reminder that training and professional development need to be available not only for leaders and the emerging workforce but also for midcareer staff.

New concepts such as health in all policies, cross-jurisdictional services sharing, and quality improvement are gaining awareness for a majority of the workforce. These concepts are central to the work approach of modern Public Health 3.0 departments. It is also exciting to see that awareness of these concepts is gaining ground in state and local health department workforces. The gap between awareness and impact highlights the need to provide robust and accessible training programs for the incumbent and emerging workforce. The responsibility for developing such programs falls to many, but the Association of Schools and Programs of Public Health and the training programs themselves need to ensure that the curricula for undergraduate and graduate public health trainees reflect the array of complex health issues they will have responsibility for, including those related to the social determinants of health.[1]

A PEOPLE- AND SKILL-INTENSIVE INFRASTRUCTURE

Public health is a people- and skill-intensive infrastructure. However, to do their work effectively and to continue to lean into emerging public health challenges, the public health workforce will need adequate resources. These are more than data and partnerships. As called for in Public Health 3.0, the public health infrastructure needs flexible, sustainable, and enhanced funding—not only to address crises, but to ensure strong foundational capabilities to protect the public every day. Given the concerns about public health workforce recruitment and retention in the articles in this issue of *AJPH*, we should recognize that we will not attract the best and brightest in public health training programs unless we are able to adequately compensate staff, ensure them job security, and provide them with the resources to do their work. The estimated gap in funding these foundational capabilities is only $12 per person per year, or an estimated $4.5 billion.[7] That's a relatively small investment to ensure the health of our nation.

CONCLUSION

A strengthened public health infrastructure, including a modernized workforce, is needed now more than ever in the United States to reverse the disturbing trends in life expectancy and to address more acute, equally concerning health threats here and across the globe. All people in America have the right to expect that a vibrant and modern public health infrastructure is supporting them every day. The results from Public Health WINS is a call to arms as well as a roadmap for all who care about a thriving, healthy nation. AJPH

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Bringing Parenting Policies in Line With Evidence at US Schools of Public Health

See also Morain et al., p. 722.

Becoming a parent and sustaining a new life is challenging. It is also transformative, with the power to alter the trajectory of an individual, a family, or a community. In the field of public health, our research clearly indicates that investments in paid parental leave, breastfeeding, and high-quality childcare are necessary and worthwhile.[1] Indeed, the American Public Health Association (APHA) recognizes the public health detriments that stem from a lack of workplace-based protections for parents in the United States and the imperative for supportive policies, stating, "APHA supports breastfeeding, paid maternity leave, and workplace accommodations for mothers in the United States."[1] Schools of public health should be leaders in modeling such policies.

PARENTAL SUPPORT AT SCHOOLS OF PUBLIC HEALTH

An important new empirical study published in this issue of *AJPH* shows that our field is not

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living up to its ideals. Morain et al. (p. 722) reviewed publicly available policies on parental leave, lactation, and childcare for faculty and staff at the top 25 ranked schools of public health in the United States and then followed up with faculty affairs or human resources offices at each school to confirm these policies. In many cases, top schools of public health offer at least some support to new parents, yet the authors show that these policies fall short of our professional society's own guidelines in many ways.

A sizeable portion of the top public health schools do not come close to achieving minimum standard policies supporting parents. Morain et al. show that 20% offer no paid childbearing leave to faculty, and 52% offer no paid childbearing leave to staff. For nonbirth parents, including adoptive parents, 32% of schools offer no paid leave to faculty, and 48% offer no paid leave for staff. More than one third of schools (36%) have no publicly available policy on lactation support, and 28% of schools have no university-based childcare options on campus. Recognizing the many thousands of faculty and staff employed at these 25 institutions, it is clear that too many of us, and our colleagues, are not experiencing what APHA implores of governments across the world: "policies and programs that promote increased availability of paid maternity leave and workplace accommodations for breastfeeding."[1]

ACCESS TO PARENTAL LEAVE

APHA states that, "the failure of the United States to ensure paid sick and family leave for all US workers harms individual workers and the public's health."[1] Indeed, a recent study showed that the chances of rehospitalization for both a mother and her infant were about 50% lower among women who took paid leave, compared with those who had unpaid leave or no leave.[2] Nationally, just over 60% of employed mothers reported having access to paid leave[2]; the current study shows that public health faculty have higher-than-average access to paid leave, whereas staff fall below the national average. This directly contradicts APHA's stated commitments to ensuring access for "all US workers" and may have equity implications, because staff generally have lower income and are more racially and ethnically diverse than faculty. Additionally, as the authors point out, limited clarity of information on policies and frequent reliance on obtaining proof of clinical need may create obstacles to actually using leave.

ACCESS TO BREASTFEEDING SUPPORT

APHA asserts that "exclusive breastfeeding rates are unlikely to change substantially without workplace interventions supported by public policies."[1] Schools of public health should lead this policy change, not lag behind. Morain et al. show that 64% of top schools of public health have publicly available policies on lactation support, but all of these simply cite university policies, and it is not clear to what extent these policies align with evidence or how they translate in practice. Workplace accommodations matter for breastfeeding success; women with access to both break time and private space to pump breastmilk at work are more than two times as likely as those who do not have these accommodations to be exclusively breastfeeding at six months.[3] Additionally, APHA correctly notes that "there are documented barriers to breastfeeding once a mother returns to work, and even in instances in which accommodations exist, they are often inadequate."[1] For example, eight of the top US public health schools require that women use regular paid breaks for expressing breastmilk, with any additional needed breaks being unpaid. Tying potential compensation penalties to the time required to pump is an unnecessary restriction, again with equity implications.

ACCESS TO CHILDCARE

Finally, childcare access helps mitigate the stress of returning to work. Although the current study shows that more than half of the top schools of public health have on-campus, university-run childcare options, almost all of these centers had lengthy waitlists, and at some schools, the center was located far from where the school of public health was located.

It is important to note that Morain et al. documented policies, not people's experiences. Not everyone who is offered leave, lactation support, or university-based childcare is able to take it,[4] so efforts to improve the policy environment for early parenting should pay careful attention to equity in design and implementation. The field of public health should put its values into practice, ensuring consistency between policy statements aimed at external audiences and our own experiences as public health professionals. Hypocrisy should not be the legacy we bequeath to the children we have while working as faculty and staff at schools of public health.

TOWARD A BETTER FUTURE

The core principles of feminism and equity should guide a path forward for schools of public health to implement policies and practices worthy of the substantial and conclusive evidence our field has produced about the value of parental leave, breastfeeding, and high-quality childcare for the health of parents, infants, families, and communities.[1] Pregnancy-related discrimination and gender inequities in the workplace are pernicious and long-standing.[5] Structural racism pervades all aspects of pregnancy, childbirth, and parenting, producing staggering racial disparities in maternal and infant health.[6] Schools of public health are not exempt from these forces. Evidence-based policies that support parenting are needed to help combat health inequities.

Schools of public health produce much of the evidence on which the APHA's policy statements are based. We can lead not only in research but also in policy action on parental leave, lactation support, and childcare access. First, we can learn from the leaders among us. For example, Morain et al. showed that some schools of public health (e.g., Harvard, Yale, and Columbia) offer faculty leave policies that are more generous than university-wide policies. Second, the

creation and implementation of new policies should be inclusive of and led by those most marginalized by current practices to achieve greater equity. The value of breastfeeding, parent–child bonding, and newborn development is well documented in our field. We have shouted these benefits from the rooftops while denying them to those inside our own home. It is time to take seriously our own advice and make the first year of life the best it can be for all families, including those of us working at schools of public health. AJPH

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To Prevent Child Maltreatment, Home Visiting Programs Are One Part of a Complete Response

See also Easterbrooks et al., p. 729.

Child maltreatment is a pressing public health problem. In 2017, 3.5 million US children were reported to Child Protective Services (CPS) for maltreatment concerns.[1] This is equivalent to 4.71% of US children annually. The cumulative prevalence is much higher. A recent study that used 2003–2014 nationwide CPS records estimated that 37.4% of US children would experience at least one maltreatment investigation by age 18 years.[2] Using self-report, the 2013–2014 National Survey of Children's Exposure to Violence provided a similar estimate: 38.1% of children aged 14 to 17 years reported at least one incidence of maltreatment during their lifetimes.[2]

The scientific literature has documented a wide range of adverse consequences stemming from maltreatment. The 2014 National Research Council report provides a comprehensive review on this topic.[3] Adverse health outcomes include atypical early brain development, chronic and debilitating diseases (e.g., liver disease, chronic bronchitis or emphysema, cancer, ischemic heart disease, diabetes, and obesity), and increased health risk behaviors (e.g., substance abuse, smoking, sexual risk behaviors, and physical inactivity). There are also various cognitive, psychological, and behavioral consequences, such as lower IQ, poor academic achievement, and various internalizing and externalizing problems. Maltreated children experience increased mortality through childhood, extending into adulthood. The social costs for maltreatment are heavy. The total lifetime cost of maltreatment for the US children newly investigated by CPS in 2008 was estimated to be approximately $585 billion.[4]

HOME VISITING PROGRAMS

Prevention efforts offer promise in reducing maltreatment. Home visiting (HV) has been a popular prevention model, providing regular home visits by nurses, social workers, or paraprofessionals from birth (or pregnancy) to kindergarten entry.[5] Common services include (1) training, support, and information for parenting; (2) screenings for children and parents; (3) goal-setting activities to promote education, employment, and life skills; and (4) referrals to other services and resources.[5]

The Home Visiting Evidence of Effectiveness project launched by the Department of Health and Human Services has conducted an exhaustive review of the research literature regarding HV.[5] The project has identified 20 evidence-based HV programs. Among them, eight programs have demonstrated at least one favorable effect on maltreatment or relevant outcomes. When outcomes were further narrowed down to official CPS records (i.e., reports, substantiated reports, and foster care placements), five programs were found to have a favorable outcome in the existing literature (Table 1).

The article by Easterbrooks et al. in this issue of *AJPH* (p. 729) adds something exceptional to the existing evidence base. This article examines the prevention effect of its HV program not only on the onset of maltreatment reporting (i.e., first report) but also on the subsequent recurrences from second through fifth reports. Easterbrooks et al.

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