



# A Life –Course Approach and the Future of MCH

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MCH National Retreat

July 25, 2011



# Acknowledgements

*Ideas and Slides Freely Adapted  
From MCH Colleagues*

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Milton Kotelchuck

Michael Lu

Neal Halfon

Cheri Pies

Deborah Allen

Deborah Klein Walker

Paul Wise



# What Life Course Is ... and Isn't

- Is a theory, perspective, framework
- Not a model
- No single, definitive text
- Reflects a convergence of ideas, informed by multiple sources



# What Life Course Is ... and Isn't

- Life Course is a theory or perspective that seeks to ***understand, explain, and improve*** health and disease patterns across population groups.



# Key Questions

MCH Life Course literature focuses on two key questions:

- Why do health disparities exist and persist across population groups?
- What are the factors that influence the capacity of individuals or populations to reach their full potential for health and well-being?



# Social Determinants & Health Equity Roots

How does Life Course interface with social determinants and health equity models/concepts?

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- Life Course literature reflects and incorporates both.
- Life Course inquiry is rooted in both.



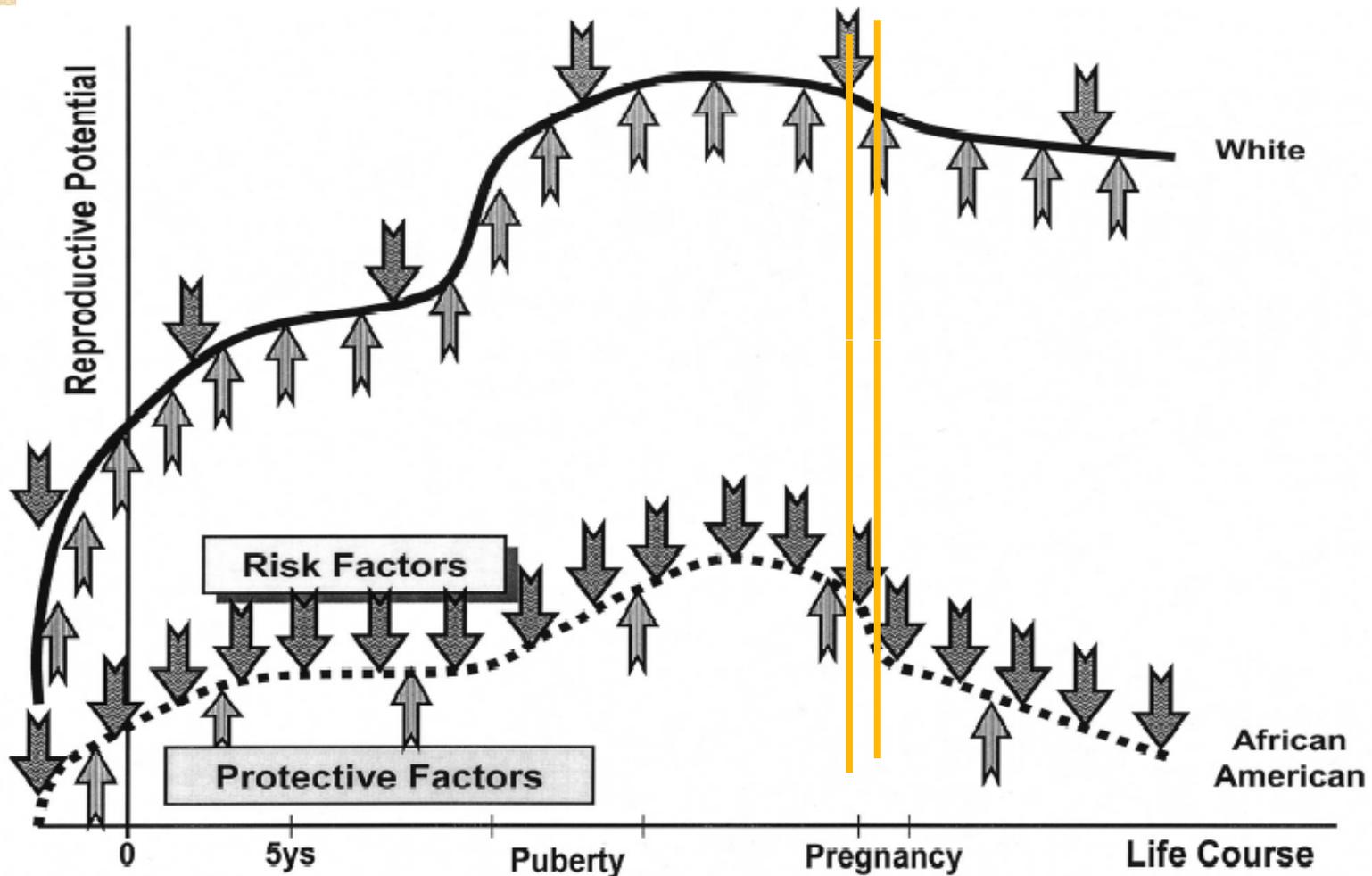
# Key Terms

- Pathways and Trajectories
- Early Programming

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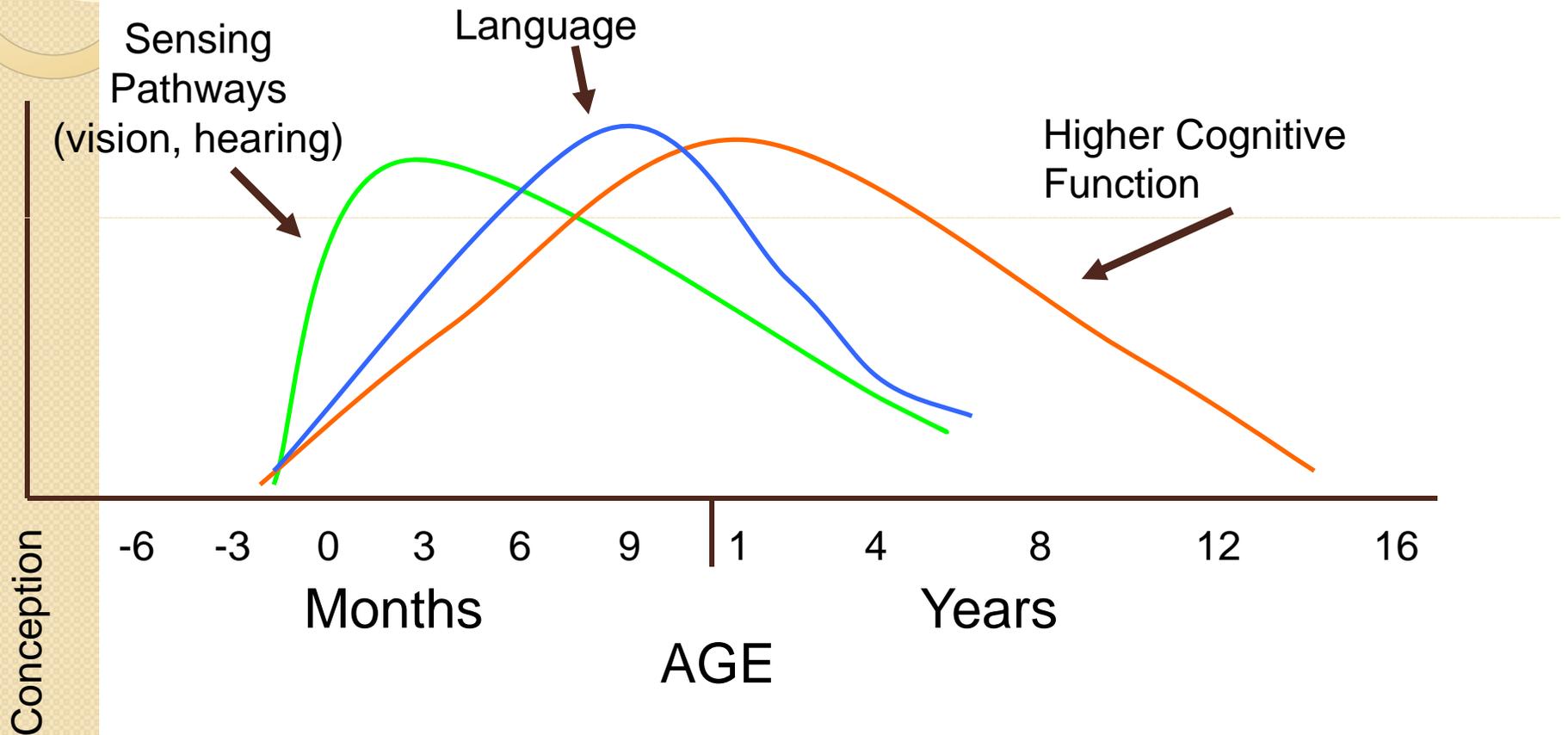
- Risk and Protective Factors
- Cumulative Impact
- Critical or Sensitive Periods

# Life Course Perspective



Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. *Maternal Child Health J.* 2003;7:13-30.

# Sensitive Periods: Brain Synapse Formation



C. Nelson, in *From Neurons to Neighborhoods*, 2000.



# Life Course Core Concepts

- Today's experiences and exposures determine tomorrow's health (Timeline)
- Health trajectories are particularly affected during critical or sensitive periods (Timing)
- The broader environment –biologic, physical, and social –strongly affects the capacity to be healthy. (Environment)
- Inequality in health reflects more than genetics and personal choice (Equity)

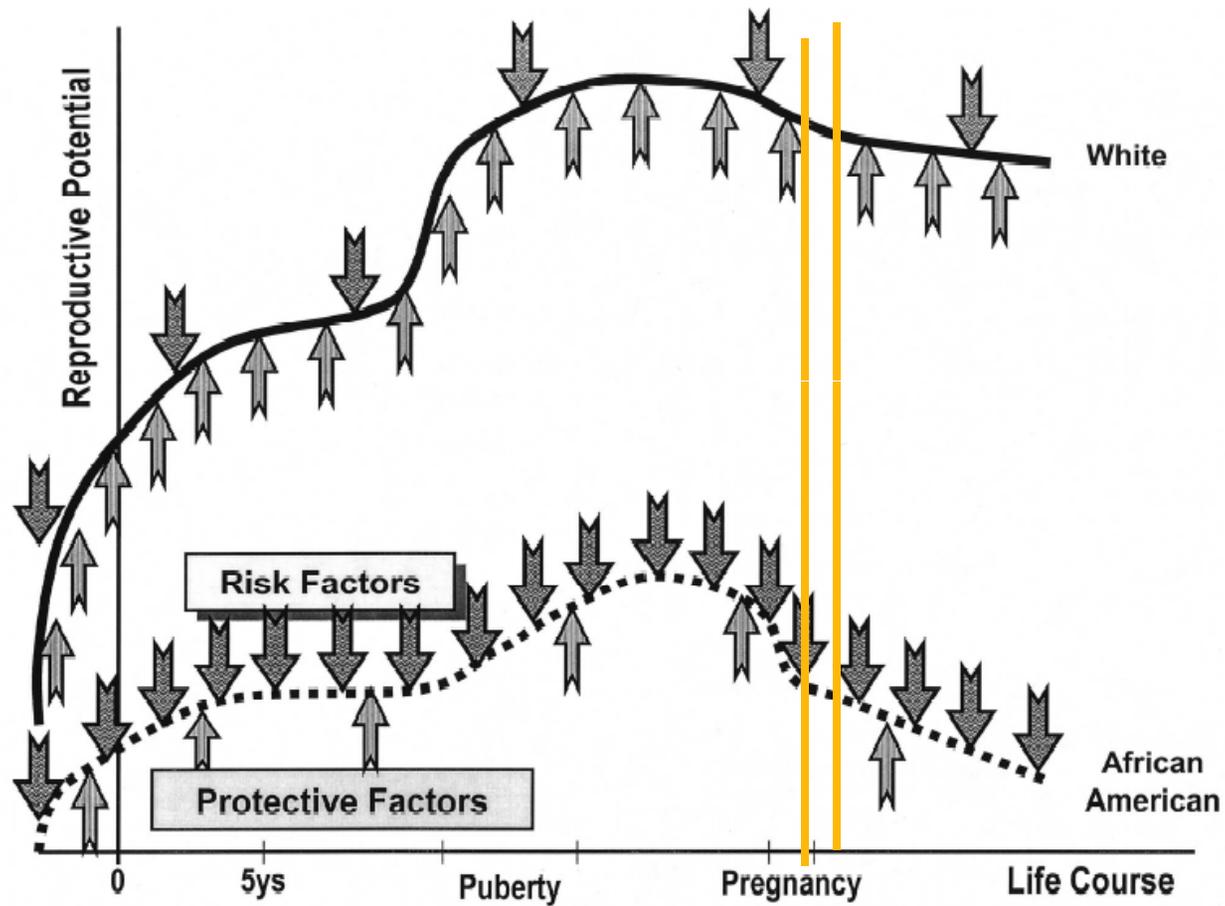
*Fine, Kotelchuck, Address, Pies 2009*

# T2E2: The Real “Cliff Notes”

- **Timeline** – health is cumulative and longitudinal, i.e., developed over a lifetime.
- **Timing** - health and health trajectories are particularly affected during critical/sensitive periods.
- **Environment** – the broader environment (biologic, social, physical, economic) affects health and development.
- **Equity** – health inequality reflects more than genetics and personal choice.

*Fine and Kotelchuck, 2010*

# T2E2



Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. *Maternal Child Health J.* 2003;7:13-30.

# Is Life Course Old or New?

- LCT marries long-term MCH concepts with new science
  - Barker Hypothesis – links LBW to increased risk of heart disease, diabetes
  - Felitti's ACE Study – links adverse childhood events to increased risk of obesity, heart disease, diabetes, depression
  - Neurons to Neighborhoods, NAS – early environments, nurturing relationships, parents are the “active ingredients” in healthy brain development – from the earliest ages forward.
  - Lu/Halfon – link disparities in birth outcomes to differential developmental trajectories of the mother, based on early life experiences (programming) and cumulative stress.
  - Epi-genetics – links environmental triggers to gene expression.
- The same science is also informing other fields.



## Is Life Course Old or New?

- Life Course Theory (LCT) adds a new emphasis on ***timing and timeline*** to MCH focus on social determinants and equity.
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# Is Life Course Old or New?

- In some respects we have always been engaged with LC work:
  - Most of our efforts to date have focused on SDOH and equity
  - Fewer efforts on timing and timeline
  - Fewer efforts focused on all four components



# Aligning Policy & Practice with LCT

- LCT tells us that interventions that reduce risks and increase protective factors can change the health trajectory of individuals and populations.
- LCT tells us that intervening early and during sensitive periods can change outcomes.
- These ideas are not inconsistent with the current practice of medicine and of public health.

# Aligning Policy & Practice with LCT

But, LCT also...

- Greatly expands the opportunities for intervention:
  - a much broader set of venues and partners,
  - over a much longer timeline
- Suggests the need for better linkage (vertical, horizontal, temporal)
- Encourages us to rethink and realign some of the current strategies and add new ones.

# The Work Ahead

- Explore how LCT might best be applied:
  - Within MCH training programs
  - Within health departments, and
  - In partnership with others working to improve the health and well-being of women, children and families.
- Explore the implications of LCT for the Future of MCH



# Getting from Here to There: Applying Life Course

- To realize the full potential of a life course approach, we need to:
  - Understand the history of MCH as it relates to Life Course concepts
  - Grapple with a series of challenges related to LCT.



# Why Life Course? Why Now?

- How does life course fit with MCH origins, history and current focus?
- Strategically, should we be adopting a life course approach in MCH now? If yes, explicitly or implicitly?
- What are the benefits or pitfalls to the field?
- If we embrace life course what are the challenges? How do we overcome them?



# Origins of MCH as a Field

- With its beginnings with the Children's Bureau, the field of MCH has its origins in the social determinants of health (SDOH) and health equity
- SDOH and equity concerns are part and parcel not only of our legacy but of our practice
- Social determinants – socio-ecological model, risk factors beyond the individual, broader and holistic perspective

# THE CHILDREN'S BUREAU

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Department of Commerce and Labor

CHILDREN'S BUREAU

Washington

## ESTABLISHMENT OF THE BUREAU.

The Children's Bureau was established by an act of Congress approved April 9, 1912, and began active operations upon the passage of the legislative, executive, and judicial appropriation bill on August 23, 1912. The text of the law establishing the Bureau is as follows:



# **Children's Bureau**

## **Established 1912**

**“To investigate and report upon matters pertaining to the welfare of children and child life among all classes of our people and especially investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, accidents and diseases of children, employment, (and) legislation affecting children in the several states and territories”**



## How has MCH Field Carried out its Commitment to SDOH and Equity?

- Sheppard Towner included lay community health workers
- Title V adoption in 1935:
  - MCH defined broadly with respect to prevention, even CCS
  - Title V included a welfare component
  - Title V initially housed in the Dept. of Labor
- EMIC Program- universal access to health care for spouses of lower grade servicemen

# How has MCH Field Carried out its Commitment to SDOH and Equity?

- 1960's - M and I and C and Y– must include nurse, nutritionist, social worker, physician- comprehensive (social-ecological) model of care
- 1970's - continue to support comprehensive models of health care; WIC and Title X brought into MCH fold as key partners
- 1980's – focus on expanding access to care; CDC makes racism a focus of study as a cause for MCH health disparities
- 1990's - MCH Pyramid; building the base of pyramid with increased emphasis on capacity; commitment to family centered care
- 2000's – focus on cultural competency, partnership; evidence based interventions; importance of communities and families



# How has MCH Field Carried out its Commitment to SDOH and Equity?

- Carrying out our commitment to SDOH and health equity in the second decade of the 21<sup>st</sup> century
  - Selection of a Life-Course Approach as a way to embrace/solidify/renew our commitment to multi-level, multi-factorial approach to maternal and child health problems and interventions/solutions
  - Addition of Timing and Timeline and understanding of cyclical nature of life events



# Specific Challenges of Adopting a Life Course Approach

- Conceptual challenges
- Data challenges

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- Operational challenges
- Strategic and Political Challenges



# Challenges of Life Course Approach

- **Conceptual**

- Early programming - too deterministic?
- Too front-loaded? Does focus on early life events diminish impact of events in adolescence and later life?
- Is fetal programming the new genetics? (what are the implications for genetic services and CSHCN?)
- If health determinants and health status are all connected over a life time, how do we make the case for a particular focus on MCH?



# Overcoming Conceptual Challenges

- **What has been done?/What have we begun to do?**
- Rethink/change the language of fetal “programming” and to acknowledge trajectories are not fixed
- Reiterate that early life interactions are themselves affected by later factors and results of these interactions may be amenable to intervention at many points
- Emphasize that intervention in each period is important and can have synergistic effects; likewise, failure to act in a later period may not allow for the full positive effects from an earlier period to manifest
- Remember that life course supports the idea that each individual should have the opportunity to live to his/her full potential despite “differences”
- Emphasize cyclical nature of Life Course- wherever we begin has an impact on the next phase and potentially the next generation



# Challenges of Life Course Approach

- **Data:**

- Weakened vital statistics system
- State to state variation; no federal mandates
- Linkage across programs/  
exposures/ interventions for one person not  
routine
- Linkage across generations not routine
- Linkage to SES data not routine
- Insufficient community and neighborhood  
level data



# Overcoming Data Challenges

- **What has been done?/ What have we begun to do?**
  - PELL – MA Pregnancy to Early Life Longitudinal Data System
  - National Children’s Study
  - Linked Data Sets across generations
  - CDC vision of integration of chronic disease with women’s health and MCH
  - Life Course Research Network (MCHB funded)



# Challenges of Life Course Approach

- **Operational:**

- Silo funding makes integrating activities/ services/strategies difficult
- Budget cuts mean fewer staff, fewer resources
- How far to extend partnerships? What is an MCH problem? What is an MCH solution?
- What/how much can be accomplished in food, housing, income sectors, with Title V dollars? With Title V leadership or partnership?
- How can we move from LC “programs” to LC “systems”?



# Overcoming Operational Challenges

- **What has been done?/ What have we begun to do?**
  - Recognize that public health cannot implement LC approach alone. Need to work with partners and utilize a **common results framework** to develop cross-sector strategies and to drive change.
  - Use **shared resources to link** across services/programs /sectors
  - , Embrace a **dual focus** for services, programs, policies to “bend the curve” for whole populations:
    - **Universal** – prevention, promotion, risk identification
    - **Targeted** – additional services/supports for those at-risk or with greater needs
  - **Build both individual and community capacity --** individual services and supports are necessary but not sufficient

# Challenges of Life Course Approach

- **Political/ Strategic (vis a vis implications for the field of MCH) :**
  - What are the implications of adopting LCT for our ability to claim a unique niche for MCH? If every age group and part of the life span is important, what becomes our special identity as MCH?
  - We have always focused on SDOH and equity. We have considered multi-level and multi-factorial etiologies as well as solutions to problems, all within the MCH umbrella. However, if our umbrella is too wide, will our unique identity be lost?



## Political/Strategic Challenges (continued)

- Are we using the term life course when we mean SDOH and equity? Is this similar to framing problems as infant mortality or teen pregnancy when we mean poverty?
- At a time of budget cutting and increased vulnerability as MCH loses “facts” on the ground, a life course approach may be essential to our survival as a field as well as to the improved health of women and children and families but in this climate how is our MCH identity maintained?

# Overcoming Political/Strategic Challenges

- **What has been done?/What have we begun to do?**
  - MCHB has taken a Leadership Role in LC Theory and Practice, recognizing that MCH as a field has to adapt in very tough times whether or not we embrace LCT
  - MCHB is supporting the notion that Life Course is an MCH “Solution” to MCH “Problems”
    - Commissioned concept paper, “Rethinking MCH, the Life Course Model as an Organizing Framework” which goes beyond SDOH and equity to emphasize timing and timeline
    - Providing Support for discussions at multiple levels in diverse venues in the MCH community
    - Adoption of Life Course in MCHB Strategic Plan with invited comments from wide audience



# Conclusion:

## Getting from Here to There

- In an aging society, where children are disproportionately poor and of color, *life course approach to MCH may be our lifeline*
  - *Strategic approach*
  - *Evidence-Based*
  - *Requires intentional partnerships*
  - *Requires shared actions and embracing shared outcomes*
- Taking on and overcoming the challenges to life course and directly promoting its multiple concepts may be the best way to maintain MCH as a field while improving the health status of women, children and families



## Conclusion:

### Getting from Here to There- Your Part

- How can adopting a life course approach become the lifeline you need to continue pushing forward in your work?
- In each areas of challenge, what more needs to be done to:
  - make life course a living/breathing concept?
  - make life course actionable to “everyone”?



## Questions to Ponder

1. What additional challenges need to be addressed?
2. What needs to happen to overcome these challenges?