How Do We Influence Others?
Political Will and Persuasive Partnerships for Change

The following remarks were excerpted from a closing keynote presentation by Kay Johnson at the CityMatCH 2004 Urban MCH Leadership Conference:

I sometimes wish it were another day and another world. We might pick the fall of 1932: Franklin Roosevelt was about to become president, and the legacy of the Hoover administration would be wiped away. Roosevelt and the liberal leaders that came into his administration advanced new policies, enormous changes, furthering the Children’s Bureau and revolutionizing the way we conduct child labor in our country. They brought about dramatic improvements in family protections, changed the way we thought about social security, and finally began to move our country beyond the poor laws and the almshouses of England.

You might be wishing for the 1964-65 period when the Great Society policies were created and before the tragedy of Vietnam brought down Lyndon Johnson from the power he held and the leadership he exercised. But it is not those days. Now, we scramble and fight to assure we don’t lose what we have, don’t lose what was created and developed as progressive policies in the twentieth century. We do not have the majority Democratic Congress and Liberal Progressive Party available to FDR or the Congress that was available during the Reagan era to protect the poor with Medicaid expansions and other family supports. You may not have people elected to office who share your views and represent the needs of families and children. I say to you that if you don’t have a sense of outrage to stir you, I don’t know what will. Or, as my current favorite bumper sticker says: If you’re not outraged, you have not been paying attention.

Twice every minute a child is abused or neglected. Every minute a baby is born to a teen mother. Every two minutes a low birthweight baby is born. Every 20 minutes a baby dies before her first birthday. Every day in America a mother dies in childbirth; five youths commit suicide, eight children or teens are killed by firearms; 75 babies die before their first birthdays; 1200 babies are born to teen mothers, and more than 2000 of our children are born into poverty.

I want to suggest five action steps: 1) turn outrage into action, 2) protect the vote, 3) monitor what’s happening, 4) work for change, and 5) promote a civil society.

Leadership, Knowledge, Action, Influencing Others: Each day of Conference shone a spotlight on one of these subjects, utilizing an effective and interactive mix of training activities, hard-hitting plenary sessions such as Cutting Edge Science for Urban MCH, Strategic Action for Making a Real Difference, Advocacy and Action, targeted workshops and cutting-edge skills-building sessions with all the tools necessary to enhance participant capacity in those areas.

Expedition 2004 put forth exciting, innovative and creative approaches to solving problems confronting local public health practitioners on a daily basis. To find out more about this significant leadership and navigational journey…

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Political Will and Persuasive Partnerships for Change

(Continued from page one)

gressive era at the turn of the last century. They took what they knew and their outrage about what was happening to families and made change. Remember the physicians Abraham Jacobi and Josephine Baker and more recently, Reed Tuckson, whose thought-provoking speech at an MCH leadership conference in 1991 expressed this vision, “You need to be catalysts for change. We must make something happen, we need to somehow grab the nation by the collar and say, ‘Look here something is very wrong! I see it every day. I try to manage this incredible degree of pathology with such meager, insufficient, and insulting resources.’ Something is very wrong.”

Protect the Vote. Voting is a fundamental right. Do not be afraid to talk about it anywhere you go. College students, people who are homeless, and minorities are routinely kept out of the electoral process.

Monitor what’s happening. You can, you must document and witness; turn the data you have into action; and fight rhetorical battles.

In the 1920’s the Children’s Bureau documented child poverty, infant mortality, employment conditions for workers, and other situations in our nation’s largest cities. Where is our report about urban poverty and infant mortality today?

In the beginning of the Reagan administration, Congressman George Miller and others took responsibility for monitoring the results of budget cuts and block grants. They created a Select Committee on Children, Youth, and Families and brought that message to a bipartisan group in Congress; they made the case for us.

Are you ‘working’ the data triangle, using your data to make the case? Who is hearing the stories your data tell? Where are your translators, are you using them?

Are we fighting the rhetorical battles or do we allow conservative voices to shape public attitudes about what children and families deserve? Our society is split on many issues. The one I care about most passionately is that too many believe children are the sole possession and responsibility of their parents. If you can blame children’s problems on bad parenting or make the case that the government should not interfere in childrearing, you have left some children behind. For example, many believe parents have primary responsibility for providing health insurance.

I don’t agree. I also don’t agree that parents get the best prices on vaccines to immunize their children. I do not think that parents have the sole responsibility to ensure good nutrition, no matter how many vending machines there are in schools, what the FDA does, or what grocery prices are, and how much sales tax is charged on food. I also don’t believe that poor women can take responsibility for bearing healthy children alone if they are denied needed health care and access to family planning throughout their lives. Every one of us benefits in some way from government subsidies. You’ve benefited if you have a mortgage, if your employer subsidizes health coverage, if you went to a public school or a university. We should not allow policymakers to say support for low-income families is wrong.

Work for Change, both incremental change and major reforms.

Incremental reforms can make a difference. Medicaid reforms proposed in the Carter administration failed twice, yet those same Medicaid reforms were incrementally adopted during the second term of the Reagan Administration and the Administration of George Bush, Sr. This is not about partisanship; it is about using windows of opportunity. Three years after the Clinton health care reform plan died, we had the State Children’s Health Insurance Program, providing health insurance coverage for millions of children who otherwise wouldn’t have it.

We must strive for major reform. Editorial writer Katha Pollitt reminds us that “Every politician has a stump speech and a [health] plan - usually a rather complicated one…The simple solution would be a single-payer system like Canada’s, a mantra the left has been humming about for decades, but where’s the big, irate, energetic movement for it?” Pollitt suggests maybe we are just used to ignoring the kinds of people who are uninsured or perhaps people really don’t want to pay for universal coverage. While policy works debate, the crisis deepens, the number of uninsured Americans goes up; where is our outrage?

Promote a civil society. Work in partnership and fellowship, develop citizens who are ready and able to participate in our democratic society and engage in public life. The core elements of good partnerships are the same as that of other relationships: shared purpose and common ground, mutual benefit and win-win strategies; opening doors of communication, and dropping the barriers that exist to building trust with other human beings. I challenge all of us to action because we can, we should, we must.

We each must take responsibility. Frances Moore Lappe wrote the “Diet for a Small Planet” and more recently a book about civil engagement in a civil society, where she spoke of limiting myths and empowering insights. The first myth is that people who are in the limelight are the people who have public lives. The first empowering insight is that each of us has a public life. Every day our behavior shapes the public world, and public life in a civil society draws on the strengths of all of us.

Lappe’s second myth is that public problems are too big and it is too depressing to get involved. The second empowering insight is that public engagement serves a deep human need, to know that one’s life counts and you can make a difference, whether you are a mentor to a young person, whether you’re going to become a volunteer advocate regardless of what your job title says in the daytime.

Do you have the courage to act beyond the boundaries of your government job title, to place yourself at risk for the good of others? During the Reagan administration people at the National Center for Health Statistics could not publish statistics. Similar experiences occurred at the CDC, where staff had data they could not release through government channels. Yet, envelopes of data would turn up in my inbox at the Children’s Defense Fund.

Lastly, maybe some of you may even find the courage to run for public office and represent the voice of others.

For more information, contact City-MatCH at 402-561-7500 or via E-mail at citymch@unmc.edu.
Optimal and effective public health practice and policy requires understanding and navigating complex pathways between science and action. Expedition 2004’s opening plenary mapped out complementary approaches for framing maternal and child health prevention, risks, opportunities and outcomes, beyond the traditional boundaries of reproductive health. Social determinants of health, a life course approach to health, and chronic disease prevention can broaden our perspectives and offer new possibilities for urban MCH impact. Three key presenters shared the stage to offer perspective and personal vision. Selected highlights follow:

Paula Braveman, Director, Center on Social Disparities in Health, University of California, San Francisco

Braveman offered the following basic points:

Major economic and psychosocial hardships are relatively common, not rare, occurrences during pregnancy. These hardships affect a broad and diverse cross section of women rather than being confined to just one or two groups. Current scientific knowledge gives us a basis for believing that these are likely to adversely impact maternal and infant health. Based on the recognition of these points, a need exists to reassess the social and economic as well as the medical content of prenatal services given in this country. Social determinants of health that should be considered when designing prenatal services include neighborhood conditions and racism. Accumulating literature says neighborhood context is very likely to matter for birth and other health outcomes. Racism, as a source of chronic and acute stress, could affect birth outcomes. Studies of the effects of racism on birth outcomes are in their infancy but the mechanisms and pathways are plausible.

Michael Lu, Assistant Professor, David Geffen School of Medicine, University of California, Los Angeles

Lu’s “life-course perspective” offers a simple message: birth outcomes are the product of experiences over the entire life-course of the woman. Disparities in birth outcomes are the consequences of differential exposures during pregnancy and across the life-course of the woman. An early programming component and a cumulative pathways component comprise the life-course perspective.

The first refers to experiences in utero, as an infant or in early childhood that can influence the development of health and disease later in life. The cumulative pathways model refers to chronic stress which can cause wear and tear on the body’s adaptive systems leading to a decline in health and function over time.

Disparities in birth outcomes, especially preterm labor, can be traced to differential exposures to stress or infection during pregnancy and to differential stress reactivity and immune-inflammatory dysregulation patterned over the life course. To improve birth outcomes and reduce disparities, stop looking for a quick fix during prenatal care. To improve birth outcomes and reduce disparities, we must start taking care of women long prior to pregnancy.

Donna F. Stroup, Director, Coordinating Center for Health Promotion, CDC, Atlanta

Stroup reminded participants that the number one killer of this country is not bioterrorism, it is heart disease. The number two killer is cancer of the lung. Depression and disabilities are far more prevalent in women throughout their life span. Chronic diseases appear to be transmissible from mothers to their children.

Stroup perceives CDC’s Futures Initiative as an attempt to streamline the collaborative process for partners at the local, state and national levels. CDC recognizes the importance of a life stage approach to health promotion, prevention, and disease protection, and will develop specific health promotion and accountability goals for each of the life stages including infants, children, and women.

CDC has a clear role to play with CityMatCH members to implement health interventions: they provide data to inform national, state, and local decision makers. CDC provides funds for programs and states and communities, conducts prevention research to determine what works, provides tools to communities to implement those interventions, works with partner organizations and provides leadership in training.

Stroup reminded participants of the 1996 WHO resolution which said in part, “Health is created and lived by people who lived within the settings of their everyday lives where they learn, work, play, and love.” Stroup invited participants to break down the boundaries between MCH and these other areas to improve the lives of women, children, and families in their communities.

2004 CityMatCH Membership Meeting

CityMatCH membership took the opportunity to get to know each other and lead CityMatCH into the future during Expedition 2004. During this meeting, critical amendments to the CityMatCH bylaws were approved; members participated in the governance of the organization, and provided feedback to Action Group (Best Practices & Policies, Education and Training, Infrastructure) leaders and staff about current priorities and future direction for CityMatCH.

Approved bylaws changes give CityMatCH more current information technology avenues for members’ services and crystallized the role of Magda Peck as Senior Advisor and CEO of CityMatCH, affording her a permanent position on the Board.

Facilitated discussions refined action group roles, planned for greater membership involvement via targeted recruiting, defined CityMatCH membership requirements, and elicited members’ recommended issues for CityMatCH focus, i.e. members’ skills development training; sharing of best practices through web conferences and e-forums; priority issue institutes modeled after the successful DaTA Institute; leadership training, incorporating skills-building and mentoring for new public health leaders via seasoned leaders, ongoing web-based discussion threads, and hands-on training around the current Urban Women’s Health Initiative.

Lastly, Kandi Buckland, Colorado Springs (CO), Board of Director’s Region VIII Representative and current Board Chair, introduced the Board and recognized Gary Oxman, outgoing At-Large Board member and 2004 conference host for his service to the Board. Other outgoing members recognized for service were: Barbara Ferrer, Boston (MA), Claude Dhararmaj, St. Petersburg (FL), and Llamara Padro Milano, Syracuse (NY).

CityMatCH members are a diverse group. The meeting gave members the opportunity to appreciate this and to play a role in transforming CityMatCH today and into the future. Plans are underway for the next Membership Meeting on September 10, 2005 in Ft. Worth, TX, in conjunction with the annual Urban MCH Leadership Conference. We look forward to seeing you there.
José F. Cordero, Acting Director of the National Center on Birth Defects and Developmental Disabilities (NCBDDD) at the Centers for Disease Control and Prevention in Atlanta, Georgia, and Peter C. van Dyck, Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) shared perspectives with participants in an interactive closing day session moderated by Mary Balluff, CityMatCH Board of Directors.

Cordero described the CDC’s Futures Initiative which has resulted in significant changes in how the organization relates to their customers, their partners, and to the public. (See CityLights, Volume 12, No. 3, CDC Announces New Goals and Organizational Design)

CDC identified two health protection goals: the first is preparedness and protection for people everywhere from infectious agents, environmental agents, and terrorism. The second goal is achieving health promotion and prevention of disease, injury, and disability for all people in every stage of life. The CDC is goal-driven, yet recognizes that science also needs to be creative and innovative, and should foster innovation by supporting scientists as they identify new ideas and take risks. CDC’s new structure will allow them to leverage key strengths for the greatest health impact and focus on reducing health disparities.

What is not changing? CDC’s commitment to scientific excellence. Science will continue to be the base of their programs. CDC’s commitment to their partners. CDC’s integrity and stewardship of the public’s trust. Cordero believes that “through our combined efforts we can improve the lives of children and their families, create a public health system that is accessible and responsive to all our nation’s citizens. We can help shape our nation so every child is born healthy and remains healthy throughout her or his life span.”

Peter van Dyck described selected areas of current focus for the Maternal and Child Health Bureau. These efforts can impact CityMatCH initiatives and provide support and a science base for our work. Early Childhood, Anti-bullying, Bright Futures, Newborn Screening, the Children with Special Health Care Needs Survey, the Children’s Survey and Obesity, were highlighted.

As one example, van Dyck described the Bureau’s campaign for anti-bullying, with a website, fact sheets, resources, videos, tapes, programs, educational campaigns, “webisodes” cartoon characterizations on the web site for kids.

Leadership Encounter

The 2004 CityMatCH Conference “Leadership Encounter,” afforded participants an opportunity to gain requested skills for championing MCH in their local communities. Skills-building sessions were fused with an inspirational plenary session led by Hugh Tilson, University of North Carolina - Chapel Hill, School of Public Health. Moderator Mary Balluff, Douglas County (NE) Health Department observed that, “Leadership is changing, resources are changing; our time commitments are changing; our partners are changing. That makes a significant difference in how we do our jobs.” Tilson identified key leadership challenges facing public health today, saying, “Our job is to facilitate what the public needs, not to tell them what to do.” He familiarized participants with the Institute of Medicine’s report on “The Future of the Public’s Health in the 21st Century” (see http://www.iom.edu/report.asp?id=4304). As one participant stated, “Tilson is a brilliant leadership educator, teaching…by drawing out the experiences of others and by example, through his inclusive, respectful and encouraging leadership of the session.”

Leadership will once again be highlighted during Conference 2005, September 10-13, in Fort Worth (TX).
Urban Women’s Health: Beyond Reproduction

Grason stated, “Income differentials can impact the health of women in the service sector, as well as that of their families. Discrimination, hiring, advancement, distinguishing between paid work and unpaid work, have not been sufficiently addressed in terms of health and income security in health care. We need to think broadly about poverty-related health problems and seek opportunities for screening women for such problems. Gaps in insurance coverage before, after, and between pregnancies, can lead to late initiation of prenatal care despite best intentions. Threats to enhanced Medicaid maternity coverage and presumptive eligibility are emerging. The polarization of this country presents great challenges beyond the elections. Unity is a much better strategy than denial; we must address the gaping need for truly progressive health care reform.”

Zenobia Harris’ personal story illustrated the need to advocate for comprehensive women’s health services and for community change advocates to express the concerns of urban women, to further services and resources for women in urban communities to improve their health status, and the health status of their children.

The panelists and audience discussed issues influencing urban women’s health. They spoke of access to health care, the fraying safety net, and emphasized the need to address root causes of poor health such as poverty. Racism and sexism were acknowledged as factors that affect health and wellness. This session focused on threats to urban women’s health and emphasized the need for action. By focusing on women’s health, we may impact the health of individual women, their families, and our future generations.

For more information about urban women’s health activities at CityMatCH, see below or contact CityMatCH at 402-561-7500.

CityMatCH: Fostering Urban Women’s Health

During Pre-Conference activities, the CityMatCH Urban Women’s Health Subcommittee and invited guests engaged in thoughtful conversation about future directions. This year saw the publication of a second issue brief, development of a compendium of Promising Practices due out in 2005, initial preparations for a third Issue Brief, and plans for a Women’s Health Toolkit providing practical tools to help communities build capacity to improve urban women’s health.

Subcommittee members recognize the importance of making a business case related to benefits and cost savings from improving the health of urban women. Though we intuitively know healthy women lead to healthier children, families, and communities, what does the research say? We know data exists for certain types of women’s health care services such as family planning and prenatal care, but what else exists? This information is vital in making strong arguments for supporting services directed at urban women.

A featured guest speaker at the Urban Women’s Subcommittee meeting was Michelle Berlin from the Oregon Health & Science University. Berlin is one of the primary authors of, “Making the Grade on Women’s Health–A National and State-By-State Report Card 2004,” and serves as the director of OHSU’s National Center of Excellence in Women’s Health.

Berlin described the work of the OHSU Center for Women’s Health, which is pioneering a model of women’s health care that treats the whole woman—meeting her physical, emotional, spiritual and psychological needs in one convenient location. For more about the National Centers of Excellence in Women’s Health, visit http://www.4woman.gov/COE/centers/index.htm

The Urban Women’s Health Subcommittee reviewed current accomplishments and began outlining next steps. Hearing what other dedicated people are doing to improve the health of women in their communities was thought provoking and inspired conversations that were passionate, interesting, and provocative.
Navigation Teams Explore Ways to Make Posters Most Effective

Navigating a complex array of learning opportunities can be more rewarding if you don’t do it alone. To enhance the CityMatCH Conference learning experience, participants were assigned to “Navigation Teams” and a series of exercises were woven throughout the meeting. The Promising Practices Poster Review session afforded participants practical experience in reviewing posters for composition, construction, and presentation. Prior to the peer review exercise, Elliott Churchill, Senior Communications Officer, Epidemiology Program Office, Division of International Health, CDC, offered strategies for effectively presenting posters to a critical audience. Churchill posed questions addressing key domains for poster development and criteria for review:

**Visual Effect:** How will you make your poster effective visually? What visual effects will you use? - Photographs; Graphs (not tables); Spatial Diagrams; Maps; Line Drawings (cartoons, other illustrations)

**Public Health Implications:** This should be your last panel—How will you illustrate that panel? Can you create a “theme” illustration that can be used as an icon throughout the poster that leads the viewer to this final panel? In other words, can you create a visual Single Overriding Communication Objective (SOCO) for your poster?

**Color:** What color will you use on the mats for your poster panels? Why? How will it show up on the display board (which, for this conference, is white)? Where will your handouts be?

**Dimensions:** What will be the dimensions of the mats for your display panels? The dimensions of the poster panels themselves? The size of the font used for the text?

**Flow:** How will you guide the viewer from one panel of your poster presentation to the next? Read left to right with stacked rows of panels? Read in a clockwise fashion with panels surrounding a central panel? Some other arrangement?

Recognizing and Rewarding Promising Practices in Urban MCH

The Promising Practice poster presentations and reception, partially funded by the March of Dimes Birth Defects Foundation (See related story on page four), offered participants opportunities to network with peer MCH professionals, recognize outstanding efforts and learn the strategies they are using to promote MCH in urban areas. Zenobia Harris, CityMatCH Vice Chair for Education and Training, shared the results of the Promising Practice Poster Presentation. Awards were presented to recognize outstanding efforts and showcase these promising strategies to promote MCH in urban areas.

Promising Practice abstracts accepted for Expedition 2004 reflected recent innovative activities, strategies or lessons learned that strengthened conference participants’ capacity to serve children and families. Profiles responded to a “persistent barrier” and offered replicable practices. These profiles provide key information and offer additional strategies and practical advice for our members as they address new and chronic MCH issues. All profiles are available as a pdf document for viewing, downloading or printing at the CityMatCH website: http://webmedia.unmc.edu/community/citymatch/Conf04/PromisingPracticeAbstracts.pdf. For more information, contact CityMatCH at 402-561-7500 or via E-mail at citymch@unmc.edu. (See related story on page seven.)

Several exceptional Promising Practices abstracts submitted for Expedition 2004 were selected to receive awards in the following categories:

**Most Innovative:** The award for an abstract presenting innovative responses to specific problems, issues or barriers, was presented to: Anand Chabra, San Mateo County (CA) Health Services Agency, for their program, “What Fathers Need: A Countywide Assessment of the Needs of Fathers of Young Children.”

**Most Replicable:** The award for an abstract documenting the essentials for feasible replication, was presented to: Cynthia Farkas, Jefferson County (CO) Department of Health and Environment, for their program entitled, “Community Antepartum Alternative Program (CAAP).” (See related story on page seven)

**The STAR Award:** The award for Strategic Translation of Action and Results, was presented to: Muriel Nagle, Madison (WI) Department of Public Health for their program entitled, “Evaluation of a Public Health Nursing Perinatal Care: Coordination Program in a Local Public Health Department.”

**The EXTRA - EXTRA Award:** The award for Excellance in Translating Results to an Audience, was presented to: Sue Mitchell, Saint Paul-Ramsey County (MN) Department of Public Health, for their program, “Engaging Families on Welfare in Ramsey County, MN...Public Health Presents the Big Picture.” (See related story on page seven)

For more information, contact CityMatCH at 402-561-7500 or via e-mail at citymch@unmc.edu. See related stories on page six.
Engaging Families on Welfare in Ramsey County...Public Health Presents the Big Picture

Editor’s Note: Saint Paul-Ramsey County (MN) Department of Public Health was awarded the 2004 CityMatCH EXTRA - EXTRA Award for this project. (See related story on the preceding page)

More than seventy percent of teen parents end up on welfare at some point in their adult lives; over 50 percent of families on the Minnesota Family Investment Program (MFIP) in Minnesota in 2001 began with a birth to a teen mom; and only 41 percent of mothers who have children before age 18 ever complete high school. What to do?

In previous years, employment services were delivered inconsistently to Ramsey County (MN) pregnant and parenting teens receiving TANF benefits. Only one-third of those teens voluntarily chose to receive public health nurse (PHN) home visiting services. Yet, research has shown that PHN home visiting services are the most effective strategy in promoting healthy outcomes and self-sufficiency.

In July 2003, the Saint Paul-Ramsey County Department of Public Health was offered a contract to provide PHN home visiting services as well as job/school counselor services to pregnant and parenting teens who receive TANF cash assistance. Nurses now were given the ability to sanction the cash benefits of teens not in compliance with their school plan. This program works to assure that teens will graduate from high school; will demonstrate positive attachment to their children; will increase child spacing; will maintain housing stability; and children will have well-child exams, health insurance, up-to-date immunizations, reduction in unintentional injury, and normal growth and development.

Due to positive outcomes associated with PHN home visiting services, many pregnant and parenting teens in the community chose to voluntarily receive PHN home visiting services, yet only one-third of those teens were being served. Pregnant and parenting teens receiving TANF assistance, called MFIP in Minnesota, are each assigned a job counselor and must have an approved job/school plan in order to receive cash assistance. Under current Minnesota law, job counselors have the ability and obligation to sanction the benefits of a teen who is not in compliance with their job/school plan.

Initial results show more pregnant and parenting teens participating and receiving more coordinated, intensive, and comprehensive services; essential collaboration with county departments and the school district has been established; improved service delivery, increased efficiency of services, and more effective communication between service providers.

This is the first program in the country where TANF employment services are delivered through a public health department home visiting program. Matched caseloads among nurses, financial assistance staff and child care funding staff, providing relationship-based services; intimately involving nurses in all aspects of program design and implementation and creating multidisciplinary home visiting teams, including nurses, social workers, nutritionists, health educators and other paraprofessionals are key components to program effectiveness.

For more information, please contact Sue Mitchell, Saint Paul-Ramsey County (MN) Department of Public Health at 651-266-2428.

Community Antepartum Alternative Program (CAAP)
Focuses on Assurance

Editor’s Note: The Jefferson County (CO) Department of Health and Environment was awarded the 2004 CityMatCH Most Replicable Award for this project. (See related story on preceding page)

The Community Antepartum Alternative Program (CAAP) is a joint project of the March of Dimes and the Jefferson County (CO) Department of Health and Environment (JCDHE), now in its third year of funding. CAAP addresses the problem of low birthweight (LBW) rates. The Healthy People 2010 goal for LBW is 5.0 percent, and the LBW rate in Jefferson County is 8.2 percent.

Nurse home visiting services are provided to pregnant women with risk factors for preterm birth or other health complications of the mother or newborn. Risk factors identified on the prenatal referral include a previous preterm birth, substance use or abuse, less than twelve months between pregnancies, teen pregnancy, late or no prenatal care, inadequate weight gain in pregnancy or other health complications, and high levels of stress.

Services include three antepartum home visits by the Community Health Nurse (CHN), which highlight assessment, teaching, and encouragement of healthy behaviors. Referrals are made to appropriate community resources. Delivery is followed by one postpartum visit to assess maternal and newborn well-being after discharge from the hospital, and to review self and infant care and breastfeeding. In the first year of CAAP, 25 pregnant women received services. Funding increased during the second year, and forty women received services.

CAAP focuses on the core public health function of assurance and provides a funding source for an “alternative” home visitation program for women who are at risk for a low birthweight infant and who are not eligible for the other two prenatal home visitation programs.

All clients enrolled in CAAP present with multiple physical, medical and/or socioeconomic risk factors for complications of pregnancy, including preterm birth and low birthweight. Pregnant women at risk for complications of pregnancy and childbirth including preterm labor and low birthweight, and who are not eligible for more intensive nurse home visitor programs, benefit from the individual attention and teaching of a home visiting CHN with extensive maternal and child health experience.

Contacting a transient client referral base continues to present the greatest barrier to enrolling clients, as well as to continuing to follow them throughout their pregnancies. The client’s willingness to resolve high-risk behaviors and impinging factors of a socioeconomic nature, often present barriers to the effectiveness of the program.

Low-income, pregnant women with identifiable risk factors for poor birth outcomes can benefit from a short-term home visitation program such as CAAP. The CHN can provide education and counseling that address those factors that are potentially modifiable and include inadequate weight gain, smoking, entry into prenatal care, and inter-pregnancy interval. This program is integrated into existing services and remains flexible to accommodate the needs of the prenatal client.

For more information, please contact Cynthia Farkas, Jefferson County (CO) Department of Health and Environment at 303-239-7003.
CityMatCH Champions Recognized by Coalition for Excellence in MCH

Two CityMatCH champions were acknowledged for their significant contributions to Maternal and Child Health (MCH) by the Coalition for Excellence in MCH Epidemiology during the Tenth Annual MCH Epidemiology (MCH EPI) Conference in Atlanta (GA) on December 9, 2004. These awards are reserved for the best and brightest in maternal and child health.

Magda Peck has championed women’s and children’s health for much of her professional life. Peck was nationally recognized when she was named an “Outstanding Leader.”

Peck is CEO, Senior Advisor and founder of CityMatCH, the national public health organization dedicated to improving the health and well-being of women, children and families in America’s urban communities. It was her vision to bring together urban MCH leaders and programs in a mutual effort to learn from one another, strengthening urban MCH capacity, which ultimately developed into CityMatCH. Her vision and passion have led to innovative national initiatives (including City Data, the Rapid Fax Query, the Data Institute, the Perinatal Periods of Risk [PPOR] Collaborative, and the Urban Perinatal HIV Project) to assist urban public health leaders and agencies address MCH issues using sound practice and salient information.

Carol Brady, Director, Northeast Florida Healthy Start Coalition, was recognized for “Effective Practice at the Community Level.” No stranger to CityMatCH, Carol Brady has been a valuable asset in promoting and teaching the PPOR approach to reducing infant mortality, participating in numerous PPOR trainings as faculty, and sharing her successes and challenges with public health professionals across the United States.

Ms. Brady used data to advocate for the establishment of Florida’s Healthy Start, pioneered the utilization of the PPOR Approach in her own community and state, and developed a local and state data management system for fetal and infant mortality (FIMR). Her effective use of data led to the Northeast Florida Healthy Start Coalition’s establishment of the Magnolia Project in 1999, incorporating pre- and inter-conception interventions to reduce infant mortality, far ahead of current, national trends.

The National MCH EPI Awards recognize individuals, institutions and leaders for making significant contributions to improve the health of women, children and families. Also receiving awards were David Savitz, Cary C. Boshamer Distinguished Professor and Chair, University of North Carolina School of Public Health, for “Advancing Knowledge;” Paul Allen Buescher, Statistician, Division of Public Health, North Carolina Department of Health and Human Services, for “Effective Practice at the State Level;” Laura Kann, for “Effective Practice at the National Level;” and Kay Marie Tomashek, Medical Epidemiologist, Division of Reproductive Health, Centers for Disease Control and Prevention, for “Young Professional Achievement.”

Our congratulations to Peck, Brady and to all the 2004 awardees.

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