Because children are dependent on their parents, families, caregivers and communities to thrive, grow and have their needs met, it is critically important to embrace and support the adults in children’s lives. We must embrace a two-generation approach that addresses multiple determinants of health – which include genetics, the physical environment, access to clinical care, health behaviors and social and economic factors.

Michigan offers several outstanding examples of successful interventions that have helped children and their families achieve positive health and development milestones, starting from birth. The common thread in each of these cases is the focus on relationship building. Research indicates that many Blacks have a tendency to view government, medical and professional interventions with distrust. The only way to overcome this distrust, which is rooted in historical travesties such as the Tuskegee experiment, is to create trusting, non-judgmental, caring and supportive relationships that will ultimately help to achieve positive outcomes.
IMPROVING HEALTH BEGINNING AT BIRTH
Consider the experience of a long-standing infant mortality prevention program in Detroit, The Infant Mortality Program, which is sponsored by St. John Providence health system, and which takes a holistic approach that addresses the determinants of health to improve outcomes for new mothers and their children. It started as a collaborative of several faith-based hospitals and has been in place for over 25 years. While it continues to serve high-risk women of all races from Detroit and surrounding communities, the majority of those served are Black women who are at twice the risk of preterm birth and infant death than women of other races. This program has served over 2,000 families through three primary components:

1) increasing access to health care during pregnancy and post-partum, for both mothers and infants
2) providing resources, supplies, parenting education and literacy support to parents, and
3) providing ongoing mentoring, coaching and support to parents, through staff and volunteers

This program, which has served as a model and best practice for many other programs, also provides group support, individual instruction and home visits by professionals and peers. The combination of these program components, in the context of a family hierarchy of needs, produces better outcomes for the participating women. Many women experience depression and high rates of stress, anger and anxiety by the time they enter the program. Yet out of their despair, so many rise to meet the needs of their children based on their desire for a better life, and the support the program provides.

Mothers, often in combination with other family members or friends who commit to being supportive of the mother in caring for the baby, are taught about nutrition, stages of growth and development and the importance of reading and talking to their children, as well as how to navigate the health care system while being encouraged to continue their own education. They receive support from peer counselors as well as referrals to obtain needed items. Because food insecurity is a major problem, resulting in poor nutritional status, the program connects parents with programs that provide food and other basic necessities. Through group prenatal visits, which are garnering a strong research and evidence base of success across the country, mothers are given guided opportunities to connect with other mothers who share their situations, resulting in interactions that normalize their conditions, reduce isolation and provide needed education in an open atmosphere.

The overall goal of the infant mortality reduction program goes beyond preventing infant deaths; indeed, it is to equip women to be effective parents and support them in making choices that will improve the health status and quality of life of their infants and children. The program reports six infant deaths among approximately 2400 program participants in the 25 year period of its operation which is a much lower infant mortality rate than for non-program participants. Additional program outcomes for the mothers include increased self-sufficiency, increased pursuit and achievement of education and training, and changes in their parenting behaviors to support the school readiness of their young children. Many have also chosen to volunteer as mentors for other women in the program.

Indeed, the most important aspect of this program is the mentoring and the relationships established between the participants, staff and mentors. One of the program’s social workers reports that she receives calls from program participants years after they have left the program, asking for advice or support or to report an important milestone such as graduation. This program can attest to the fact that when tending to mothers – and young mothers in particular – a successful approach must include the understanding that many of them need nurturing rather than blaming. Instead of a “you need to be fixed” program approach, they require and respond to the same thing as all of us, namely an atmosphere of acceptance, in which they can receive information and resources that allow them to develop a positive and achievable future vision for themselves and their families.

IMPROVING HEALTH THROUGH SCHOOL-BASED HEALTH CENTERS
Poor children are challenged to make the best of their early school years due to the presence of food insecurity, housing instability and difficult environmental circumstances that are so characteristic of poverty, and that lead to a number of poor health outcomes. The incidence of chronic health conditions such as asthma and lead poisoning are prevalent in poor communities. Preventative health measures such as immunizations may also be lacking. School health personnel report higher incidence of hypertension, diabetes, and obesity in Black school age children as young as 8 years old regardless of economic status.

One of the most successful and strengths-based models to address these and other health and development needs is the presence of school based health centers. The state of Michigan’s Department of Community Health and The School-Community Health Alliance of Michigan have documented the success of this model. State funding is available to hospital systems that provide services...
to children in schools that meet defined criteria, including eligibility of 70% of children for the free lunch program. At this writing, there are 23 school based health centers in the city of Detroit. They are typically located within the school building or on school grounds and staffing often includes a nurse or nurse practitioner, a mental health therapist, and a medical assistant. These health centers provide services, with parental consent, to address the physical, mental, cognitive and developmental needs of children in the school.

The presence of a school based health center significantly increases access to health care and results in reduced absenteeism. A study of elementary school-based health centers found a reduction in hospitalization and an increase in school attendance among inner-city school children with asthma. Because of their location and the relationships developed between students, staff and community partners, these centers also provide the best opportunity for children to receive preventive health services such as immunizations, eye exams and dental care.

In addition to basic medical and health care needs, the teams of professionals employed in school-based centers report significant mental health needs; children they serve are often depressed, anxious and fearful, and/or are experiencing unidentified or unresolved grief over a loss. On the positive side, however, a study of student users of health centers found that students who reported depression and past suicide attempts were significantly more willing to use the school-based clinics for counseling compared to other mental health treatment centers. Further, students who received mental health services had an 85% decline in school discipline referrals.

In addition to addressing critical mental health needs of their students, school-based centers, working with school faculty and administration, are also able to use their relationships with students to address other social determinants of health — including behaviors that students may be reluctant to reveal or discuss with parents and teachers. Indeed, schools in poor communities are adapting to meet the needs of students in efforts to help them stay focused — and, ultimately, stay in school. School programs provide breakfast, lunch and, in some cases, take-home food for dinner to address food insecurity. Some school centers have purchased washers and dryers, towels, soap and other personal hygiene items to address the lack of these resources at home and to help children feel better about themselves. A grief support program is often provided to students identified with unresolved grief issues that may be affecting their school performance. Nearly every center provides programming that addresses the need for healthy food and physical activity. “Kidsmile” is one such program, in which students are introduced to physical fitness, nutrition education and, crucially, are provided with opportunities to develop a vision for their lives through exposure to the wonders and diversity of the world, beyond the neighborhoods in which they live. Students enter events such as the Detroit Free Press Marathon; they receive prizes, new gym shoes, and running outfits as part of participation, and stay overnight in a downtown hotel in preparation for the event. Each of these programmatic elements may take on added importance for the children in foster care or who are living in homeless shelters.

For these children, as for all children, it has become increasingly important for school and school-based health centers to partner with other organizations in the community to address the needs of the students and their caregivers. Examples of these partnerships and collaborations abound across Michigan and include the following:

- **Partnerships that address the need for Neighborhood Patrols that provide a safe passage to and from school, especially in urban areas that have blight, and high incidences of crime.**
- **Partnerships that provide recreational activities, which are particularly important for poor children who live in areas where it is unsafe to play outside or where there are few, if any, parks or recreational facilities.**
- **Partnerships that provide onsite dental care for students to receive teeth cleaning and other preventive dental and oral health services.**

Each of these efforts can work together to provide the best possible opportunity for children to grow and be healthy in the midst of difficult circumstances; and as the school provides the base for these activities, they can become oases of hope, health and help.

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**37.2%** OF BLACK CHILDREN AGES 10 MONTHS TO 5 YEARS RECEIVED A SDBS DEVELOPMENTAL SCREENING IN THE PAST TWELVE MONTHS, COMPARED TO ONLY 22.9% OF WHITE CHILDREN.
CONCLUSION

Successful interventions that actually improve health outcomes for low-income children and their families address the social determinants of health across multiple generations, and involve communities and institutions as partners. For young children in particular, these interventions include, but are not limited to, the following relationship-based best practices and approaches:

- Programs that provide attention, support and education to mothers that begin prenatally, extend beyond the basic need for access to medical care, and last as long as needed.
- Policies that explicitly address and substantially fund the basic health and development needs of children and families in poverty, such as the provision of meals in school and summer lunch programs, as well as access to healthy food and adequate affordable housing in their communities.
- Programs and policies that support access to preventive and curative mental and behavioral health services, particularly through school-based health centers, to address problems such as substance abuse prevention, depression and grief.
- Programs that provide opportunities for after-school activities such as sports, scouting, and other engaging and interactive activities for children to learn how to work and play with others in different settings.
- Programs and policies that ensure children have safe passage to and from school.

Yet without changes in communities, systems, and norms, even successful interventions will have limited effect. In health care we often speak of doing a root cause analysis of problems or situations. The root of so many of the problems our communities face is poverty, and the related systems and policies that make it difficult for families and individuals to break out of it. The Institute of Medicine states that “It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”76 Any intervention to address challenges facing Black children must include interventions to eliminate disparities, and reduce or eliminate poverty and its impact on the determinants of health of the parents, caregivers and the community. As Dr. Marcella Wilson, the CEO of Matrix Human Services Agency in Detroit notes, “The most important lifelong gift we can give to our children is to provide the support their parents need to move out of poverty.”77

In the meantime, however, we need all adults to adopt a child friendly posture wherever and whenever they are in the presence of children. Seemingly small positive interactions can make a huge difference in the life of a child. When a child proudly brings her report card to the staff at the school-based health center every marking period, because she knows she will receive positive affirmations and support, it matters. When a student grows up and enters a health profession because he had a role model and mentor in the field, who showed him the value of making choices that include obtaining higher education, it matters. All adults must take responsibility to create and maintain a child friendly and safe environment where each and every child is valued, appreciated, affirmed and respected for his or her individuality – as well as his or her culture, identity and community. Children are in training to be adults, and like it or not, we are all role models for them. Our words and actions need to convey our belief in them and support them in their journey to create a vision for their future – a positive vision of what life can be, which will motivate them to continue to grow, learn, and make daily choices that will lead them to achieve their dreams.

BLACK CHILDREN FROM LOW-INCOME FAMILIES ARE MORE LIKELY TO BE INSURED THAN WHITE CHILDREN FROM LOW-INCOME FAMILIES AND BLACK CHILDREN WHO DO NOT COME FROM LOW-INCOME FAMILIES.78

In addition, less than half of Black parents felt they were receiving family-centered care, which focuses on physicians’ cultural sensitivity and parents’ involvement with the physician, compared to 80% of white parents who felt so.78

BLACK CHILDREN (33.7%) HAVE ACCESS TO A MEDICAL HOME, COMPARED TO 1 MILLION WHITE CHILDREN (68%).

OF BLACK CHILDREN UNDER AGE 6 HAVE HEALTH INSURANCE.

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