NEW APPROACHES TO COMPREHENSIVE PRENATAL CARE FOR MIGRANT WOMEN

by Kim Larson, R.N., M.P.H. and Elizabeth Watkins, DSc.

The University of North Carolina School of Public Health and Tri-County Community Health Center (TCCHC), a federally funded migrant health center, have been collaborating on a maternal and child health improvement project since 1984. The impetus for this project came from the findings of a 1983 study of the maternal and child health needs at this migrant health center by Dr. Elizabeth Watkins. Findings in that study identified two major problem areas: the high-risk status of migrant mothers and children, and fragmentation and low utilization of health and social resources by migrant farm families (Watkins, et al). Specifically, there were few prenatal and postpartum follow-up visits, lack of coordination of services between local and state maternal and child health programs and the migrant health center, and lack of standard protocols for maternal and child health programs within the center. This paper will discuss the interventions implemented in the first two years of a three-year demonstration project to improve maternal health status and pregnancy outcome.

Project staff consists of a public health nurse coordinator, public health nutritionist, nurse health educator, social worker, and computer operator. The Project Director, faculty from the School of Public Health, county health directors and consultants

---

This paper was presented at the 114th Annual Meeting of the American Public Health Association, October 1, 1986, Las Vegas, NV.

from the North Carolina Division of Health Services compose a steering committee to offer recommendations on directions and activities to achieve the Project objectives. The Project was planned jointly with the Administrator and Medical Director of the Center, and other key staff. Project staff work cooperatively with, TCCHC counterparts to develop protocols, health education materials, and strategies for improving the delivery of services.

Tri-County Community Health Center is located in rural south eastern North Carolina, 70 miles from the University in Chapel Hill, and serves three counties: Harnett, Johnston, and Sampson. Between 17,000 and 30,000 migrant farmworkers come to North Carolina annually from April through November to plant and harvest cucumbers, bell peppers, tobacco, sweet potatoes, and apples (in the western region). The Center is open 12 months a year to serve seasonal farmworkers who reside in North Carolina and the increasing number of migrant farmworkers who are "settling out".

In 1985 the ethnic composition of the maternal health population was 13% American White (primarily married to Hispanic men), 22% American Black, 55% Hispanic, and 10% Haitian. To work with a multiethnic population it was necessary for the project to employ bilingual staff, especially since few staff (no nurses) at the Center spoke Spanish. Dr. Watkins' earlier study revealed lack of documentation on a large percentage of the migrant women because of the lack of bilingual staff. At the outset Project staff provided a great deal of translation within the Center and with other agencies providing care to non-English speaking

migrants. The Center now employs two bilingual nurses, and two bilingual family practitioners.

Lack of available and reliable transportation remains the most significant barrier for migrant families in accessing health and social services. Transportation needs were assessed for each prenatal on the Project and arrangements were made with a variety of transportation services including: the Episcopal Migrant Ministries bus, the county Departments of Social Services, two TCCHC drivers, the TCCHC outreach program, the Migrant Headstart Center, and the MCH project staff. With this effort in coordination of transportation prenatal visits increased from 2.7 per prenatal to 5.5, and from 60% of the women receiving a 6-week postpartum exam to 83%.

Clearly, provision of transportation and translation services are not necessarily innovative interventions to comprehensive prenatal care. However, without these services few other creative interventions, that I will speak of now, would have been effective.

Protocol for case-finding of pregnant women has been developed to include the Center staff, outreach staff, Headstart staff, and county health department staff referring all pregnant migrant women to the MCH Project staff for follow-up. Physicians in Sampson County have requested that women living in Sampson county attend the prenatal clinic which they conduct at Sampson County Health Department in order to provide continuity of prenatal care with delivery. These women return to TCCHC for postpartum care and family planning services. In 1985, the

proportion of women who initiated prenatal care in the first trimester of their pregnancy (52%) improved as compared to 1982 (42%).

The migrant Headstart is a daycare center for migrant farmworker children ages 6 weeks to 5 years located 20 miles from the Center. Their buses transport the children from the camps to the school. Arrangements were made for the Headstart bus to transport prenatal patients as far as the school. The Center driver, outreach worker or MCH staff would bring them in to the Center.

The Project health educator developed protocol for prenatal and postpartum home visits to assess family needs. This responsibility was coordinated with a nurse outreach worker employed at the Center through the East Coast Migrant Health Project. All prenatal patients and women who delivered in North Carolina were visited at least once in their home. At this visit much more was revealed regarding family relationships and social stresses. The health educator also developed a birth-coaching service for the non-English speaking women who would deliver in North Carolina. The local hospitals depended on volunteers for translation and expressed their frustration at not being able to communicate with the women themselves. The birth-coaches were bilingual Project and outreach staff who were notified by the hospital when migrant women were admitted for delivery. This cooperative arrangement led to improved discharge planning for the migrant women which increased postpartum and newborn follow-up, as well as providing emotional support for women without family. The Project nutritionist designed wallet-sized cards for

the migrant women to give to hospital nurses indicating their desire to breastfeed, and made hospital visits to those women who requested assistance after delivery. The nutritionist also developed a series of bilingual cue cards for the obstetric nurses at the local hospitals to assist them with communication problems.

In conjunction with the Center's WIC Program, the Project and Center nutritionists have conducted tri-lingual classes on breast-feeding and counselled mothers on its advantages. As a result over 50% of the mothers delivered in the past year breastfed their newborn infants. Classes on childbirth preparation and family planning have also been implemented at the Center by Project and outreach staff.

A unique feature of this project is the training of lay health advisors in the migrant population to disseminate culturally appropriate preventive practices to other migrant families. The Project health educator is presenting a paper on the training program at this conference so I will not discuss this in detail today. Briefly, the curriculum covered five topics on women's health: health promotion (eg. PAP and breast exam), family planning, pregnancy and childbirth, nutrition, and community resources and family violence. The child health sessions included: child growth and development, childhood nutrition, childhood illnesses, safety and environment, community resources and family violence. The classes are given in three languages; English, Creole, and Spanish; thirty lay health advisors were recruited; ten in each class. The general theme in each session

is how to share the information with other families, and accessing appropriate resources.

One of the objectives of this project was to utilize and link resources of North Carolina and Florida Title V Maternal and Child Health agencies and the migrant health center to improve the delivery of health services. The Center is now utilizing the maternal health record system developed by the Division of Health Services. Since the record is used by county health departments and is familiar to the local physicians who provide delivery services to TCCHC patients, this is an important step in facilitating consistent and accurate documentation and achieving integration of services. Through coordination with the county health departments, funding for ultrasound examinations and non-stress tests are authorized for TCCHC patients. Migrant hospitalization funding provides coverage for delivery. However, these funds are depleted rapidly. The state Title V delivery funds also assist with hospital coverage of migrant deliveries. To address the issue of continuity of care a tool for monitoring weight gain during pregnancy and another for monitoring the growth of children were developed by the project nutritionist in collaboration with the Florida state and county nutritionists.

A comprehensive tracking system to retrieve pregnancy outcome data begins with an updated current and permanent address of each migrant woman. If a woman delivers out-of-state, pregnancy outcome is tracked through the use of the National Migrant Referral Project directory of migrant health centers by matching the address to the area center. Women were also given

self-addressed stamped postcards to inform staff of outcome; 20% returned the card. The project has received pregnancy outcome data on a total of 79% of the 1985 prenatal patients through these methods of tracking. There were 101 deliveries, including one set of twins, to the 128 women in 1985. There were 93 live births, including the set of twins, seven spontaneous abortions, and one therapeutic abortion. The Caesarean section rate was high for this population (15%) as was the low birthweight rate (13%). There were no stillbirths, neonatal deaths, or congenital anomalies. The predominate methods of family planning chosen following pregnancy were oral contraceptive agents (31%) and sterilization (29%).

Major obstacles which have delayed the project's progress have been in the recruitment and retention of the migrant health center staff. In the project's two years, the Center lost its prenatal nurse, health educator, and nutritionist - the latter two positions are currently vacant. This alone makes it difficult for the Center to carry on the project activities. Low salaries in migrant health centers do not generally attract qualified bilingual health professionals.

What have we learned from the prior years which can be applied in the upcpoming and final year of our project?

On the administrative level, the addition of a TCCHC board member on the Project's steering committee for ongoing support of the Project's goals and objectives. The TCCHC administrator and board President were involved in planning the Project, however during the Project's first year there was a change of administrators and board President. Incorporating the Project's

goals and objectives into the Center's annual health care plan would be another avenue to continue certain activities deemed important.

On the health care delivery level, bilingual public health professionals are essential for the success of health care programs for multiethnic populations. There are a variety of ways to recruit and retain staff: by offering job flexibility, having clearly defined job descriptions, and maintaining a working organizational structure are but a few. The Center's organizational structure changed three times in the Project's first year. The University of North Carolina School of Public Health can provide a wealth of expertise, including graduate students in Health Education, Public Health Nursing, and Nutrition, to supplement the delivery of services. There needs to be one person responsible at the Center for the coordination of students and program planning. The lay health advisor program would be feasible with this kind of University - Center relationship.

In summary, a comprehensive maternal health program includes open communication among a myriad of health and social service professionals and multifaceted intervention strategies. The MCH Project has demonstrated improvements in prenatal care visits, postpartum and newborn visits, earlier initiation of prenatal care, through coordination of local agencies working with migrant women, prenatal and postpartum home and hospital visits, development of trilingual health education materials, individual and group health education classes, and integration of state and

regional maternal and child health resources.

Special acknowledgement to:

Sampson County Health Department

North Carolina Department of Health and Human Services, Division of Maternal and Child Care