Interconceptional Care Meeting

Meeting Brief

On March 15, 2012, the United States Agency for International Development (USAID) Office of Population and Reproductive Health (PRH), in collaboration with USAID’s flagship Maternal and Child Health Program (MCHIP), and the Maternal and Child Health Bureau (MCHB) of Health Resources and Services Administration (HRSA) convened a meeting to bring together domestic and international experts to discuss possible linkages and shared learning in the field of maternal and child health (MCH). The meeting focused on HRSA’s model of interconceptional care and USAID’s approach to integrating postpartum family planning into MCH interventions overseas. Twenty-one representatives from USAID, HRSA and MCHIP participated in the meeting.

USAID and HRSA began with an overview of MCH programs they support, followed by presentations from four Healthy Start grants projects (US-based); MCHIP’s work with community health workers offering postpartum care home-visits (Bangladesh); and a review of 52 Demographic Health Surveys that demonstrates the impact of pregnancy spacing on infant and child mortality, underweight and stunting. The final portion of the meeting was set aside for group discussion to identify common themes and linkages, and discuss future collaboration.

The overall objectives of the meeting were:

1) Provide an overview of HRSA’s interconceptional care approach implemented through the Healthy Start grants projects and USAID’s integrated programming approach through the Maternal Child Health Integrated Program (MCHIP).

2) Discuss experiences in program implementation in the United States and in developing countries, with examples from several settings.

3) Identify common experiences, challenges, evidence-based state-of-the-art approaches, and lessons learned.

4) Identify next steps, including the possibility of convening a larger informational exchange meeting.

Highlights from the Presentations

Dr. Scott Radloff, Director of PRH for USAID, welcomed the participants and presented an overview of USAID’s Family Planning (FP) and Reproductive Health Program, highlighting that voluntary FP is a key intervention for health and development and that USAID’s program aligns with the Global Health Initiative and Millennium Development Goals. USAID
currently has 24 priority FP countries, 23 additional assisted countries, and 21 countries that have graduated from the program. He also provided an overview of some of USAID’s technical priorities, including, Healthy Timing and Spacing of Pregnancies, FP/MCH Integration, Community-based FP, Long Acting and Permanent Methods of FP, Contraceptive Security, FP/HIV Integration, Gender Equality and Women’s Empowerment, and Equity.

**Discussion points:**

- FP and MCH should go hand in hand, however it’s imperative to integrate only where it makes sense.
- Postpartum family planning (PPFP) is an important component of integration. Home births make it challenging to reach women in the postpartum period. Women are more likely to visit the facility for their children’s health. By integrating PPFP with services such as ANC, labor and delivery services, well baby visits and immunization visits we are able to decrease the number of missed opportunities.
- Task shifting plays a role in limiting missed opportunities.
- Challenges in developing countries are similar to domestic rural communities. Some of these challenges include: lack of human resource and capacity, lack of access to services, lack of transportation and education. Cultural issues and myths and misconceptions of contraception are rampant in both areas. Male involvement is important in both areas.

**Dr. Michael Lu,** Associate Administrator for Maternal and Child Health for HRSA, presented an overview of the Life Course Theory that addresses risk factors exposed to girls and women throughout their lives and not just addressing risk factors during pregnancy. He discussed several theories are supported by a growing body of evidence from animal and epidemiological studies: Barker Hypothesis (increased odds ratio for adult-onset coronary heart disease, hypertension and obesity if that individual’s birth weight was low); Epigenetics (prenatal stress such as poor nutrition can turn up negative gene expression that increases susceptibility for obesity, diabetes and stress in the baby's adult life). These are all examples of the early programming component.

Additionally he reviewed cumulative pathways. Dr. Lu said that when a person is exposed to a stress factor the physiological reaction is to increase stress hormones CRH and ACTH that increase heart rate, available glucose and enhance immune functions. However, exposure to chronic stress these hormones are never turned off and result in hypertension cardiovascular disease, glucose intolerance and infection/inflammation and increased risk for preterm birth.
In summary, his three take home messages were (1) Even early prenatal care may be too late; (2) If we want to improve maternal and child health, we start by improving women’s health; (3) Interconception care offers a window of opportunity to restore allostasis and optimize women’s health before their next pregnancy.

Discussion points:
- There is a need to translate clinical biological data into a public health perspective since there is a need to reach a large number of women.
- There is a need to broaden the agenda to include a holistic set of services from women instead of focusing purely on medical interventions. Need to address issues such as income generation, gender based violence, racism and education.
- Training - most providers have narrow disciplinary focus and do not talk about nutrition, environmental health and toxicology, and therefore are not set up to provide quality prenatal care. A new model of care is needed that is also more cost effective.

Dr. David de la Cruz, Deputy Director of the Division of Healthy Start and Perinatal Services for HRSA, presented an overview of Healthy Start. The presentation included an overview of core public health services delivered by MCH agencies, as well as an in-depth look at Healthy Start and Perinatal Services, including the target audience, risk reduction and risk prevention activities, infrastructure building activities, health promotion, national leadership activities. In addition, he provided a brief history of the Healthy Start initiative and an overview of the program today, including goals, program components, and core interventions. Dr. de la Cruz introduced the 4 healthy Start projects; Pittsburgh – one of the initial 15Healthy Start programs and one of the highest funded projects today; Michigan and Florida – both mid-size programs; and Arizona – the lowest funded project.

Discussion points:
- All of these healthy Start projects include home visits before and after pregnancy.
- The programs began with incentives (baby supplies), and the incentives changed to focus on priorities for mothers, such as helping them lose weight, get housing and education.

Dr. Maurine Jones, Executive Director, and Sharon Ross Donaldson, Director of Operations, for the Gadsden Federal Healthy Start Project, Center for Health Equity in Florida presented an overview of their Bio-psychosocial Outreach Program – an interconceptional home visiting model. The project uses an interdisciplinary team approach to provide outreach, education, and case management services in a rural community in North Florida where there are significant disparities in infant death rates for African Americans. The preliminary findings suggested that a bio-psycho-social interdisciplinary team approach does have an impact on selected health outcomes.
<table>
<thead>
<tr>
<th>Measurement</th>
<th>Baseline Score</th>
<th>Final Score</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waist Circumference</td>
<td>42.6</td>
<td>41.92</td>
<td>Significant</td>
</tr>
<tr>
<td>Stress Score</td>
<td>20.94</td>
<td>14.66</td>
<td>Significant</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>53.80</td>
<td>57.5</td>
<td>Significant</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>76.69</td>
<td>77.74</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Physical Activity Score</td>
<td>58.91</td>
<td>66.64</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Water Intake (oz)</td>
<td>30.02</td>
<td>30.96</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>34.37</td>
<td>34.73</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Depression</td>
<td>7.44</td>
<td>7.05</td>
<td>Not Significant</td>
</tr>
</tbody>
</table>

**Discussion Points**

- Healthy Start is known to community through home visits & community trusts the program
- Working in a high school that has become very engaged. The curriculum is 8 weeks. The school gets permission from parents for this project. Pre and post test are administered to evaluation change in knowledge acquisition. Parents are engaged during case management

**Cheryl Flint**, Executive Director, and **Raynard Washington**, Evaluator for Pittsburgh/Allegheny County Healthy Start, Inc., presented their approach to interconceptional care, which includes an integrated program of case management, health education and promotion, breastfeeding support, behavioral health services, family planning and local health systems action plans, all of which are provided by a multidisciplinary team.

**Elizabeth Kushman**, Project Director for Maajtaag Mnobmaadzid Healthy Start and Teen Pregnancy Project for the Inter-tribal Council of Michigan presented an overview of how they operationalized their vision/model of interconceptional care, which includes expanding the scope of services provided by the case management team, as well as expanding the scope of community education and outreach.
Joyce Latura, MCH Manager for Mariposa Community Health Center in Arizona presented a the project they are implementing under a Healthy Start grant in a border community in Southern Arizona, highlighting their home-based and community-based education components, which are centered on a health worker model of care and active case management.

Dr. Shea Rutstein, Technical Director for ICF International, presented a multivariate cross-country analyses that looks at the effect of birth intervals on mortality and health. His presentation focused on (1) the effects of birth spacing on mortality and poor nutrition (underweight and stunting), (2) actual birth intervals and desired birth intervals, and (3) effects of avoiding short birth intervals on mortality. Some of the overall conclusions from his analyses show that (1) birth-to-pregnancy intervals of less than 36 months pose substantial mortality and nutritional risks for infants and children, (2) delaying conception two years or longer after a birth substantially decreases the risks compared to delays of less than two years, and (3) many mothers report the desire to have longer birth intervals.

Dr. Catharine McKaig, Team Leader for the Family Planning at MCHIP, gave a brief overview of MCHIP programs. She then highlighted the importance of FP during the first year postpartum and gave an overview of The Healthy Fertility Study, an integrated MCH and Family Planning program in rural Bangladesh, where a community-based maternal and neonatal health program is delivered through home visits by female community health workers. Conclusions and lessons learned were (1) it is feasible to integrate postpartum FP within a community-based MCH program, (2) the model used led to increased modern method FP use at 12 months postpartum (16% increase), (3) the promotion of the Lactational Amenorrhea Method (LAM) increased exclusive breastfeeding (25% higher at 6 months among LAM users compared to non-LAM users), and (4) there are no notable negative effects on the delivery of MNH services.

Note: Presentations available upon request - contact Leah Elliott lelliott@mchip.net
**Highlights from the Group Discussion**

The final portion of the meeting was set aside for group discussion in order to identify common experiences, challenges, and lessons learned, as well as to identify next steps, including the possibility of convening a larger informational exchange meeting.

**Discussion points:**

- After 20 years of the program, it is time for Healthy Start to re-evaluate its programs to ensure that approaches are state of the art. Best practices identified from preliminary evaluation include: outreach, case management, building a consortium of key community leaders and program participants, and health education.

- Health education is important for both the provider and community members. Healthy Start has found that many of the providers are competent, but there is a need to build consensus and standardize the many components of a successful program. These components include: standardizing data elements and collection, standardizing tools, and maximizing training and supervision tools in limited resource settings.

- US-based research is not always available and feasible. The group hoped that international research being done can be used to inform programmatic guidance domestically. The clearest example is research on hormonal contraceptive methods such as injectables.

- International guidance on FP distribution/administration often do not pertain to the US. For example, the provision of Injectable contraceptives by community health workers internationally.

- An area of focus identified by both domestic and international participants is the continued documentation of program successes. Programs often don’t have the time or resources to write up success stories.

**Common themes identified:**

- HRSA best practices that were identified as beneficial to share:
  - Importance of:
    - Identifying a core package/standardizing services
    - Identifying what works and can be scaled up
    - Identifying minimum needs for implementation
  - Holding a pre and interconceptional summit
  - Suggested linking in the Office of Global Health Affairs

- International best practices that were identified as beneficial to share:
  - FP commodity distribution at the community level
  - Global evidence on working with community health workers
  - Male involvement in MCH programming
Partnerships

- Shared challenges identified:
  - Referrals
  - Remuneration of community health workers
  - Funding and program management gaps
  - Taking programs to scale
  - Evaluation of programs/proof of concept
  - Stress in target population
  - Male involvement
  - Mobile Technology
  - Data use by community health workers

**Closing and Next Steps**

The overall objectives of the meeting were met. Participants were pleased with the opportunity to share experiences, learn from one another’s experiences and expertise, and discuss issues related to integrated MCH programming. They expressed appreciation for interagency collaboration, as well as expressed interest in continuing to build upon this collaboration through a continued working relationship.

**Next Steps**

- The Healthy Start All Grantee Meeting will take place on May 17 & 18. HRSA invited USAID and MCHIP to send representatives and will provide additional information.
  - Discussion will take place prior to the meeting on the possibility of adding on time for a side meeting to further today's discussions.
- A Community Health Worker Evidence Summit from international work will be taking place soon. USAID will send HRSA additional information.
- The Global Health Conference will take place in July in Washington DC. It is key venue for global health presentations – HRSA may find it valuable to attend.
- The group agreed they would like to have a larger meeting in the future. Some key common themes suggested for the focus of this meeting were:
  - Case Management and Outreach, Partnerships, Sustainability, and Evaluation.