

Healthy Beginnings,

Nursing student Sarah Gray ensures healthy breathing.



Healthy Life

The State and Future of Maternal and Child Health Care in the United States

by Lee Erica Elder

In 1990 the outlook for expectant mothers in Central Harlem, in New York City, was grim. Only 25% of pregnant women entered prenatal care in their first trimester, almost 20% of newborns had a low birth weight (less than five pounds, eight ounces), and the infant mortality rate was 27.7 deaths per 1,000 live births. When Mario Drummonds, executive director of the Northern Manhattan Perinatal Partnership (NMPP)—a nonprofit organization providing comprehensive health and support services to pregnant and parenting women—decided to focus his work in Central Harlem, many colleagues cautioned that his efforts would be fruitless. “I like a challenge, so I disregarded what my colleagues said, and I’ve been here 17 years,” says Drummonds. “And when we look at the data now, the infant mortality rate is around 7.5 deaths per 1,000 live births. We still have the highest low-birth-weight rate in the city, but it’s not 20%, it’s around 11.5%, and over 93% of women here in Harlem enter care in the first trimester.” Drummonds received an award from the U.S. Department of Health and Human Services (HHS) in 1996 for his work in reducing the infant mortality rate in Harlem, and his health- and birth-outcome models are being replicated throughout the country.

Though overall statistics for maternal and child health care (or MCH, as public health advocates refer to the field) have improved in the U.S. since the 1990s, the numbers here still lag behind those in other countries; the infant mortality rate

is more than twice that of nations such as Japan and Sweden, according to a new study by the Institute of Medicine.

In general, health care access—or its lack—shapes the lives of mothers and children, and those who are homeless or living in poverty are the least likely to receive adequate treatment. “Women experiencing homelessness have high rates of pregnancy and are at higher risk for birth complications, like low birth weight, and nutritional deficiencies,” says social-work trainer Melissa Berrios-Johnson, MSW, of the Homeless Health Initiative (HHI), founded in 1988 at the Children’s Hospital of Philadelphia. “A disproportionate number of women of color experience homelessness. ... It has been found that African American women have lower rates of participation in prenatal care, imperative for maternal/infant health. Preterm births occur more often among African American and Latina mothers than white women.”

Maternal and child health care organizations prioritize the health of mothers and children and try to create safe spaces for them to thrive. This work is particularly vital to women who are homeless. “We are dealing with a pretty entrenched population of women trying to improve their economic lot as well as their housing situations and, more importantly, their educational status,” says Drummonds. Women dealing with homelessness and transient situations comprise about 40 to 50% of NMPP’s clients.

Lifecourse Theory and “Medical Homes”

“Many are practicing maternal and child health on an old paradigm, focused on a nine-month period,” says Drummonds. Those professionals are “not concerned about ... women’s health over a lifecourse—they are thinking about managing current pregnancy and then sending women out into the community without trying to provide services or do work during [the intervals between pregnancies].” Drummonds credits Dr. Michael Lu, associate administrator for Maternal and Child Health of the Health Resources and Services Administration (HRSA), with revolutionizing the public health industry through his ideas concerning MCH lifecourse theory—a focus on the health of mothers and children over the course of their lives.

NMPP is a hub for several service programs that incorporate that idea. Baby Steps is a Healthy Families America (HFA) program funded by the New York State Office of Children and Family Services (OCFS); through NMPP, it provides home visits to expecting parents and parents of children up to two years of age, assessing their needs and capabilities and providing help as required. The Head Start program in Harlem and Washington Heights provides classroom education for children and links their families with social and community services. Drummonds is also excited about a grant that his organization recently received through the HRSA’s Maternal and Child Health Bureau (MCBH) to fund Thrive, a between-pregnancy-care case-management program. Thrive works with women to extend the period between the birth of one child and conception of another to about 18 months.

Health experts agree that in addition to care over a life course, every mother and child must have a stable “medical home” for optimal health. “A lot of times women have a number of medical providers who don’t know anything about their health histories and make proposals for health interventions that really are out of context,” says Drummonds. “A medical home has to have an extensive array of public health and clinical services that will hopefully address all the family’s needs over the life course.” An ideal medical home is a facility located in the client’s community, one that is family-focused and culturally sensitive and has an atmosphere of compassion.

“Prematurity is more impactful than heart disease and cancer—it’s a big problem and one that doesn’t get a huge amount of attention. No one hears from a preterm infant who dies.”

As the concepts of lifecourse theory and medical homes suggest, the scope of MCH extends far beyond the doctor’s office and delivery room. “Some of us are attempting to get maternal child and public health clinical partners to understand that we

have a much larger role to play and that we have to bring in and make connections to the business community, to make sure that women are employed and have the educational capabilities to get a good job, because we know the relationship between health and economic development,” Drummonds explains.

Preparing for a Lifestyle Change

HRSA-funded Healthy Start programs are leading the way in creating holistic, multidimensional support systems for pregnant and parenting women. The Healthy Start Initiative began in 1991 with 15 urban and rural sites in communities with exceptionally high mortality rates; it has grown to include 105 grantees nationwide currently. At NMPP’s flagship, Central Harlem Healthy Start, high-risk pregnant women (many of whom have previously had adverse pregnancies) are each matched with a case worker who addresses pre- and postnatal needs and helps to obtain services such as public assistance, job training, and domestic-violence intervention.

“The Healthy Start Program helped me a lot,” Valerie, the mother of a two-year-old girl, says. (As with other clients interviewed, her name has been changed in this article.) “When I first came to the program, I was four months pregnant. My case manager told me to prepare for a lifestyle change. She helped me understand that the baby would be more important and that I would not be able to go out as much. My baby and I went to Washington, D.C., with the Consumer Involvement Organization [CIO].” (NMPP’s CIO provides an opportunity for clients to engage with other mothers and participate in leadership and strategizing activities.) “I learned that I could be a great speaker once I get over my shyness. I also learned peer networking, and met other girls in similar situations. I also learned to be consistent and not just say I am going to do something, but to follow through with it. Now I am back in school working toward my associate degree.”

Similarly, Marlene, a mother of three children, says about Healthy Start, “I really like this program because I learn a lot and it motivates me to be better and become wise. I like the classes that teach us about our bodies and about health issues like diabetes, STIs [sexually transmitted infections], and smoking. The people are very nice and respectful—they make you feel welcome. They also help me with doctor’s appointments, metro-cards, and stuff for the kids.”

Downstate New York Healthy Start (DNYHS) is a partnership of Columbia University Mailman School of Public Health and three community-based organizations in New York City and Long Island: the Economic Opportunity Commission of Nassau County Inc., Queens Comprehensive Perinatal Council Inc., and Suffolk County Perinatal Coalition Inc. Women in DNYHS-served communities are at risk of poor birth outcomes due to poverty, unemployment, limited education, racial and ethnic disparities

in care at time of delivery, and other factors. DNYHS works to connect women to medical homes and health care as soon as possible. DNYHS's supportive case-management services include information and referrals, care between pregnancies, advocacy, and health education. In 2010 DNYHS implemented an innovative program designed to alleviate the depression experienced by at-risk mothers: the Circle of Caring (CoC) psychosocial support group for women during and between pregnancies. In this social-support network, women learn about the signs, symptoms, and treatment of depression as well as coping and stress-management skills. "The goal of the intervention is to provide support, education, and coping skills for women to learn to effectively negotiate stressful situations," says DNYHS Senior Project Officer Vernique Montrose, MPH. Stress and depression, she added, not only affect women but also put strains on their families.

Why Care Is Important

In Philadelphia, HHI provides free services to children and mothers living in shelter, including primary and specialty care, dental screenings, autism and developmental screenings, access to health insurance, and health education. "HHI serves a population primarily comprised of women and children, the [fastest] growing segment of the homeless population, living in shelters in West Philadelphia," says Berrios-Johnson. "Most families have survived trauma, such as violence, illness, and loss of loved ones, often compounded by the trauma of experiencing homelessness and moving into a shelter. Some mothers struggle with mental health issues, while many children have developmental delays and behavioral challenges." In addition to parenting education, HHI offers Safe Sitter—a certified babysitting-training program that educates children (11 to 14 years old) in providing safe care for younger children, including CPR, and strengthens their future parenting skills.

An encouraging aspect of the current landscape of maternal and child health care is a focus on not just providing such care but educating providers about why it is so important. A core component of HHI's success is increasing understanding of the grave effects of homelessness on the lives of mothers and children, and other MCH organizations agree that staff training and sensitivity are crucial. According to Montrose, "An educated, culturally sensitive environment—availability of translation services at medical centers, forms in multiple languages, confidential, private, and welcoming medical offices and personnel—and workforce is one way we can increase the chances that a woman will willingly and consistently take advantage of health care services. I think that in order to improve not only women's health but population health, it is integral to have a well-trained, culturally competent workforce."



Children play at the facilities of Community Advanced Practice Nurses (CAPN) in Atlanta.

Stakeholders in the MCH community in Cincinnati, Ohio, are working together to meet the needs of at-risk women and families. "In Cincinnati there are pockets of very high infant mortality rates that are certainly more consistent with what you would characterize as developing countries," according to Dr. James Greenberg, director of the division of neonatology at the Cincinnati Children's Hospital Medical Center (CCHMP) and co-director of CCHMP's Perinatal Institute. "That's not new, but what is new is an appreciation that we in health care and health care institutions had to become directly engaged in the health of communities. There is no question that preterm birth in the U.S. has a huge impact on quality of health on a national level. Prematurity is more impactful than heart disease and cancer—it's a big problem and one that doesn't get a huge amount of attention. No one hears from a preterm infant who dies. Loss of potential is more difficult to measure."

Karen Bankston, associate dean of Clinical Practice, Partnership and Community Engagement and professor of clinical nursing at the University of Cincinnati, chaired a local government board focused on the reduction of infant mortality and the improvement of maternal and infant health. Bankston, who grew up in poverty, became a mother as a teen, and went on to earn a PhD, says that there is room for intervention to help young mothers with healthy decision making. “Some of the decision making really comes down to how [people feel] about themselves. I believe it is possible to overcome some of these challenges if the right initiative, actions, and environment are in place. It has to start early. We were [seeing] girls that were 11 years old [deliver babies], and that still happens in our community today. How does one equip an 11-year-old, if she’s being molested by a relative, how do we equip her to deal with that? One of the things we learned over the last few years is how much social determinants and things that affect environment influence choices women make and when and where they receive their care.”

A girl rides a horse as part of the Emerson Davis program of New York’s Institute for Community Living.



Greenberg and Bankston are just two of the collaborators—among doctors, health agencies and advocates, community leaders, and others—building a multifaceted effort to eradicate problems facing mothers and children in Ohio. “We are working to organize a ... collaborative to [implement] knowledge gained through our work, sharing that knowledge with relevant community agencies in a position to directly impact the problem of preterm birth at a community level,” says Greenberg. “There are extraordinary disparities that map with poverty and race in the U.S.—racial disparities around preterm birth and infant mortality are pervasive, and if we are really going to make an impact, we have to pay attention to and directly take on the issue of disparity. In Cincinnati, African Americans have a three-fold higher risk of delivering preterm than their white counterparts. Differences are not explained entirely—some relate to poverty and socioeconomic status and some do not. It’s tempting to say that it must be genetic, but we are fairly certain that while understanding genetics is important, hoping to identify a gene present in high-incidence populations is not the explanation. In a high-incidence area in Cincinnati, between 20 and 25% of babies are born preterm. That still means that 75 to 80% of women in the region are delivering in term, so what may

be helpful is understanding resilience or reasons why many women in those areas do deliver to term, rather than focusing solely on the women who don’t. The nature of resilience can help teach us what it is about racism, environment, poverty, and so on that lead to a higher risk of preterm birth.”

Mental Health Is Key

For women experiencing poverty and homelessness, access to care and treatment for mental health issues are often elusive. “It is very difficult to obtain mental health services for women with depression, post-traumatic stress disorder, and bipolar disorder,” says Linda Grabbe, family nurse practitioner at Community Advanced Practice Nurses Clinic for Homeless Women and Children in Atlanta (CAPN) and a clinical assistant professor at Emory University’s Nell Hodgson Woodruff School of Nursing. “Our patient population suffers from considerable chronic stress related to poverty and homelessness.” CAPN is a free, nurse-led clinic for homeless and uninsured women, children, and youth living in shelters, in transitional housing, or on the street. “Lack of access to health care providers and family planning methods or money to pick up a prescription leads to unplanned pregnancies. Often, postpartum insurance coverage ends before a woman obtains contraception, and a second pregnancy ensues,” says Grabbe. The clinic received a Healthy People 2020 Community Inno-

vations grant, funded by HHS, to increase mental and gynecological health services to homeless youth.

“By going to the shelter to screen youth for mental distress and to identify at-risk/suicidal clients, we were able to refer them directly to CAPN’s advanced practice psychiatric nurses or county mental health services,” Grabbe notes. “We also initiated a monthly educational session for the young women on health issues, which has been well attended.”

Stella Pappas, a licensed clinical social worker, is executive vice president and chief operating officer of the Institute for Community Living (ICL); she oversees an organization dedicated to helping people with mental illness and developmental disabilities lead healthy lives. “It’s difficult for people to access help when they need it—we are a reactive system, not a preventive system, and a lot of time you can’t get mental health help for a family member or a loved one until something happens,” says Pappas. “We need to be able to access that care before something happens.” ICL provides innovative treatments, rehabilitation programs, and support services to adults, children, and families in the New York metropolitan area, through over 104 specialized residential and clinical programs that include but are not limited to supportive-housing services. Of particular note is the Brooklyn-based Emerson Davis program, which reunites and prevents separation of mentally ill mothers and their children. The program was founded 18 years ago to help clients who were recovering from substance abuse and other disorders and wanted to reside with their children while doing so. “There was a lot of stigma that mentally ill individuals could not be parents or raise their children successfully, but literature shows that as long as the child is safe, they thrive and prosper with their parents more than in any other environment,” says Pappas.

The stories of several ICL clients bear this out. Jennifer reunited with her two children, three and five years old, after moving into Emerson Davis in 2009. She continues to care for her children with the support of the program staff. Both children are attending school, and Jennifer has successfully completed training as a medical assistant.

Janice was reunited with her children in 2008, when they moved into the Emerson Davis family program. In 2010 the family moved into their own housing through Emerson Davis, allowing them to live independently while having access to services. Janice continues to live with her two sons.

Diana has remained sober since her admission into the Emerson Davis program, in 2006. After demonstrating that she was a stable parent, in September of 2012 she was moved into her own housing through Emerson Davis, where she enjoys even greater independence. Recently, her daughter

Children from homeless families can access free health care at the CAPN facilities.



successfully applied to several public schools for gifted students, and Diana is planning to become a certified alcohol and substance abuse counselor (CASAC).

Annette is a substance-abuse counselor for the Inpatient Medically Managed Detoxification Unit at St. Mary’s Hospital of Brooklyn. She is also an ICL client. Born and raised in the Bronx, she has three children (a 24-year-old and 13-year-old twins). In 1994, during the re-entry phase of treatment for alcoholism, she was diagnosed with bipolar disorder and was involuntarily admitted to a hospital, where her condition was treated and stabilized.

While at Emerson, Annette attended a Mentally Ill Chemical Abuser (MICA) Outpatient Program, through which she developed interpersonal and coping skills and participated in programs to maintain her sobriety. Support services at Emerson enabled Annette, her children, and other family members to make the transition to an alcohol- and drug-free lifestyle. She returned to college and obtained a BS degree, after which she assumed her present position at St. Mary’s Hospital. In a few months, she will complete educational training for the CASAC exam. Annette’s professional goal is to obtain a master’s degree in health care administration and to become a grant writer for early-intervention health care programs that target at-risk communities.

The landscape of MCH is expanding. Caregivers are focused on eliminating barriers to health care for mothers and children, no matter their economic situation. “Women are often the gatekeepers in their family,” says Montrose. “If public health professionals can maintain the woman’s commitment to improving her health, we will have successfully gained entry to improving the health trajectories of her immediate family, community, and hopefully the nation.” Such care and attention will give more families the chance to thrive for generations to come. ■