

**STATE MATERNAL AND CHILD HEALTH PROGRAMS  
TO ADDRESS THE HEALTH AND HEALTH CARE NEEDS OF WOMEN**

**FINAL REPORT**

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## EXECUTIVE SUMMARY

State Maternal and Children Health (MCH) Agencies and the Federal Maternal and Child Health Bureau (MCHB) have a long history of addressing the needs of children and mothers. Over the years, the importance of promoting health over the lifespan has been recognized and efforts at both the State and Federal level have been expanded to emphasize the importance of women's health and family health. The ways in which States are addressing the health and health care needs of women is the subject of this review. Official State MCH agency documents including 2005 Needs Assessments and 2008 Application/2006 Annual Reports from selected States were reviewed. The areas of women's health that States are addressing as exemplified by their Priority Needs statements are explored and specific State efforts to improve the health of women are highlighted. Finally, State Performance Measures for women's health are described along with implications for a possible National Performance Measure for women's health.

### **State Priority Needs Indicate a Commitment to Women's Health**

States frame Priority Needs to address the needs of women in the following ways:

Broad Health and Health Care Needs of MCH Populations Including Women - Forty-two (42) States and Jurisdictions have Priority Needs that address broad health or health care needs of MCH populations and that include women either implicitly or explicitly. An example of a broad Priority Needs is North Carolina's Priority Need to increase access to care for women, children, and families.

Health and Health Care Needs of Pregnant Women - Almost all States and Jurisdictions (n=50) have Priority Needs statements that address the needs of pregnant women. Priority Needs for pregnant women emphasize different aspects of pregnancy health including improving access to prenatal care and other health care services such as dental care during pregnancy, improving birth outcomes, and improving the health of pregnant women.

Specific Health and Health Care Needs of Women of Childbearing Age - Preconceptional and interconceptional health programs strive to improve the health of women who intend to be pregnant by addressing their health needs before or between pregnancies. MCH agencies have embraced this widened mandate and have developed policies and programs to provide preconceptional and interconceptional care, frequently targeting women who receive care in the public health system. States also target women regardless of childbearing status or intent for programs to reduce unhealthy behaviors or other health risks including programs to reduce smoking and alcohol use and programs to promote healthy nutrition and exercise and reduce obesity. Other MCH areas of focus for women include mental health, reduction of domestic violence and cancer screening.

## **Selected States with a Priority Need for Preconceptional and Interconceptional Health**

Examples from ten (10) States profiled in this report demonstrate the breadth of programmatic activity that is being undertaken by State MCH initiatives for women's health. The importance that States give to these goals is evident not only in the programs they create, but also in the organizational changes made in some States that focus staff and resources on women's health. States are using comprehensive data analysis such as the Perinatal Periods of Risk system to document a need for improvement in women's health. Raising awareness of the importance of women's health not just for women themselves but for their children is a focus of many State efforts and States are developing and disseminating educational materials to multiple stakeholders to emphasize the importance of preconceptional and interconceptional health. State MCH agencies are working not only at the State level, but providing resources at the local level and partnering with many other private and public entities to improve women's health.

The States whose preconceptional and interconceptional programs are described in the report were among those with both a Priority Need to provide these services and sufficient detail in their Needs Assessment and Annual Report to describe their programs. The States and their Priority Need included:

- California - Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.
- Colorado - Improve preconceptual health among women.
- Connecticut - Increase access to pre-conception education and parenting.
- Florida - Improve preconception and interconception health and well being.
- Georgia - Promote preconceptional health.
- Kansas - Increase early and comprehensive health care before, during, and after pregnancy.
- Kentucky - Percentage of women of childbearing age who receive preconceptual care in the local health department.
- Louisiana - Promote pre-conceptional and inter-conceptional health care including family planning and folic acid education
- New Mexico - Improve indicators of health in the preconceptional and perinatal periods, including but not limited to smoking, alcohol, folic acid use, family violence, intention of pregnancy, access to and use of health care.
- Wyoming - Improve women's pre-conception and inter-conception health.

## Performance Measures for Women's Health

Almost all States (an average of 52) had a State Performance Measure (SPM) for women's health either currently or as part of their 2005 or 2000 Needs Assessment. SPMs in the following categories were the most commonly reported:

Reproductive health / family planning	39 States
Legal and illegal substance use	37 States
Birth defects / genetics	24 States
Nutrition / obesity	20 States
Mental health / domestic violence	19 States
Sexually transmitted diseases	14 States

A National Performance Measure for women's health, like all national measures, should meet several criteria. It should address a problem in women's health that is national in scope, that can be addressed by MCH programs or their partner agencies, and that can be measured. The following are examples of National Performance Measures for women's health that might be considered.

- Increase the percent of women with a primary care provider.
- Increase the percent of women who report that they are in good health.
- Increase the percent of women with a dental care provider.
- Decrease the percent of women with bad mental health days.
- Increase the percent of women who report that their pregnancy was planned.
- Decrease the percent of women who smoke.
- Decrease the percent of women who binge drink.
- Decrease the percent of women who are overweight or who are obese.
- Increase the percent of women who eat five servings of fruits or vegetables each day.
- Decrease the percent of women who report domestic violence.
- Reduce the number of cases of HIV per 100,000 women.
- Increase the percent of women who had a Pap smear within the past two years.

Recognition of the need for longitudinal data on the health of populations and investment in these data systems has resulted in the availability of data from on-going national surveys as well as from vital records. National surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk

Assessment Monitoring System (PRAMS) would enable measurement of success in meeting a National Performance Measure for women's health for the majority of States that participate in these surveys.

## Summary

State MCH agencies have indicated a commitment to women's health as evidenced by their Priority Needs. States include the needs of women in their broad goals to improve the health of all the populations they serve. In addition, they include the needs of women in their "traditional" services for pregnant women and have sought to expand their ability to influence the health of pregnant women by addressing not only health care needs related to their pregnancy but other aspects of their health such as dental health, mental health and health behaviors.

State MCH agencies focus specifically on the health of women in programs that are designed to improve women's health in the preconceptional period and after they give birth and some MCH programs extend specifically to all women regardless of reproductive status or pregnancy intent. Examples from the ten States profiled in this report demonstrate the breadth of programmatic activity that is being undertaken by State MCH activities for women's health. The importance that States give to these goals is evident not only in the programs they create, but also in the organizational changes made in some States that focus staff and resources on women's health. States are developing and disseminating educational materials to multiple stakeholders to emphasize the importance of preconceptional and interconceptional health and they are working not only at the State level, but providing resources at the local level and partnering with many other private and public entities to improve women's health.

Most State MCH agencies include a State Performance Measure for women's health that cover a variety of women's health issues and are not limited to reproductive health. Reduction of legal and illegal substance use by women, particularly tobacco use, remains a major focus for State MCH programs and one for which they hold themselves accountable in their State Performance Measures. Reduction of obesity and screening for and treatment of mental health problems including post-partum depression are two areas of increasing focus for State MCH agencies and States are assessing their progress in these areas also with a State Performance Measure. In order to measure success of their women's health programs, States are informing their programmatic decisions themselves with data from national surveys with State-level estimates, e.g., BRFSS and PRAMS, and also investing resources in the development of local data systems to document their impact on women's health in their State.

The commitment to women's health demonstrated by State MCH agencies supports the development of a National Performance Measure for women's health. The emphasis on women's health that is apparent in State Priority Needs

and also in State Performance Measures supports the development of a National Priority Need for women's health to complement existing NPMs that address the needs of other populations served by State MCH agencies. Longitudinal data collected by national surveys such as BRFSS and PRAMS are available for many potential women's health National Performance Measures and participation in these national surveys by individual States is high. Successful implementation of a National Performance Measure for women's health would be enhanced by discussions between the Maternal and Child Health Bureau and its State partners and by agreement on the value of a women's health NPM. Agreement on the focus of the measure, e.g., general health or a specific health problem or health behavior, and the population whose needs are being addressed by programs to address the health need or behavior, i.e., all women or pregnant women, is also important.

## **STATE MATERNAL AND CHILD HEALTH PROGRAMS TO ADDRESS THE HEALTH AND HEALTH CARE NEEDS OF WOMEN**

### **INTRODUCTION**

State Maternal and Children Health (MCH) Agencies and the Federal Maternal and Child Health Bureau (MCHB) have a long history of addressing the needs of children and mothers. Over the years, the importance of promoting health over the lifespan has been recognized and efforts at both the State and Federal level have been expanded to emphasize the importance of women's health and family health. Similarly, it is no longer enough to address the health of women only when they are pregnant. Women need to be healthy before they become pregnant and after they give birth. Indeed, women's health is important regardless of reproductive health status and this need includes those who may never have children and those whose childbearing days are past.

Preconceptional health was introduced as a health care focus many years ago and in the ensuing years research has supported the importance of beginning a pregnancy in the healthiest state possible. Programs to promote nutrition (including folic acid supplementation) and healthy weight, to address needs for basic health care including dental care, and to reduce lifestyle factors that impact women and their babies are now part of the MCH armamentarium. State MCH agencies recognize the importance of healthy mothers and many have instituted programs and set goals to improve preconceptional and interconceptional health.

Preconceptional health and interconceptional health by their very definitions put an emphasis on the health of women who will become pregnant and on those who are between pregnancies. Many use these terms, however, as a proxy for women's health and include all women of childbearing age and sometimes all women as their target population for their programs and activities. This report focuses on women's health in the broadest sense and includes review of State priorities for all women.

The ways in which States are addressing the health and health care needs of women is the subject of this review. Official State MCH agency documents including 2005 Needs Assessments and 2008 Application/2006 Annual Reports from selected States were reviewed.

The report consists of three sections. The first section includes a general review of the areas of women's health that States are addressing as exemplified by their Priority Needs statements. The second section highlights specific State efforts to improve the health of women. The third section examines State Performance Measures for women's health and discusses a possible National Performance Measure. As in previous reports on State Priority Needs prepared by the Sheps Center for MCHB, review of "States" includes all 59 States and Jurisdictions.

The programs of State MCH agencies are complex and address many needs of multiple populations. Priority Needs developed by the States as part of their most recent MCH needs assessment process (2005) have already been compiled and classified by population and topic by the Child Health staff at the Sheps Center in previous reports to the Bureau. For this report, a subset of those needs that were considered to address women's health was explored in more detail.

Priority Needs statements are important indicators of the areas that States see as the major problems of the populations they serve. Priority Need statements serve to guide State efforts over 5-year performance periods. State Performance Measures are another indicator of the importance States place on specific issues. These performance measures provide a quantitative measure that serves as one way by which States can measure success in addressing needs of the MCH population. By reviewing Priority Needs and the Performance Measures associated with them, we get a picture of the importance of women's health for State MCH agencies.

## **SECTION I: STATE PRIORITY NEEDS THAT INDICATE A COMMITMENT TO WOMEN'S HEALTH**

Every five years, each State specifies seven to ten Priority Needs as part of their needs assessment process. Although required to list no more than ten needs, States may include more in their plans for the year. As a result of the 2005 needs assessment, the 59 States and Jurisdictions listed a total of 559 Priority Needs. Of those, nearly half (N=266) could be classified as addressing the health and health care needs of women, from the most broadly stated, e.g., "ensure access to care for all MCH populations" to the very specifically stated, e.g., "improve receipt of mammography screening." States frame their Priority Needs to address the needs of women in the following ways:

- A. Broad Health and Health Care Needs of MCH Populations Including Women***
- B. Health and Health Care Needs of Pregnant Women***
- C. Specific Health and Health Care Needs of Women of Childbearing Age or All Women***

These categories of State Priority Needs are described in more detail. Priority Needs statements from individual States provide examples of how a State describes its problems and its program goals and how women are included.

## ***A. Broad Health and Health Care Needs of MCH Populations Including Women***

Forty-two (42) States and Jurisdictions have Priority Needs that address broad health or health care needs of MCH populations and that include women either implicitly or explicitly.

Some States as part of their overall philosophy state their needs very broadly in order to be comprehensive in their specification or to demonstrate large overarching goals for their programs. Other States specifically include women in their broad Priority Needs statements. Examples of the former (WA) and latter (NC and PR) include:

**Washington** - “Sexual health and sexual responsibility”, “Lifestyles free of substance use and addiction” and “Access to preventive and treatment services.”

**North Carolina** – “Increase access to care for women, children, and families.”

**Puerto Rico** – “To reduce barriers to comprehensive care and quality services for the population of women, children, adolescents, and children with special health care needs.”

## ***B. Health and Health Care Needs of Pregnant Women***

Almost all States and Jurisdictions (n=50) have Priority Needs statements that address the needs of pregnant women. Priority Needs for pregnant women emphasize different aspects of pregnancy health as illustrated below:

1. Priority needs to improve access to prenatal care (PNC) and other health care services. Examples include:

**Virginia** – “Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.”

**Indiana** – “To reduce barriers to access to health care, mental health care, and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women, and families.”

2. Priority Needs to improve birth outcomes, which often involve addressing the health of the mother. Examples include:

**Guam** – “To decrease infant mortality and morbidity, preterm births and low birth weight.”

3. Priority Needs to improve the health of pregnant women.

Health care provided during the course of a woman's pregnancy may be critical to her long-term health as this may be the only time that women who have limited contact with the health care system have access to health care services. In addition to enabling access to primary care, dental care, and mental health care, many State MCH programs promote healthy lifestyle choices, particularly abstinence from smoking and other legal and illegal substances. Addressing these lifestyle factors not only addresses the health of the baby and the pregnant woman, but also has the potential to help women make long-term behavior changes that will benefit their health over their lifetime. The use of legal and illegal substances including tobacco and alcohol in pregnancy is one health behavior addressed by 27 States in their Priority Needs. Examples of Priority Needs to address the substance use and abuse needs of pregnant women include:

**Hawaii** – “Increase abstinence from smoking during pregnancy.”  
“Increase abstinence from alcohol use during pregnancy.”

**New York** – “To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women”

**Oregon** – “Reduce low birthweight and improve the health of women and their newborns by increasing the percent of smoking pregnant women who quit smoking during pregnancy and continued quit after pregnancy.”

A second important lifestyle consideration is healthy weight for pregnant women and this area is another focus of State MCH Priority Needs, for example:

**Utah** – “To reduce proportion of women of childbearing ages, pregnant women and children and youth with BMIs in the underweight, overweight and obese categories.”

### ***C. Specific Health and Health Care Needs of Women of Childbearing Age or All Women***

By the most stringent definition, preconceptional and interconceptional health programs strive to improve the health of women who intend to be pregnant by addressing their health needs before or between pregnancies. MCH agencies have embraced this widened mandate and have developed policies and programs to provide preconceptional and interconceptional care, frequently targeting women who receive care in the public health system. The previous Sheps Center review of Priority Needs found that the number of States with a Priority Need to address preconceptional and/or interconceptional health for women increased four-fold (3 vs 13) from 2000 to 2005.

Some programs to improve women's health may fall under the rubric of pre- and interconceptional health even though they are directed at all women regardless of their reproductive status and though they may be provided outside of the context of prenatal and perinatal services. Broadly stated Priority Needs to address pre- and interconceptional health include:

**New Mexico** – “Improve indicators of health in the preconceptional and perinatal periods, including but not limited to smoking, alcohol, folic acid use, family violence, intention of pregnancy, access to and use of health care.”

**Wyoming** - Improve women's pre-conception and inter-conception health.

Finally, States specifically target women for programs to reduce unhealthy behaviors or other health risks and have stated their goals for women regardless of childbearing status. Among the lifestyle choices and other health and health care needs that are the focus of Priority Needs for women's health are: a) tobacco, alcohol, and other substance use [6 States]; b) healthy weight, nutrition and exercise [9 States]; c) mental health [6 States]; d) domestic violence [9 States], and e) cancer screening [2 States]. It should be kept in mind that these State tallies represent only those States that specifically mention women in their priority needs and do not include States with broad program goals to address these problems in all of the populations they serve.

Examples of these State Priority Needs for all women include:

**Missouri** – “Prevent and reduce smoking among adolescents and women.”

**North Dakota** – “To increase physical activity and healthy weight among women.”

**Utah** – “To reduce depression and mental health issues for women, especially before, during and after pregnancy, and in children and youth.”

**California** – “Decrease unintentional and intentional injuries and violence, including family and intimate partner violence.”

**Marshall Islands** – “To increase access to preventive services for women who are at risk for cancer.”

## **SECTION II: FOCUS ON SELECTED STATES WITH A PRIORITY NEED TO ADDRESS PRECONCEPTIONAL AND INTERCONCEPTIONAL HEALTH**

The second section of this report examines in more detail selected States with Priority Needs specifically targeting women. Most Priority Needs were stated in terms of pre- and/or interconceptional health but many goals are broad and can have an impact on women regardless of their pregnancy intent.

Ten (10) States were selected for inclusion in this section. The ten States chosen were among those with 2005 Priority Needs to address pre- and interconceptional health and whose Needs Assessments and Annual Reports included sufficient detail to describe their programs. States reviewed include California, Colorado, Connecticut, Florida, Georgia, Kansas, Kentucky, Louisiana, New Mexico, and Wyoming.

Each State's Needs Assessment document for 2005 and their 2008 Application/2006 Annual Report were reviewed to answer the following questions. These questions served as a guide only; States were not asked these questions on their annual report/application form.

- a). What information or concern identified as part of the Needs Assessment led to the specification of the State's Priority Need for women's health?
- b). What measures have States developed to gauge success in meeting their Priority Need?
- c). What activities and/or programs have been developed to address the needs of women identified in this Priority Need?

This review is intended to give a brief overview of activities in each State and is in no case an exhaustive review of the many and complex interconnected initiatives undertaken on behalf of women and children by each State MCH agency.

## ***Focus on CALIFORNIA***

**Priority Need:** “Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.”

In their 2005 Needs Assessment, California examined infant outcome data using the Perinatal Periods of Risk (PPOR) system and determined maternal health to be a major contributor to infant mortality. The 2005 Priority Need to enhance preconception care replaced a 2000 Priority Need to eliminate disparities in infant outcomes and shifted the focus from the outcome to the cause while recognizing that disparities exist in multiple measures of maternal and child health and should be considered as part of all Priority Needs.

California has linked the following State and National Performance Measures to their Priority Need to enhance preconception care:

- State Performance Measure 6: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.
- National Performance Measure 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition[s] mandated by their State-sponsored newborn screening programs
- National Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy
- National Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
- National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

California works with multiple partners to improve preconception care. The Preconception Care Council of California (PCCC) under the leadership of the Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) and in collaboration with the California March of Dimes and other stakeholders was charged with developing a comprehensive plan to promote preconception care statewide. Preconception care informational materials were developed through the California Preconception Care Initiative (CPCI) and distributed to primary care programs for women as well as to family planning and pregnancy care services. MCAH/OFP also works with local agencies, for example, Women’s Healthy Weight Collaboratives in Los Angeles and Sonoma County. In addition, the Los Angeles Collaborative is evaluating the success of various models of preconception care. Preconception information has been added to

maternal interviews undertaken by the Fetal Infant Mortality Review (FIMR) Program in Contra Costa County as part of their case management and family support services.

California played a national role in the promotion of preconception care by leading the preconception care plenary session at the Association of Maternal and Child Health Programs 2007 national meeting and hosting with the CDC the National Summit on Preconception Care the same year.

## ***Focus on COLORADO***

**Priority Need:** “Improve preconceptional health among women.”

Many Priority Needs identified in Colorado’s 2005 needs assessment address the need for primary and preventive care for the MCH population. Preconceptional health is one of their ten focus areas for activities in the 2005-2010 period. The Women’s Health Unit is one of six units of the Colorado Center for Healthy Families and Communities.

Colorado has identified the following Performance Measure for their Priority Need to improve preconceptional health:

- State Performance Measure 6: Percent of mothers smoking during the three months before pregnancy.

A 2000 report released by the Women’s Health Unit linked inadequate weight gain in pregnancy to Colorado’s low birth weight rate. A statewide campaign to promote healthy weight during pregnancy was launched and later expanded to include information regarding smoking cessation. Efforts to reduce smoking have been augmented by Colorado’s selection as a participant in the Action Learning Lab: Tobacco Prevention and Cessation for Women of Reproductive Age. This multi-agency initiative will develop an action plan to “...increase collaboration and comprehensive implementation. Through training and presentations...(to) educate health care providers and provide smoking cessation materials at no charge.”

The need for preconception planning was emphasized in a presentation as part of a Learning Community on First Trimester Care. The Learning Communities Forum will continue to explore evidence-based approaches to improvement in preconception care.

## ***Focus on CONNECTICUT***

**Priority Need:** “Increase access to pre-conception education and parenting.”

Connecticut’s 2005 Priority Need to increase access to pre-conception education and parenting was a newly stated need in 2005 although Connecticut noted that most of their 2005 Priority Needs were similar to those identified in 2000. The most comparable need in 2000 was much more broadly stated and indicated the need to “improve access to and quality of care for women and children.” The Connecticut Needs Assessment acknowledged disparities in key health indicators that are linked to poverty and racism but also linked to a lack of preconception and parenting education. Thus, this Priority Need for preconception services focuses primarily on women in their roles as mothers and includes the need to reduce unintended pregnancies and to provide education to enable women to have healthy babies and to be good parents.

Connecticut’s State Performance Measure to assess success in preconception and parenting education:

- State Performance Measure 6: Percent of infants born to women under 20 years of age receiving prenatal care in the first trimester.

Among the activities identified in Connecticut’s 2005 Needs Assessment to address this Priority Need were pre-conception and parent education programs including educational materials and curricula to promote healthy sexual behavior as well as proper health seeking behavior with a focus on teens and young women. Another component was training of providers to encourage them to provide pre-conception counseling. In addition, a Region I MCH workshop was planned to better understand the Life Course approach, particularly in terms of implementation in MCH activities. Connecticut’s Annual Report for 2006 also describes collaboration with the Hartford Health Department on their technical assistance grant to address preconception care. An action plan was to be developed and a summit meeting held. In addition, a new program for case management services for pregnant women and teens was to focus on early entry into prenatal care and on interconception care.

## ***Focus on FLORIDA***

**Priority Need:** “Improve preconception and interconception health and well being.”

As a result of their 2005 Needs Assessment, Florida shifted its focus from addressing birth outcomes to addressing the factors that contribute to poor outcomes. An overarching priority to improve preconception and interconception health and well-being replaced the more narrowly focused 2000 priority to reduce the rate of maternal infections. Data considered during the 2005 needs assessment process supported the need for a lifespan approach to women’s health. Florida examined five years of infant and fetal death data using the PPOR method and found that among the four components of perinatal risk the highest death rate was in the maternal health category and that rate had not changed significantly over the five years. These data, along with other data indicating a need for more attention to women’s health, e.g., increasing rates of Chlamydia infection, and Healthy Start data indicating a lack of services for women, led to consensus in Florida to make preconceptional and interconceptional health a Priority Need for their 2005-2010 plan.

National and Florida State Performance Measures linked to goals to improve pre- and interconception health include:

- National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- State Performance Measure 3: The percentage of women reporting tobacco use during pregnancy.
- State Performance Measure 8: Excess feto-infant mortality attributed to the maternal health/prematurity category in the PPOR statewide analysis.

Organizational changes in Florida have supported women’s health. An Office of Women’s Health Strategy was created, and activities of the Office continue although with limited State budget support. The Family Planning Program was merged with the Office of Maternal and Child Health to form the Infant, Maternal, and Reproductive Health Unit (IMRH).

The first Governor’s Conference on Women’s Health was held in 2006 followed by a second conference the next year. Florida was one of three recipients of an Integrating Comprehensive Women’s Health into State Programs grant from the Health Resources and Services Administration (HRSA.) The Florida Vitagrant project provides funds for education about the importance of folic acid for women of reproductive age and provides the folic acid supplements. Pre- and interconception health guidelines were developed and disseminated to local health departments, family planning, and Healthy Start staff. IMRH staff also assists with implementation of guidelines.

## **Focus on GEORGIA**

**Priority Need:** “Promote preconceptional health.”

The Georgia Department of Health participated with other Georgia agencies in the development of the 2004 report entitled *Maternal and Child Health in Georgia Birth Through Age 5*. This report includes multiple recommendations regarding preconceptional health in a section on Pre-pregnancy Health and Health Promotion. The nine recommendations provide a comprehensive plan that addresses both access to care and education for women and providers, including attention to specific health problems and lifestyle factors. In its official list of Priority Needs, developed as part of the 2005 Needs Assessment process, Georgia included a need to promote preconceptional health.

Georgia Performance Measures and other indicators that will be used to gauge success in addressing pre- and interconception health include:

- State Performance Measure 5: Percent of women of reproductive age who consume at least 400 mcg of folic acid daily.
- Health Status Indicator 5b: Rate per 1,000 women aged 20-44 with reported case of Chlamydia
- Several Healthy People 2010 Objectives including intendedness of pregnancy, interpregnancy interval, male involvement in family planning, use of folic acid, reduction of congenital syphilis and other maternal sexually transmitted diseases.

The Women’s Health team is one of four population teams in the Programs and Services Section of the Family Health Branch (FHB) in the Georgia Department of Human Resources. One of the goals of the team is “...to create public awareness of the importance of overall good health of the women in the achievement of good birth outcomes.” An OB/GYN Liaison provides a link between the FHB and its services to the private OB/GYN community. Georgia implemented an assessment of private sector OB-GYN knowledge of the availability of public health services and information about various services was highlighted in the Georgia Obstetrical and Gynecological Society (GOGS) newsletter and disseminated at GOGS educational seminars and conferences. OB-GYN residents learn about public health programs through presentations by FHB staff at Grand Rounds. Finally, the Chronic Disease Branch and GOGS cosponsored an education brochure about the benefits of smoking cessation in pregnancy.

A statewide “Improving Birth Outcomes – Shifting the Paradigm” symposium was held to focus on the importance of comprehensive women’s health services. The symposium included an overview of the Centers for Disease Control and

Prevention preconception guidelines. A Preconception Health Toolkit will be provided to private and public providers including family physicians.

Another example of programs to support women's health is the partnership with the FHB Nutrition Branch, the Georgia Folic Acid Coalition, and Emory University to implement a folic acid supplementation program. The program was piloted in three local agencies, further implemented in family planning clinics and at Grady Hospital, and, at the time of the 2008 Block Grant application, under review for continuation with increased focus on the African-American community. The program includes education for women and providers including a media campaign, distribution of folic acid supplements, and follow-up and evaluation of the effectiveness of the program. In addition, Nutrition Branch initiatives for 2007 included planning and preliminary implementation of the preconception health and care initiative.

## ***Focus on KANSAS***

**Priority Need:** “Increase early and comprehensive health care before, during, and after pregnancy.”

Kansas identified a need for comprehensive health care for women in their 2005 Needs Assessment. Previous Priority Needs had focused on access to primary care for vulnerable populations and access to all care for children with special health care needs. Analysis of data from Kansas using the PPOR system presented as part of the 2005 needs assessment process indicated that strategies targeted to improving the health of women before, during and after pregnancy were those that are most likely to improve perinatal outcomes. Thus, Kansas identified improvement in access to care as a strategy likely to have a positive impact on the health of women and their children and one that is within the influence of the MCH system.

Kansas has linked the following State and National Measures to their Priority Need to address the health of women:

- State Performance Measure 1: The percent of women in their reproductive years with public or private health insurance coverage.
- National Performance Measure 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
- National Performance Measure 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
- National Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy.
- National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- National Outcome Measure 1: The infant mortality rate per 1,000 live births.
- National Outcome Measure 2: The ratio of the black infant mortality rate to the white infant mortality rate.
- National Outcome Measure 3: The neonatal mortality rate per 1,000 live births.

Kansas is addressing the need to improve access to care for women at the State level, at the local health agency level, and in partnership with other entities whose mission includes improving the health of women of childbearing age and

their children, e.g., private obstetrician/gynecologists, the Kansas Perinatal Council, etc. The Zero to Age 21: Information Promoting Success (ZIPS) newsletter serves as a vehicle for disseminating information to partners on best practices to improve preconceptional health as well as program information. Examples of specific women's health focus include efforts to obtain resources for assistance in reducing tobacco use among preconceptional women and promoting optimal health in the interconceptional period. The Governor's Public Health Conference of 2007 included an MCH focus and featured preconceptional health.

## ***Focus on KENTUCKY***

**Priority Need:** “Percentage of women of childbearing age who receive preconceptual care in the local health department.”

Recommendations from the Kentucky 2004 Work Group Assuring Maternal and Child Health were among those considered by Kentucky in their 2005 Needs Assessment process. Work group recommendations included multiple strategies to improve preconceptional and prenatal health. Kentucky’s ten Priority Needs that resulted from the 2005 Needs Assessment included a need to improve preconceptional health.

Kentucky specified the following State Performance Measure to help them meet their preconceptional health care goals:

- State Performance Measure 7: Increase the percent of women of childbearing age that present to a local health department that receive a preconceptual service.

A commitment to women’s health in Kentucky is evidenced by organizational changes that created a Division of Women’s Physical and Mental Health (previously the Women’s Health Section) incorporating in this new Division other women’s services that include not only services related to childbearing but services that apply to all women such as breast and cervical cancer screening.

The goal of Kentucky’s preconceptional care initiative is to improve birth outcomes by improving the health of the mother. Using CDC guidelines for preconception care, Kentucky began by providing counseling to Family Planning clients. They recognize, however, the need for ongoing attention to health for women and are working to develop interdepartmental relationships that will assure that discussions and counseling about pre- and interconceptional health, if appropriate, are held whenever women receive care through the Kentucky Department for Public Health.

## ***Focus on LOUISIANA***

**Priority Need:** “Promote pre-conceptual and inter-conceptual health care including family planning and folic acid education.”

In their 2005 Needs Assessment, Louisiana added a Priority Need to promote pre- and interconceptional health.

State and National Performance Measures linked to Louisiana’s Priority Need to promote pre- and interconceptional care include:

- State Performance Measure 2: Percent of women in need of family planning services who have received such services.
- National Performance Measure 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Louisiana is promoting interconceptional care as part of their Family Planning program. In addition to postpartum health services, Family Planning staff can address mental health issues and social health issues. Pre-conception counseling is one topic that was slated to be offered for Family Planning personnel by the Title X Region VI Training Center. At the local level, the Baton Rouge Infant Mortality Review Initiative offers a program entitled “Healthy Bodies, Healthy Living – Throughout Life.” Topics covered include preconception health.

## ***Focus on NEW MEXICO***

**Priority Need:** “Improve indicators of health in the preconceptional and perinatal periods, including but not limited to smoking, alcohol, folic acid use, family violence, intention of pregnancy, access to and use of health care.”

New Mexico examined preconception health in depth in their 2005 Needs Assessment, starting with the assumption that optimal pre- and interconception health is essential for healthy mothers and babies. Using Pregnancy Risk Assessment Monitoring System (PRAMS) data, they developed a Healthy Preconception Index for New Mexico that found that less than 15% of new mothers in New Mexico exhibited the lifestyle choices and health status, e.g., abstinence from alcohol and tobacco, use of prenatal vitamins, etc., that are associated with healthy pregnancies. In their determination of their Priority Needs for the 2005-2010 period, New Mexico focused on three broad areas: healthy families, births to healthy families, and reduction of violence in families. Their Priority Need to improve preconceptional health ties to all three goals.

New Mexico developed the following State Performance Measure to help them meet their preconceptional health care goals:

- State Performance Measure 5: Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index.

New Mexico’s Family Health Bureau (FHB) is providing marketing and other educational materials to care providers for pregnant women and users of family planning programs. A preconception education program entitled *Life Long Happiness* emphasizes healthy behaviors including avoidance of tobacco and alcohol and improvements in diet and exercise. Other programs support New Mexico’s efforts to improve the indicators included in the NM preconception health index. Violence, Alcohol, Substance Abuse, Tobacco Use (VAST), WIC, and Families FIRST are all programs that address some aspect of the index including healthy behaviors before and during pregnancy, e.g., use of alcohol and tobacco, healthy weight, use of multivitamins, freedom from domestic abuse, and access to care through health insurance.

## ***Focus on WYOMING***

**Priority Need:** “Improve women’s pre-conception and inter-conception health.”

In their 2005 Needs Assessment, Wyoming’s Maternal and Family Health (MFH) Section conducted an extensive review and analysis of data regarding the health of the MCH population and sought input from many groups. Their deliberations resulted in a new Priority Need for 2005 to improve women’s preconceptional and interconceptional health.

Wyoming will use information obtained from their Women’s Health Assessment to guide efforts to improve two Performance Measures:

- State Performance Measure 4: Percent of infants born to women who smoke during pregnancy.
- National Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy.

The Office of Women’s Health serves as a “central point of contact” for women’s health issues. As part of MFH’s strategic plan for system development in support of the populations they serve, Wyoming MFH worked with many collaborators to design and implement a Women’s Health Needs Assessment. At the time of the 2008 Title V Block grant application (2006 Annual Report), analysis of data from the assessment was being conducted. Data from this study will help identify the health and health care needs of women and identify gaps in the system to address these needs. Results will be used to plan policies and programs to address women’s health and health care needs. Among the needs already identified is a need for smoking cessation services.

## **SECTION III: PERFORMANCE MEASURES FOR WOMEN'S HEALTH**

### **A. BACKGROUND**

MCH Title V Block Grantees develop State Performance Measures (SPM) to track their progress in addressing problems identified for the populations they serve. These State measures supplement the National Performance Measures (NPM) that address broad MCH concerns and that are required of all MCH Title V grantees. Details regarding State Performance Measures are available on the Title V Information System (TVIS) website and include measures for the current application year, from the 2005 Needs Assessment, and from the 2000 Needs Assessment.

Specification of a National Performance Measure for women's health is being considered. In order to explore what would be valuable as a NPM for women's health, it is informative to look at what States have already identified as performance measures to assess their programs for women.

### **B. REVIEW OF CURRENT AND PAST STATE PERFORMANCE MEASURES FOR WOMEN'S HEALTH**

#### **Process**

Current or past SPMs for women's health were explored by examining all SPMs listed on the TVIS website from the three reporting periods listed above and tallying SPMs addressing women's health. Particular emphasis was placed on SPMs that would be appropriate for all States. Decision rules guided this review and only SPMs meeting specific criteria were considered.

The following guidelines were used to select SPMs for women's health for more detailed review:

- SPMs that focused on access to care or outcomes for individual women were included, but those that addressed specific State systems to improve women's health were not. For example, an SPM to implement a training process in local Health Departments for preconception care might not be appropriate for all States. Further, it is likely to be time limited and not appropriate for a National Performance Measure.
- SPMs to address access to prenatal care in general were not included since adequate PNC is already an NPM. Measures of access to specific components of PNC, e.g., percent of women screened for depression during PNC, were included.
- SPMs to address disparities in NPMs, e.g., reducing LBW for specific populations, were not included. Examining outcomes for population subsets

for specific NPMs may not be appropriate for all States and is more appropriately included as an SPM for those States with identified disparities.

- SPMs limited to adolescent girls were not included. Emphasis in this review was on women throughout the lifespan.

### **Summary of Current and Past State Performance Measures for Women Health**

Almost all States (an average of 52) had an SPM for women's health in one of the three reporting periods reviewed.

#### **SPMs in the following categories were the most commonly reported:**

<b>1. Reproductive health / family planning</b>	<b>39 States</b>
<b>2. Legal and illegal substance use</b>	<b>37 States</b>
<b>3. Birth defects / genetics</b>	<b>24 States</b>
<b>4. Nutrition / obesity</b>	<b>20 States</b>
<b>5. Mental health / domestic violence</b>	<b>19 States</b>
<b>6. Sexually transmitted diseases</b>	<b>14 States</b>

Each category of current or past SPMs for women's health is described in more detail below.

#### ***1. Reproductive health / family planning***

Many States (n=39) had an SPM for reproductive health and/or family planning in at least one of the three reporting periods.

- Various reproductive health goals were represented in this category of SPM, but the overwhelming majority were performance measures to reduce unintended pregnancies.

Unintended	2000	24 States
pregnancies	2005	21 States
	Current Yr	21 States

- Six (6) States had SPMs to ensure access to family planning services in general, regardless of pregnancy status, and six (6) States had SPMs to address interpregnancy interval.
- Most States use PRAMS data for these measures. Others use vital records (interpregnancy interval) or family planning program data.

## **2. Legal and illegal substance use**

Almost two-thirds (n=37) of States had an SPM to reduce substance use by women.

Use of Tobacco	2000	25 States
	2005	27 States
	Current Yr	25 States
Use of Alcohol	2000	12 States
	2005	9 States
	Current Yr	11 States

- Virtually all States targeted pregnant women in their performance measures to reduce tobacco and/or alcohol use.
- The majority of States focused on only one issue, e.g., tobacco use, although in the current year, five (5) States had comprehensive measures to reduce all substance use in pregnancy.
- One-half of States with a current year SPM to reduce tobacco use rely on birth certificate data to measure progress; another one-quarter use PRAMS data.
- States with an SPM to reduce alcohol use in pregnancy were equally likely to use birth certificate data or PRAMS data for their measure.

## **3. Birth defects / genetics**

Forty percent (40%) of States (n=24) have or had an SPM in at least one of the three reporting periods to reduce birth defects or increase genetic counseling

Birth defects / genetics	2000	21 States
	2005	8 States
	Current Yr	7 States

- Of note is the finding that more than one-half of the States with a 2000 SPM regarding reduction of birth defects or genetic counseling dropped that SPM following their 2005 Need Assessment. In 2000, 18 States had an SPM to reduce Neural Tube Defects; in 2005 only five (5) States included this SPM.
- Recent SPMs were more likely to focus on access to genetic services.

#### **4. Nutrition / obesity**

State Performance Measures can be specified to alleviate a problem or improve access to a program or activity that leads to reduction of a problem. SPMs to reduce obesity or improve nutrition provide examples of how an SPM can be specified to focus on different outcomes, recognizing that a focus on nutrition can address nutrition needs other than for the purpose of reducing obesity. Twenty (20) States had a SPM for women that targeted nutrition and/or obesity. While the number of States with SPMs that focused on nutrition was constant since 2000, the number of States with an SPM that targeted obesity in women increased markedly since 2000.

Nutrition	2000	9 States
	2005	9 States
	Current Yr	8 States
Obesity	2000	2 States
	2005	8 States
	Current Yr	8 States

- Nutrition SPMs focused mainly on pregnant women; 11 of 14 States with a nutrition SPM in any reporting period targeted this population.
- Specific nutrition measures varied and the data used to measure them also varied and included, for example:
  - consumption of fruits and vegetable - BRFSS data
  - WIC enrollment - WIC program data
  - adequate weight gain in pregnancy – PRAMS data
- Obesity measures were more likely to be targeted at women of childbearing age regardless of reproductive status. Most States used Behavioral Risk Factor Surveillance System (BRFSS) data to measure obesity.

#### **5. Mental health / domestic violence**

State Performance Measures to improve women’s mental health and/or decrease the incidence of domestic violence were the fifth most common type of SPM for women’s health.

Overall, nineteen (19) States have or had an SPM for women’s mental health in one of the three reporting periods. The 2005 Needs Assessment resulted in a notable increase in the number of States with a performance measure to address this important issue.

Mental Health	2000	2 States
	2005	12 States
	Current Yr	11 States

- Seven (7) States with a current mental health performance measure focus on pregnant women and most rely on PRAMS data to measure the effect of their programs.
- Four (4) States have a current mental health performance measure for all women of childbearing age and most use BRFSS as their data source.

Domestic violence is a problem for women that has obvious links to mental health, and ten (10) States had a current or past SPM to reduce domestic violence as part of their program goals.

Domestic Violence	2000	9 States
	2005	6 States
	Current Yr	6 States

- States with domestic violence SPMs were equally likely to target pregnant women and nonpregnant women.
- Data for SPMs regarding domestic violence came from PRAMS (pregnant women), crime statistics, or other locally collected data.

## **6. Sexually transmitted disease (STD)**

Sexually transmitted diseases were targeted by 14 States in a State Performance Measure for at least one of the reporting periods.

STDs	2000	12 States
	2005	7 States
	Current Yr	7 States

- Most States with an STD measure (n=11) specified a measure for pregnant women.
- Specific STDs targeted were not universal. Seven (7) States had a measure for HIV infection, four (4) States had one for Chlamydia and the remainder had measures for Syphilis or Hepatitis B.
- Goals of the STD measures were also not universal. Some States aim to increase screening and counseling while others specified a goal to reduce the rate of disease or transmission of the disease.

- Most States used program data, e.g., clinic data or STD program data, for these measures.

### **7. Other State Performance Measures for women – fewer than 10 States**

- Seven (7) States had a SPM to improve screening for breast and/or cervical cancer.
- Six (6) States had an SPM for specific components of prenatal care, e.g., nutrition counseling, family planning information, and depression screening.
- Four (4) States had an SPM to ensure insurance coverage for women
- Three (3) States had an SPM for dental care for women.

## **C. SPECIFYING A NATIONAL PERFORMANCE MEASURE FOR WOMEN'S HEALTH**

A National Performance Measure for women's health, like all national measures, should meet several criteria. It should address a problem in women's health that:

- is national in scope,
- can be addressed by MCH programs or their partner agencies, and
- can be measured.

### **Potential National Performance Measures for Women**

The NPMs for women's health that are proposed and discussed below range from the very general to more specific. Generic NPMs are stated recognizing that the exact wording would change depending on the data available for the measure and an agreed upon focus for the measure, e.g., outcome vs. process. Important considerations for each suggested NPM are briefly summarized. Finally, potential data sources are identified for consistent reporting across States for the measure.

In order to avoid repetition of essential strengths or weakness of data, three of the most applicable sources of data are described here:

#### **Behavioral Risk Factor Surveillance System (BRFSS)**

- Ongoing monthly national telephone survey of adults with sufficient sample sizes for individual States to allow State estimates.
- Data are self-reported by respondents.
- All 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam participate in BRFSS (54 of 59 Title V grantees).
- A core questionnaire is used in all participating States.

- Gender and age are queried, allowing creation of subsets of women in a specific age group, e.g., 18-44 years.
- Topic-specific modules are available and used by States as appropriate.
- Changes in survey questions from year to year must be monitored to maintain comparability of longitudinal data.

#### Pregnancy Risk Assessment Monitoring System (PRAMS)

- Ongoing monthly national telephone survey of post-partum women with a sample size that allows State estimates.
- Data are self-reported by respondents.
- Thirty-seven (37) States currently participate. Some States that no longer participate field their own comparable surveys.
- A core questionnaire is used in all participating States.
- Topic-specific questions are available and used by States as appropriate. These questions include standard questions and State-developed questions.
- Changes in survey questions from year to year must be monitored to maintain comparability of longitudinal data.

#### Birth Certificates

- A standard state Certificate of Birth is used by all States and Jurisdictions although States adopt changes to the form at their discretion. Therefore, recently added items to the Public Health Service (PHS) Standard Certificate of Birth may not be available for all States.
- The PHS Standard Certificate of Birth includes data on specific areas of health for women who have delivered a live infant. Areas of the mother's health include use of prenatal care, smoking during pregnancy, prepregnancy weight and weight at delivery, and selected health conditions.

### **1. NPM for Women's Access to Health Care**

Generic examples: *Increase the percent of women with a primary care provider.*  
*Increase the percent of women who report having a well care visit in the past year.*

- Applies to all women regardless of age or reproductive status.
- MCH and partner agencies may have limited authority or resources to affect change.
- May be difficult to attribute change to a single intervention or program.
- Not currently used by States as an SPM.

Potential data sources:

- BRFSS  
 - Core questionnaire collects information on the use of primary care.

## **2. NPM for Women's General Health Status**

Generic Examples: *Increase the percent of women who report that they are in good health.*

*Decrease the percent of women who report days when their health was not good.*

- Applies to all women regardless of age or reproductive status.
- MCH and partner agencies may have limited authority or resources to affect change.
- May be difficult to attribute change to a single intervention or program.
- Not currently used by States as an SPM.

Potential data sources:

- BRFSS
  - Core questionnaire includes questions regarding health status in general (scale of poor to excellent) and questions about the number of days when health was not good.

## **3. NPM for Women's Dental Health**

Generic examples: *Increase the percent of women with a dental care provider.*

*Increase the percent of women with a dental visit.*

- Applies to all women regardless of age or reproductive status.
- Recognizes the increasing awareness of the role of dental health in overall health.
- May require a new focus by MCH and partner agencies that have traditionally focused on children's dental health.
- Difficult to attribute change to a single intervention or program.
- Not currently used by States as an SPM.

Potential data sources:

- PRAMS
  - Supplemental or State-developed questions address dental problems and the use of dental care in pregnancy but the most commonly used questions are available for only 19 States.
- Medicaid Data
  - Claims data can be used to determine the percent of enrolled women who receive dental care.

#### **4. NPM for Women's Mental Health**

Generic examples: *Decrease the percent of women with a specific mental health problem.*

*Decrease the number of women with bad mental health days.*

- Applies to all women regardless of age or reproductive status.
- MCH and partner agencies may have limited authority or resources to affect change.
- Difficult to attribute change to a single intervention or program.
- Currently an SPM for some States, primarily focusing on pregnant women.

Potential data sources:

- BRFSS
  - Core questionnaire has questions on emotional support and life satisfaction.
  - Optional modules include one with more detailed questions about mental health, but this module was used by only 26 States in 2007.
- PRAMS
  - Core questionnaire has a multi-part question on stressors in pregnancy, e.g., family illness, but not questions on mental health per se.
  - Multiple supplemental and State-developed questions address mental health. The number of States using these questions ranges from 19 for a question regarding post-partum depression to one State for more detailed questions, e.g., receipt of counseling for depression during pregnancy.

#### **5. NPM for Reproductive Health – Family Planning**

Generic examples: *Increase the percent of women who report that their pregnancy was planned.*

*Increase the percent of post-partum women who report using a contraceptive method.*

*Increase the percent of women counseled regarding post-partum family planning.*

*Decrease the percentage of births occurring within 18 months of a birth to the previous mother.*

*Increase the use of family planning services by those who want them.*

- Applies to women of childbearing age.
- Longtime focus of MCH and Family Planning partners.
- More focused goal is easier to link to specific programs.

- Currently the most common women’s health SPM, although most States focus on pregnant women and not on all women of childbearing age.

Potential data sources:

- PRAMS
  - Core questionnaire queries intendedness of recent pregnancy and family planning post-partum.
  - Core questionnaire also asks about family planning discussions during prenatal care as a “yes/no” question.
  - Non-core standard questions and State-developed questions are used by a few States to obtain more detailed information on family planning.
- Family Planning Program data
  - Family Planning Program data is limited to only those women using publicly funded family planning services.

## **6. NPM for Tobacco Use among all Women**

Generic examples: *Decrease the percent of women who smoke.*

*Increase the percent of women screened and/or counseled for smoking.*

- Applies to all women, regardless of age or reproductive status.
- More focused goal is easier to link to specific programs.
- A National Performance Measure for smoking among pregnant women already exists.

Potential data sources:

- BRFSS
  - Core questionnaire has questions on use of cigarettes and other tobacco products.

## **7. NPM for Alcohol Use among Women**

Generic examples: *Decrease the percent of women who binge drink.*

*Decrease the percent of women who drink during pregnancy.*

*Increase the percent of women screened and/or counseled for alcohol use.*

- Applies to all women, regardless of age or reproductive status.
- More focused goal is easier to link to specific programs.
- An important focus of reproductive health programs.

- Goal-setting is not straightforward, e.g., no alcohol use in pregnancy, “reasonable” alcohol use for nonpregnant women. Consensus on goal may be more difficult.
- Currently an SPM for few States. Current SPMs focus on pregnant women and use PRAMS or birth certificate data.

Potential data sources:

- BRFSS
  - Core questionnaire has questions on number of drinks consumed weekly or monthly. Use of these questions would require judgment to formulate a goal, e.g., definition of binge drinking.
- PRAMS
  - Core questionnaire includes questions about alcohol use before, during, and after pregnancy.
  - Core questionnaire also asks about discussion of alcohol risks during prenatal care as a “yes/no” question.

## **8. NPM for Obesity in Women**

Generic examples: *Decrease the percent of women who are overweight or who are obese.*

*Increase the percent of women screened for overweight/obesity.*

*Increase the percent of overweight/obese women who receive services to help them to reduce their weight.*

- Applies to all women, regardless of age or reproductive status.
- More focused goal is easier to link to specific programs.
- Currently an SPM for few States but an area of increasing focus for States. Current SPMs focus on all women and use BRFSS data for their measures.

Potential data sources:

- BRFSS
  - Core questionnaire collects height and weight information for respondents that allows calculation of body mass index (BMI). Also asks for changes in weight over the last year.
- PRAMS
  - Core questionnaire collects prepregnancy height and weight.

## **9. NPM for Nutrition and Exercise among Women**

Generic examples: *Increase the percent of women who eat five servings of fruits or vegetables each day.*

*Increase the percent of women who get the recommended weekly exercise (specify).*

*Increase the percent of women who achieve the minimum recommended weight gain in pregnancy.*

- Applies to all women, regardless of age or reproductive status.
- More focused goal is easier to link to specific programs.
- Nutrition is already an important focus of prenatal care.
- Currently an SPM for few States with a focus on pregnant women.

Potential data sources:

- BRFSS
  - Core questionnaire includes questions regarding frequency of exercise and level of exercise.
- Birth Certificates
  - Weight gain in pregnancy is collected.

## **10. NPM for Domestic Violence**

Generic examples: *Decrease the percent of women who report domestic violence.*

*Increase the percent of women screened and/or counseled for domestic violence*

- Applies to all women, regardless of age or reproductive status.
- MCH and partner agencies may have limited authority or resources to affect change.
- Difficult to attribute change to a single intervention or program.
- Currently an SPM for a few States. Current SPMs are equally likely to focus on pregnant women or on all women.

Potential data sources:

- PRAMS
  - Core questionnaire includes questions about partner violence in the 12 months before pregnancy and during pregnancy.
  - Core questionnaire also asks about discussion of domestic violence during prenatal care

- Supplemental standard questions and State-developed questions collect more detailed information on physical, emotional, and sexual abuse, but these questions are used by only a few States.
- Crime Statistics
  - Crime data are available for every State but would require consensus on definition and would include only episodes of domestic violence reported to the authorities.

### **11. NPM for Sexually Transmitted Disease among Women**

Generic examples: *Reduce the number of cases of HIV per 100,000 women.*  
*Increase the percent of women counseled regarding HIV screening during prenatal care.*  
*Increase the percent of women who receive the vaccine to prevent human papilloma virus (HPV).*  
*Reduce the number of cases of Chlamydia trachomatis per 100,000 women.*

- Applies to all women, regardless of age or reproductive status.
- Longtime focus of Communicable Disease partners of MCH.
- More focused goal is easier to link to specific programs.
- STDs are reportable events and a well-established reporting system is in place.
- Currently an SPM for a few States with a focus on pregnant women.

Potential data sources:

- Communicable Disease program data
  - Infection rates for many diseases are collected using standard definitions. Completeness of reporting may vary.
- PRAMS
  - Core questionnaire asks about discussion of HIV testing during prenatal care
- BRFSS
  - Optional module queries receipt of the HPV vaccine.

## **12. NPM for Cancer Screening for Women**

Generic examples: *Increase the percent of women who had a Pap smear within the past two years.*

*Increase the percent of women over 50 years of age who had a mammogram in the past year.*

- Applies to all women.
- Focus of efforts among Cancer Screening Program partners of MCH.
- More focused goal is easier to link to specific programs.
- Currently an SPM for a few States.

Potential data sources:

- BRFSS
  - Women's Health module asks about mammography screening and Pap smear screening. Only nine (9) States use this module.

## **13. NPM for Health Insurance for Women**

Generic examples: *Increase the percent of women who have private or public health insurance.*

- Applies to all women, regardless of age or reproductive status.
- MCH and partner agencies may have limited authority or resources to affect change.
- Widely recognized as important link to health care.
- May be difficult to attribute change to a single intervention or program.
- Currently an SPM for only a few States.

Potential data sources:

- BRFSS
  - Core questionnaire has a question regarding health insurance.
- PRAMS
  - Core questionnaire queries health insurance status before pregnancy.

## SUMMARY

State MCH Agencies have a long-standing mission to serve mothers and children and that mission has expanded to include women and families. The programs of State MCH agencies are complex and include partnerships with many agencies. Review of any individual State's Needs Assessment or Annual Report quickly provides many examples of the myriad state and local programs designed to improve the health of MCH populations.

This review focused on State MCH programs for women's health. Using the comprehensive and informative reports that are produced by all State MCH Title V grantees, State MCH commitment to and initiatives for women's health were explored. State Priority Needs for women's health were categorized and described. Selected States were profiled and their programs to improve women's health were summarized. Finally, State Performance Measures targeting women's health were described and possibilities for a National Performance Measure for women's health were explored.

**Most State MCH agencies have broad Priority Needs and goals to improve the health of all the populations they serve including women.** These goals address health care of all types including dental health and mental health, and they address the need to help the MCH population stay healthy by reducing risk behaviors such as smoking and improving healthy behaviors such as diet and exercise.

**State MCH agencies help meet the health and health care needs of women by providing "traditional" MCH services to pregnant women.** State programs seek to ensure early access to comprehensive prenatal care that includes more than monitoring pregnancy related health markers. MCH services during the prenatal period help women address health concerns that may have existed before the pregnancy including dental health. Many State Priority Needs seek to help the pregnant woman achieve a healthy lifestyle that not only improves her health while pregnant and her baby's health but can also ensure better health after her baby is born. Addressing mental health is also a focus of some States' programs for pregnant woman. Although not directly stated as a women's health priority, state Priority Needs to improve birth outcomes, e.g., low birth weight, also benefit women and are yet another example of State MCH commitment to women's health.

**State MCH agencies focus specifically on the health of women in programs that are designed to improve women's health in the preconceptional period and after they give birth.** Some MCH Priority Needs and programs extend specifically to all women regardless of reproductive status or pregnancy intent. Examples from the ten states profiled in this report demonstrate the breadth of programmatic activity that is being undertaken by State MCH activities for women's health. The importance that States give to these goals is evident not

only in the programs they create, but also in the organizational changes made in some States that focus staff and resources on women's health. States are using comprehensive data analysis such as the Perinatal Periods of Risk system to document a need for improvement in women's health. Raising awareness of the importance of women's health not just for women themselves but for the health of their children is a focus of many State efforts and States are developing and disseminating educational materials to multiple stakeholders to emphasize the importance of preconceptional and interconceptional health. State MCH agencies are working not only at the State level, but providing resources at the local level and partnering with many other private and public entities to improve women's health.

**Most State MCH agencies include a State Performance Measure for women's health.** State Performance Measures for women cover a variety of women's health issues and are not limited to reproductive health. Legal and illegal substance use by women, particularly tobacco use, remains a major focus for State MCH programs and one for which they hold themselves accountable in their State Performance Measures. Reduction of obesity and screening for and treatment of mental health problems including post-partum depression are two areas of increasing focus for State MCH agencies and States are also assessing their progress in these areas with a State Performance Measure. In order to measure success of their women's health programs, States are informing their programmatic decisions themselves with data from national surveys with State-level estimates, e.g., BRFSS and PRAMS, and also investing resources in the development of local data systems to document their impact on women's health in their State.

**The commitment to women's health demonstrated by State MCH agencies supports the development of a National Performance Measure for women's health.** The emphasis on women's health that is apparent in State Priority Needs and also in State Performance Measures supports the development of a National Priority Need for women's health to complement existing NPMs that address the needs of other populations served by State MCH agencies. Potential women's health NPMs range from broad NPMs to improve health or access to health care to specific measures such as reduction of obesity or improvement in screening for cervical cancer. Longitudinal data collected by national surveys such as BRFSS and PRAMS are available for many potential women's health National Performance Measures and participation in these national surveys by individual States is high. Additionally, both BRFSS and PRAMS include supplemental questions, i.e., questions not asked by all States, which address many women's health issues that are the focus of State MCH agencies. Specification of an NPM that could be measured with supplemental data could provide the impetus for inclusion of that line in inquiry in the core questionnaire for all participating States. Successful implementation of a National Performance Measure for women's health would be enhanced by discussions between the Maternal and Child Health Bureau and its State

partners and agreement on the value of a women's health NPM, as well as by agreement on the focus of the measure, e.g., general health or a specific health problem or health behavior, and the population whose needs are being addressed by programs to address the health need or behavior, i.e., all women or pregnant women.