
Still wrong answer	1 (2%)	0 (0%)	0 (0%)
Backward	1 (2%)	0 (0%)	0 (0%)
Forward	7 (11%)	2 (3%)	0 (0%)

	Pre-questionnaire (n=63)	**Post workshop 3 (n=63)**	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
After having a baby, a woman has a better chance of having a healthy pregnancy and a healthy baby if she waits				
At least three months (3) before becoming pregnant again	2 (3%)	1 (2%)	1 (2%)	0 (0%)
At least six months (6) before becoming pregnant again	9 (14%)	2 (3%)	0 (0%)	0 (0%)
At least twelve months (12) before becoming pregnant again	14 (22%)	0 (0%)	0 (0%)	2 (7%)
At least eighteen months (18) before becoming pregnant again	15 (24%)	60 (95%)	62 (98%)	28 (93%)

Not sure/Don't know	23 (37%)	0 (0%)	0 (0%)	0 (0%)
Progress		**Pre to PW3**	**PW3 to Post**	**Post to Follow Up**
Same right answer		15 (24%)	60 (95%)	27 (90%)
Still wrong answer		3 (5%)	1 (2%)	0 (0%)
Backward		0 (0%)	0 (0%)	2 (7%)
Forward		45 (71%)	2 (3%)	1 (3%)

Self-efficacy results

	Pre-questionnaire (n=63)	**Post workshop 2 (n=63)**	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
How confident do you feel talking to family members about pregnancy and birth-related issues? ***(Circle the number that best represents you)***				
Not at all confident 1	**2**	**3**	**4**	**Extremely confident 5**
Min	1	1	2	3
Max	5	5	5	5
Mean	3.79	4.03	4.67	4.37
Progress		**Pre to PW2**	**PW2 to Post**	**Post to Follow Up**
Stayed Same		25 (40%)	26 (41%)	18 (60%)
Backward		14 (22%)	5 (8%)	10 (33%)
Forward		24 (38%)	32 (51%)	2 (7%)

	Pre-questionnaire (n=63)	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
How confident do you feel talking to family members about pregnancy and birth-related issues? ***(Circle the number that best represents you)***			
Not at all confident 1	**2**	**3**	**4** **Extremely confident 5**
Min	1	2	2
Max	5	5	5

Mean	3.13	4.46	3.93
Progress		**Pre to Post**	**Post to Follow Up**
Stayed Same		18 (29%)	15 (50%)
Backward		4 (6%)	13 (43%)
Forward		41 (65%)	2 (6.7%)

	Pre-questionnaire (n=63)	**Post workshop 3 (n=63)**	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
How confident do you feel finding trusted information and resources for before, during, and after pregnancy? *(Circle the number that best represents you)*				
Not at all confident 1 2 3 4 5 Extremely confident				
Min	1	3	2	3
Max	5	5	5	5
Mean	3.76	4.44	4.63	4.73
Progress		**Pre to PW3**	**PW3 to Post**	**Post to Follow Up**
Stayed Same		26 (41%)	44 (70%)	18 (60%)
Backward		5 (8%)	5 (8%)	6 (20%)
Forward		32 (51%)	14 (22%)	6 (20%)

	Pre-questionnaire (n=63)	**Post-questionnaire (n=63)**	**Three-month follow-up (n=30)**
How confident do you feel <u>coaching</u> (providing advice and guidance to) family members about steps that could be taken to have healthy babies? *(Circle the number that best represents you)*			
Not at all confident 1 2 3 4 5 Extremely confident			
Min	1	2	2
Max	5	5	5
Mean	3.24	4.51	3.93
Progress		**Pre to Post**	**Post to Follow Up**

Stayed Same	19 (30%)	15 (50%)
Backward	3 (5%)	14 (47%)
Forward	41 (65%)	1 (3%)

	Pre-questionnaire (n=63)	Post-questionnaire (n=63)	Three-month follow-up (n=30)
How confident do you feel coaching (providing advice and guidance to) community members about steps that could be taken to have healthy babies? *(Circle the number that best represents you)*			
Not at all confident 1 2 3 4 5 Extremely confident			
Min	1	2	1
Max	5	5	5
Mean	2.95	4.37	3.73

Progress	**Pre to Post**	**Post to Follow Up**
Stayed Same	18 (29%)	14 (47%)
Backward	2 (3%)	15 (50%)
Forward	43 (68%)	1 (3%)

Pre- and post-questionnaire surveys observational analysis

The project successfully moved nearly one-fourth of participants out of the precontemplation stage in the stages of change model (not identifying infant mortality as a health issue affecting their community) and 80% of participants forward at least one stage. A majority of participants (75%) ended in the preparation stage (felt they had the tools to do something). By the end of the project, all participants were aware of infant mortality disparities in their community, an improvement from only half of participants (54%) pre-questionnaire. After the project, participants demonstrated substantial improvements in their knowledge of the definition of infant mortality, its leading cause in Utah's NHPI communities, preconception health, and birth spacing recommendations, which participants were least familiar with before the project. The project also improved knowledge about prenatal care and when it should start. By the end of the project, participants felt more confident talking with community members, coaching family members, and coaching community members about pregnancy and birth-related issues, which participants were least confident about before the project. The project also helped participants feel more confident talking with family members about these topics and finding trusted

information and resources. All participants (100%) agreed the project was culturally appropriate for NHPI communities. The project structure and content was well received overall with only a third of participants suggesting minor improvements.

Three-month follow-up survey observational analysis

Overall, the results indicated participants retained knowledge over three months after the project in all topic areas and were engaged in sharing the information with their communities. The survey results also showed participants did not maintain the same level of self-efficacy as they did right after the project particularly related to coaching and community interactions. However, the self-efficacy of participants in all topic areas was higher in the follow-up survey than in the pre-questionnaire, showing there was some retention of increases in self-efficacy after three months..

After three months, no participants reverted to the precontemplation stage (not identifying infant mortality as a health issue affecting their community) and a majority of participants (60%) ended in the preparation stage (felt they had the tools to do something). The follow-up survey showed that a majority remained in the same stage (63%) with 30% moving backward and 7% moving forward. All participants (100%) remained aware of infant mortality disparities in the NHPI community. Participants showed knowledge retention in all topics, with the lowest at 70% of participants who answered correctly and the highest at 100%. After three months, some participants demonstrated an improvement in knowledge mainly in defining pre-term birth and preconception health. Some participants regressed in their knowledge of the definition of infant mortality, the definition of pre-term birth, the leading cause of infant mortality, and the definition of prenatal care. After three months, the self-efficacy of participants declined in all areas except finding trusted information and resources, which increased for 20% of participants. The largest declines in self-efficacy were seen in talking with community members, coaching family members, and coaching community members. Half of the participants who completed the follow-up survey completed the village project. Village projects included a booth at a festival, a YouTube video, and an informational meeting. Those who did not complete the project cited other obligations, problems working with the group, or still planning as explanations. Most (87%) participants shared the information via social media and personal conversations with an average reach of 54 people. Two-thirds (67%) of participants provided coaching, mostly to close family members and extended family members on preconception health and prenatal care. One-fourth (23%) of participants faced barriers in their efforts, mainly cultural barriers. Some participants felt they are making a difference (57%) by engaging their families and community and some felt that they are not making a difference (43%) because of time and networking constraints.

Implementation notes

During implementation, OHD staff attended all workshops and recorded observational data according to outlines following the project curriculum. Two OHD staff were tasked with performing the observational analyses. One of the staff was familiar with the project and attended nearly all the workshops in phase II. The other staff member was unfamiliar with the project and selected to provide a new perspective. Both staff were asked to review and summarize the notes from the workshops focusing on common themes, reactions, observations, deviations, and recommendations.

Overall, the curriculum was deemed engaging as evidenced by rich discussions where participants shared very personal experiences, expressed opinions, meta-analyzed their community, evaluated their growth, brainstormed, problem-solved, and acted on the information. Workshop I was described as establishing a sense of urgency and providing valuable information on birth outcomes disparities and communication skills to the community. Participants confirmed this is a sensitive and taboo topic and struggled with how to address it and start a community conversation. Workshop II was viewed as novel, introducing the foreign concept of preconception health as well as building important skills for navigating resources. Participants shared about the difficulties men have discussing these topics and communicating overall. Participants also talked about generational differences and the need for beginning conversations about motherhood early. They also identified a lack of resources tailored to their community. Workshop III was engaging with the topic of birth spacing and the connection activity that helped participants think about how they would share what they were learning. The topic of birth spacing generated a lot of positive discussion. Participants consistently identified family, friends, and church as important and close networks. Workshop IV provided a venue for reflecting and taking ownership of the project. Participants shared how they are disseminating the information in their networks and brainstormed how to spread the information further. They also identified barriers such as pride, lack of initiative, and religious beliefs. They also expressed gratitude for the incorporation of cultural concepts.

Quantitative Project Evaluation Summary

Prior to implementation, OHD set project objectives for each workshop. The objectives focused on evaluating changes in participants' knowledge, skills, and self-efficacy related to perinatal health over the project.

Objectives Workshop 1

Objective 1: By the end of Workshop 1, 50% or more of workshop participants over baseline will know the correct definition of infant mortality.

Objective 2: By the end of Workshop 1, 50% or more of workshop participants over baseline will correctly identify Native Hawaiians/Pacific Islanders as one of the racial/ethnic groups with the highest infant mortality rate in Utah.
Objective 3: By the end of Workshop 1, 50% or more of workshop participants over baseline will know the correct definition of preterm birth.
Objective 4: By the end of Workshop 1, 50% or more of workshop participants over baseline will identify preterm birth as a leading cause of infant mortality among Native Hawaiians/Pacific Islanders.

Objectives Workshop 2

Objective 1: By the end of Workshop 2, 50% or more of workshop participants over baseline will know the correct definition of preconception health.
Objective 2: By the end of Workshop 2, 50% or more of workshop participants over baseline will feel more confident talking with a family member about pregnancy and birth-related issues.

Objectives Workshop 3

Objective 1: By the end of Workshop 3, 50% or more of workshop participants over baseline will know the correct definition of prenatal care.
Objective 2: By the end of Workshop 3, 50% or more of workshop participants over baseline will correctly identify when a woman should initiate prenatal care.
Objective 3: By the end of Workshop 3, 50% or more of workshop participants over baseline will know the recommended spacing (in months) between pregnancies.
Objective 4: By the end of Workshop 2, 50% or more of workshop participants over baseline will feel more confident finding trusted information and resources for before, during, and after pregnancy.

Objectives Workshop 4

Objective 1: By the end of Workshop 4, 50% or more of workshop participants over baseline will feel more confident talking with community members about birth-related issues.
Objective 2: By the end of Workshop 4, 50% or more of workshop participants over baseline will feel more confident coaching family members about birth-related issues.
Objective 3: By the end of Workshop 4, 50% or more of workshop participants over baseline will feel more confident coaching community members about birth-related issues.
Objective 4: By the end of Workshop 4, 50% or more of workshop participants over baseline will increase their readiness for addressing birth outcomes disparities in their communities.

Overall, 10 out of 14 evaluation objectives were fully met. Despite increases, the pre-term birth and self-efficacy when talking with family members about pregnancy and birth-related issues objectives were not met. The objectives regarding prenatal care also saw increases, but the baseline precluded a 50% increase over baseline. Overall, the results indicated that the intervention is effective at raising awareness, improving knowledge, and increasing self-efficacy. The demographics of participants demonstrate the effectiveness of the project among a variety of Pacific Islanders. These include a wide range of genders, marital statuses, ages over 18, and education levels as well as the Tongan, Samoan, Native Hawaiian, and Micronesian communities. This established the ability of the curriculum as a whole to accomplish its purposes.

Successes and Barriers Encountered

Implementation processes

At the beginning of phase II, OHD encountered challenges with recruiting, scheduling, and retention. After evaluating these processes, OHD developed recruiting packets and began playing a larger role in scheduling workshops. Groups also began completing the workshops within two weeks. These efforts improved the recruitment and scheduling processes as well as participant retention.

Inclusion of NHPI groups

During phase II, OHD successfully engaged Utah's Native Hawaiian and Micronesian communities. Engaging the Native Hawaiian group was key to the project as Native Hawaiians are the next largest NHPI group after Tongans and Samoans facing infant mortality. OHD was also pleased to host the Micronesian group because it was the first time this community had participated in any type of health workshop. Working with these two communities also provided the opportunity to observe how the project content translated to other Pacific Islander cultures. Participants in the groups confirmed that the concepts resonated across these communities.

Project framework

One of the key successes of the project was the new framework. The framework sets up a village council, which meets to discuss problems and works to make a difference. This works with the Pacific Islander practice of maintaining and nurturing relationships. It enabled participants to engage and connect with each other, which likely contributed to retention rates.

Pacific Islander cultural concepts

Another key success of the project was the addition and refinement of cultural concepts. OHD was able to select cultural concepts with feedback from community members and cultural experts. OHD has been able to revise the concepts to try and account for acculturation and added in discussion questions to ensure participants understand the meaning and purpose of the cultural concepts. These concepts increased the ability for participants to connect with health topics and apply them.

Project evaluation

During the project evaluation, OHD recognized the importance of and need for baseline data. As OHD was evaluating the project, it became apparent that a standard 50% over baseline was not an appropriate target for all objectives. Thus, when no secondary data is available, it is crucial to use pilot

program data to determine the baseline and then create project objectives based on the pilot program data.

Moving Forward

Finalizing project content

After analyzing data from phase II, OHD will finalize the project content. OHD will work with a cultural adviser to confirm all the cultural content and make revisions to specifically address variations of acculturation. OHD will confirm and revise all health information and activities as well as review all the project content to better accommodate different health literacy levels. Products will include a facilitator manual, participant workbook, and project materials (PowerPoint presentations, videos, etc.).

Website

OHD is in the process of creating the *It Takes a Village* website. The website will explain the project background and framework, display content from the workshops, and make available the project materials. The purpose of the website is to raise awareness about the project among the community, public health professionals and potential implementing organizations.

Concluding Remarks

OHD is pleased to report the project activities, outcomes, successes and barriers, and future activities for the second phase of *It Takes a Village*: *Giving our babies the best chance* project among Utah's Native Hawaiian/Pacific Islander communities. Utah is a pioneer in this effort to identify and raise awareness about the birth outcomes disparities facing this community. Overall, the community has expressed concern, interest, and gratitude regarding the effort and many are eager to address the issue. OHD is looking forward to the release of the project and further engaging Utah's communities to raise awareness, increase knowledge, and change behaviors to eventually reduce these disparities.

References

1. Center for Multicultural Health (2010). Health Status by Race and Ethnicity: 2010. Salt Lake City, UT: Utah Department of Health.

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Special Thanks to
Lavinia Taumoepeau-Latu for facilitating the recruitment process and Joyce Kim (Health Choice Utah) for facilitating sites for implementation.

This project was supported by the Maternal and Child Health Bureau, Utah Department of Health through funding from the Maternal and Child Health Services Block Grant to the States (6B04MC31520-01-02), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), 2015-2017.

This project was made possible by previous efforts funded by the State Partnership Grant to Improve Minority Health (Grant # 6 STTMP131088-01-02) from the Office of Minority Health, Office of the Assistant Secretary for Health (OASH), Department of Health and Human Services (HHS), 2013-2015.