Support mothers in poverty need: Lessons learned from Mom2Mom

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Childhood stress leads to adverse developmental and health outcomes in adulthood, and childhood poverty is perhaps the most significant source of stress that exists today for Canadian children. Previously, three key factors were identified that are important in improving developmental outcomes in children: reducing the stress of poverty; connecting the mother to the child’s education; and connecting the mother to social support. The Mom2Mom Child Poverty Initiative was established as a model to improve developmental outcomes for vulnerable children. Mom2Mom combines current evidence regarding the social and biological determinants of child health with direct advocacy. It provides mentorship, and financial and practical support to families, with the goal of improving outcomes for children living in poverty.

Key Words: Advocacy; Children; Poverty; Vulnerable; Youth

In a commentary in the Journal in 2013 (1), the late Dr Clyde Hertzman articulated the challenge that lies before us to “examine how broader interventions at the level of childcare, school and community might…influence long-term developmental outcomes”. Over the past decade, there has been a growing body of literature connecting early childhood stress to adverse developmental and health outcomes in adulthood (2-4). Among negative early childhood experiences, poverty is perhaps the most important condition facing children in this century. Toxic stress, in part related to the stress of poverty, is associated with learning and mental health disorders, and poor physical health in adulthood (5,6). If we start to view child poverty as a key factor in child health then the stress of poverty; connecting the mother to the child’s education; and connecting the mother to social support are important protective factors against the negative impact of poverty on children (2-4). Childhood stress leads to adverse developmental and health outcomes in adulthood (2-4). Among negative early childhood experiences, poverty is perhaps the most important condition facing children in this century. Toxic stress, in part related to the stress of poverty, is associated with learning and mental health disorders, and poor physical health in adulthood (5,6). If we start to view child poverty as a key factor in child health rather than solely as a social problem, a clear role for paediatricians becomes apparent.

British Columbia has the highest rate of child poverty in Canada (7), including the highest poverty rate for children younger than six years of age (21%). Poverty in children younger than six years of age is of critical importance because experiences in the early years significantly affect children’s trajectories in school, life chances and long-term adult outcomes (8). When compared with their average and above-average income counterparts, children disadvantaged by poverty may have lower school completion rates and are more likely to misuse substances, or become street involved or pregnant at an early age (5). A child growing up in poverty is more likely to have cancer, heart disease and/or mental illness in adulthood (5). Action in British Columbia is long overdue for this health condition that affects one in five children (9).

Alleviating parental stress, connecting mothers to their child’s education and increasing social support are known protective factors against the negative impact of poverty on children (10,11). Families living in poverty typically receive support through many professionals including social workers, health care professionals and other community-based organizations. Two limitations of these systems of support identified by mothers living in poverty are:

1. Their vulnerability to those who appear to have power over them. Some mothers have had adverse experiences with systems in their past. They may have been taken into foster care as a child or had their own children taken into care.

2. The lack of flexibility in formal and informal support systems. Crisis situations often occur outside the working hours of paid professionals. Although these mothers may be a part of a strong social network, their family and friends often have their own financial and resource constraints.

We sought to address these identified limitations with our initiative.

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DEVELOPMENT OF THE MOM2MOM CHILD POVERTY INITIATIVE

The need for intervention, specifically in our city, became evident based on experience from a long-standing developmental pediatric outreach program in Vancouver's (British Columbia) inner-city schools. It became apparent that if a mother had not grown up in a nurturing and healthy home environment, she often had gaps in her parenting skills and knowledge. For example, if she had never experienced a bedtime routine that included reading to a child, she may not know how to do that with her own child. Furthermore, the mothers were living in poverty and were primarily focused on meeting basic needs for food and housing for their children. The Minnesota Child Study (11), identified three key components that promote healthy child outcomes at any stage of child development: reduce the stress of poverty; connect the mother to the child's education; and connect the mother to social support. By combining local experience and existing literature, the premise for Mom2Mom was developed. Its initial goal was to alleviate some of the aforementioned barriers through the establishment of a trusting relationship with another woman to enable mothers to provide the healthiest possible environment for their children.

WHY MENTORING?

Previous work has identified that mentoring occurs naturally in middle- and upper-class environments; however, individuals living in poverty rarely have the opportunity to meet other individuals for mentorship who are outside their circle of poverty (12). Furthermore, there is a strong correlation between having mentorship outside of an individual's social circle and achieving postsecondary education (12). We also know that individuals living in poverty rarely cite a program as the reason they were resilient enough to break poverty barriers. They instead typically describe a story of a caring person who reached out to them (12).

By combining clinical experience with what is known in the literature, we started a grass roots initiative in an attempt to change outcomes for women and children living in poverty.

DESCRIPTION OF THE PROJECT

Mom2Mom Child Poverty Initiative Society (M2M) (www.m2mcharity.ca) provides compassionate mentorship, and financial and practical support to families, with the goal of improving outcomes for children who are disadvantaged by poverty in Vancouver's inner city. Mothers of elementary school-age children are paired with women who have been trained as mentors. The mentors support women in multiple ways: by being a friend, by providing guidance regarding child rearing, by providing practical support such as transportation to appointments and events, and by being a stable person in the woman's life who she can reach out to. Mentors are given a monthly budget to use to help the family with items such as food and the cost of recreational activities. Additional expenses are approved on a case-by-case basis. Household items are found through a recycling network or purchased. The goal is to alleviate daily stresses to free the mother to consider other possibilities for herself and her children. She starts to enjoy her children more and participate at their school. As the mentor relationship deepens and the mother sees that she has someone who believes in her and encourages her, she may consider going back to school, applying for work or seeking treatment for past trauma. The mentor supports her practically and emotionally to achieve her goals. Eventually, a community of mentors and participant moms is created to provide a healthy social network for mothers and children.

M2M INITIATIVE: THE PROCESS

Inner-city school staff volunteers (school liaisons) and health care professionals identify families suited for M2M. A mentor coordinator pairs a mother living in poverty with two trained volunteer mentors. Training includes attendance at an information session, 2.5 h of initial training and bimonthly mentor support meetings that teach skills, and promote reflection and continued development of self-awareness. Ongoing mentor support is available from the mentor coordinator.

The mentors may start by going grocery shopping together, meeting for coffee or talking about their kids. As the relationship progresses, the participant moms start to reach out with questions or for help. Mentors use their own contacts and resources to assist the mother in navigating systems and overcoming barriers. Regular community events are organized to bring mentors and participant moms together for fun activities (eg, cooking, crafts, picnics and parties). Many of the participant moms volunteer their time on M2M committees and provide advice for the development of programs. Financial support comes from individual and corporate donors.

CONCLUSIONS

When asked informally why M2M works for them, mothers cite the relationship with the mentor as the most valuable part of M2M. Mentorship, particularly by someone who can provide resources not available within an individual's social group, has been identified as a key factor in the success of women living in poverty attending postsecondary education (12). Many of the participant moms say that that this is the first time in their lives that they have had a reliable, resourceful and compassionate person they can call, who is there because she wants to be and has no power over her. Not having to worry constantly about basic needs has freed them to plan for the future and parent more effectively. One child, who previously had very poor school attendance secondary to her mother feeling overwhelmed said: “Mom to Mom made my mom happier and now our family is happy again”. Teachers report that children are arriving at school well rested, well fed and more ready to learn. Both the mentors and moms identify the sense of community that has developed as being one of the most important aspects of M2M.

M2M combines current evidence regarding the social determinants of child health with direct advocacy. Formal evaluation is underway; however, this integration of science, social science and clinical experience is producing encouraging results. As pediatricians, we are in a unique position to have the knowledge of what makes a difference to children, and the credibility to initiate community programs that are well supported and effective. Putting that knowledge into action is part of our advocacy role and an ethical responsibility. The health consequences of poverty can be devastating for children. With adequate support, children have improved opportunities for school achievement, health and success in life – the underlying premise being that as a society, we all benefit when children are well cared for and healthy.

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