Through promoting communication and collaboration to improve the health of urban women, children and families, rates subsequently dipped back down. Only for a while. In 2003 and 2004, overall perhaps more fundable or more in focus, if rendered infant mortality a hot public. The unanticipated rise was an outcome useful for bringing infant mortality – carefully combining and scrutinizing local community data to determine potential interventions with maximum impact. So how are we really doing on infant mortality? This issue of CityLights uses Perinatal Periods of Risk (PPOR) to give an opening answer. Inside are fetal and infant mortality data from selected localities in the U.S., based on national data for 2000-2002. We provide here Phase I PPOR Mapping data, which partitions overall fetal-infant mortality rates into four “periods of risk.” We invite you to see how your city or county is doing and examine the rates in other areas. Further local level national data on estimated excess deaths and other PPOR analyses are found at the CityMatCH web site: www.citymatch.org.

This edition of CityLights also offers a series of related stories weaving the threads of fetal and infant mortality prevention together: CDC’s new guidelines for preconception care, changes to Medicaid, revised SIDS recommendations including safe sleep, recent revisions to Sudden Unexplained Infant Death scene investigation and reporting, and a data insert with updated PPOR fetal-infant mortality tables for the nation’s largest cities and counties. Each tool or strategy may impact fetal or infant losses ascribed to maternal health and/or prematurity, maternal care, newborn care and infant health.

Taken individually, no one effort can eliminate all preventable fetal and infant mortality, yet weaving these and other available threads together into a strategic fabric of optimism, individually tailored to community-identified areas of concern, remains the nation’s best hope to reduce the disturbing rates of fetal and infant mortality for all – regardless of race or ethnicity, educational attainment, income or class. What is the public health message from all of this? CityMatCH and its many partners for urban health must and will continue to champion the most vulnerable: women, children, and families living in the urban environment, where poverty, racism, decaying neighborhoods, non-existent or minimal public services, and weakened financial support strip away both prospects and hope. The data bear silent witness to entrenched disparities in health outcomes between those who have the least yet need the most and those for whom opportunity and access is nearly limitless.

Remembering Infant Mortality
by Carolyn B. Slack, MS, RN, Director, Family Health Policy, Columbus (OH) Health Department

"Infant mortality is a subject of profound social importance. The modern view has ceased to be fatalistic; infant mortality is now regarded as a preventable waste..." These powerful words were written by Julia Lathrop, the first Chief of the Federal Children's Bureau in 1914. They haunt me. As an MCH leader, they stand to accuse and indict me and public health for insufficient efforts to reduce this "preventable waste." These words are nearly 100 years old, yet the notion of fatalism persists.

Many of us are learning to understand why babies die as a result of the Perinatal Periods of Risk - PPOR methodology. It is a community planning process that looks at the numbers in new ways and results in actions focused on areas with the greatest gaps between what is and what should be. PPOR analyses take into account both infant and fetal deaths. In general, the Infant Mortality Rate remains an essential public health indicator. For public health practitioners, from the early 1900s on, to quote Sir Arthur Newsholme, we know that "Infant Mortality is the most sensitive index we possess of social welfare..."

In the high-energy, unrelentingly urgent and relatively well-funded environment of emergency preparedness, be it for bioterrorism or pandemic flu, infant mortality plays as, well, so 15 minutes ago. It is easy to forget that babies are dying all around us. And, it is horrifying to think that we do forget. Over a year, in our community, 150 babies died. That is one baby every 58 hours. That is three babies every week. They die quietly and are buried by their heartbroken families. Surely, our immediate imperative as MCH public health leaders is to break the silence and eradicate the fatalism. Giving voice, with greater knowledge, must lead to action.

How do we do this? This "methodology" may sound familiar. We gather data, information and stories to explain infant mortality and its causes, risk factors and consequences in a way that engages. We identify and implement programs, services, and policies that will make a difference. We garner political will through meaningful partnerships and by educating officials, policy makers, the general public, our family, friends and neighbors. We make it unacceptable not to do more to reduce fetal and infant deaths.

The words of Julia Lathrop quoted above were from her Letter of Transmittal about the results of the Bureau's first study to focus on Infant Mortality. This study, "Infant Mortality, Results of a Field Study in Johnstown, PA Based on Births in One Calendar Year," should be required reading for all MCH and public health practitioners. This dynamic piece of work presents both quantitative and qualitative data that resonate. It is impeccable in describing the methodologies and results; it is a document that demands action. I believe if we had implemented the recommendations put forth in 1914, we would not have such a deplorable problem now. The recommendations and observations remain germane today. They are and should be components of our PPOR action plans. I want to share some of these with you - to inspire.

"But the public's responsibility does not end merely in remedying such conditions as just noted (clean water, safe housing, paved streets and alleys, sewage disposal and garbage collection). There is a growing tendency on the part of municipalities to accept the responsibility for furnishing information and instruction to its citizens. Some cities have reduced their infant mortality rate by having expectant mothers instructed in prenatal care; others by sending instructive visiting nurses, immediately after the birth of a child, into homes that need them. Other means which have been found effective in reducing excessive infant mortality rates are baby welfare stations, consultation stations for expectant and nursing mothers, and the distribution of sound literature on prenatal care, the care and feeding of infants, the care of milk and other hygienic matters."

"The Johnstown report shows a coincidence of underpaid fathers, overworked and ignorant mothers, and those hazards to the life of the offspring which individual parents can not avoid or control because they must be remedied by community action. All this points toward the imperative need of ascertaining a standard of life for the American family, a standard which must rest upon the betterment of conditions of work and pay as will permit parents to safeguard infants within the household."

"It is therefore desired to pursue this inquiry in various typical communities throughout the country so that the facts may secure popular attention. Clearly the law creating the Children's Bureau, framed by experts in child welfare, embodies the conviction that if the Government can 'investigate and report' upon infant mortality, the conscience and power of local communities can be depended upon for necessary action."

How humbling yet empowering are these words! We need to be the "conscience" that assures what must be done, will be done, in order for women, children and families to thrive in our communities. If not us, who?
Improving Preconception Health and Care: The Recommendations are Here

Some would suggest that improvements in pregnancy outcomes in the US have slowed perhaps because we have failed to intervene prior to pregnancy, failed to detect, treat and help women modify behaviors, health conditions and risk factors that contribute to adverse perinatal outcomes. A forthcoming report, slated for release in April 2006 by the CDC in the Morbidity and Mortality Weekly Report (MMWR), suggests that “Preconception care could succeed in improving maternal and child health where the current paradigm is failing, but most providers don’t provide it, most insurers don’t pay for it, and most consumers don’t ask for it. … Even though we know that many interventions, if delivered before pregnancy, could improve pregnancy outcomes for women and babies, millions of women and couples do not receive such interventions and services.”

The significant improvements in infant and maternal pregnancy outcomes during the past 40 years have resulted largely from the intensified focus on family planning in the 1960s and 1970s, on child health in the 1970s and 1980s, and on prenatal care in the 1980s and 1990s. “Today, the greatest opportunities for further improvement in pregnancy outcomes—improving the health of women and their children—lie in prevention strategies that must be implemented prior to conception to be effective. Preconception care is the new frontier in maternal and child health. Now is the time for a paradigm shift—there is an urgent need for a renewed focus on prevention in maternal and child health,” said Hani Atrash, M.D., M.P.H., Associate Director for Program Development at the National Center on Birth Defects and Developmental Disabilities at CDC.

This definitive report identifies preconception care as, “interventions that aim to identify and modify biomedical, behavioral, and social risks to the health of a woman or her baby, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximal impact.” It identifies more than a dozen risk factors and conditions that require interventions before pregnancy to be effective. One key to improving preconception health of women and couples is changing their knowledge base and related behaviors. Equally important, the report states, is giving physicians and other health care providers the knowledge and tools to act upon the scientific evidence that exists about how and when to intervene. Preconception health and care must be integrated into existing public and private health care systems. Access to preconception care for low-income women must be improved, and a number of mechanisms are outlined to achieve this.

When it comes to improving the health of babies, the CDC report says prenatal care comes too late—starting early with preconception care is the key. Improving preconception health and health care is the focus of the CDC preconception health recommendations.

These recommendations call for action to reduce the risks that can be identified before conception, focusing on strategies to improve consumer awareness and changes in the health care system. For example, too few women know and too few providers stress that alcohol, smoking, and certain prescription drugs can cause birth defects in the first few weeks of pregnancy—before most women know they are pregnant.

The Recommendations to Improve Preconception Health and Care have been developed by a panel of 35 experts convened by the CDC and scientists from 22 programs within CDC. Through a two-year collaborative effort, the CDC successfully aligned the mission of a number of its external partners—including CityMatCH and internal programs. CityMatCH founder, CEO and Senior Advisor, Dr. Magda Peck, a long-time advocate for preconception health and health care, participated as a member of the expert panel.

The work builds on prior reports from a range of professional organizations such as the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG), which focus on three components of preconception care: 1) screening for risks, 2) health promotion and education, and 3) interventions to address identified risks.

What do the recommendations say? First, they are based upon a vision for preconception health of the entire population, and are designed to achieve four goals: to improve the knowledge, attitudes and behaviors of men and women related to preconception health; to assure all U.S. women of childbearing age receive preconception care services, to reduce risks indicated by a prior adverse pregnancy outcome through interventions in the interconception period and to reduce disparities in adverse pregnancy outcomes.

These recommendations concentrate on changes in consumer knowledge, clinical practice, public health programs, health care financing, and data and research activities. Each recommendation is delineated into action steps, which the authors say can be implemented now and will begin to yield results within two to five years—still in time to impact Healthy People 2010 goals. The combined vision, goals, recommendations and related action steps essentially create a strategic plan to improve the health of women, children and their families.

These CDC recommendations are slated for release on April 22, 2006 in the MMWR. Each CityMatCH member will be sent a copy of the publication, which can be found online at: http://www.cdc.gov/mmwr/

For more information, contact: Hani K. Atrash, M.D., M.P.H. Associate Director for Program Development National Center on Birth Defects and Developmental Disabilities at CDC Phone: (404) 498-3075 Fax: (404) 498-3070 E-Mail Hattrash@cdc.gov

Behold the turtle. He makes progress only when he sticks his neck out. –James Bryant Conant (1893 - 1978)
CityMatCH member health departments continue to seek out tools and strategies to reduce preventable infant deaths related to SIDS and SUID. CityMatCH has a role to play in helping translate scientific research and data into evidence-based tools and strategies designed for the unique needs of the urban environment.

The following two pages offer some common terms and definitions, and present selected evidence-based tools and strategies. Current recommendations to prevent SIDS and SUIDs are discussed and some of the known risk factors presented.

SIDS and SUID deaths reflect a complex interplay of known and unknown factors; the frustration for practitioners is that so much still remains unidentified or unknown.

Paul S. Rusinko, Director of HRSA’s Sudden Infant Death Syndrome/Infant Death Program, recently stated that “A number of variables (related to a safe sleep environment) including sleep surface, smoking, soft bedding, overheating, bed-sharing and unaccustomed prone sleeping, increase the risk of SIDS and other infant death.” Though most local MCH leaders are well-versed on the American Academy of Pediatrics’ SIDS recommendations, some of what Rosinko expressed is relatively new and reflects updates to those recommendations announced by the AAP in November. See page five for key updates.

Because accurate death scene investigation and reporting is needed to help determine the causes of infant deaths and to point out potential areas of intervention, CDC’s newly revised Sudden, Unexplained Infant Death Investigation (SUIDI) reporting form offers new opportunity. CDC believes consistent, comprehensive death scene investigation and accurate reporting will provide better data which can in turn inform proposed solutions. CDC also understands that training local investigators to incorporate the new, standardized forms into their procedural tool kit has additional potential for impact and as a result, developed a curriculum and will offer training; a related story is found on the next page.

Abundant resources, including current information, data, policy, program and practice related to SIDS and SUIDS, exist to help member health departments shape interventions. National foundations, research and resource centers, family support organizations, etc. provide tools such as websites, publications and data sets.


2 Willinger, James, and Catz. “Defining the Sudden Infant Death Syndrome (SIDS).” Pediatric Pathology 1991; 11(5): 677-84
3 Website: http://wonder.cdc.gov/wonder/prevguid/m0042657/m0042657.asp

Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. 2

Sudden, Unexplained Infant Deaths (SUIDs) are those for which no cause of death was obvious when the infant died. SIDS is the most frequently determined cause of SUID. 3

Leading Causes of Infant Mortality: In 2002, the three leading causes of infant mortality were birth defects, prematurity and SIDS.4

"Back to Sleep"

One example of the successful translation of data into public health tools and strategies is the Back to Sleep campaign. This well-known campaign has been instrumental in promoting infant back sleeping to parents, family members, child care providers, health professionals, and all other caregivers of infants.

This effort has been sponsored by the National Institute of Child Health and Human Development (NICHD), the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs.

The NICHD has embraced the 2005 American Academy of Pediatrics (AAP) Policy Statement on reducing the risk of SIDS and has begun to incorporate new risk-reduction messages into all of their Back to Sleep campaign materials. (See related story at right on recommendations.) Visit the website at: http://www.nichd.nih.gov/sids/.

PPOR Data suggest that efforts in SIDS and SUID prevention may impact rates reflected in the yellow (Newborn Care) and green (Infant Health) periods of risk.

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Each year in the United States, more than 4,500 infants die suddenly with no obvious cause. Half of all sudden, unexplained infant deaths (SUID) are attributable to sudden infant death syndrome (SIDS), the leading cause of SUID and of all deaths among infants aged 1–12 months.

Largely because of the national Back to Sleep campaign, SIDS rates have declined by more than 50% since 1990. However, studies have shown that since 1999, some deaths previously classified as SIDS are now classified as due to accidental suffocation or unknown cause. This finding suggests that changes in reporting of cause of death may account for part of the recent decrease in SIDS rates.

By definition, SIDS can only be diagnosed after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death. And yet we know that some SUIDs are not investigated and, when they are, cause-of-death data are not collected and reported consistently. This is concerning because inaccurate classification of cause and manner of death ultimately impedes prevention efforts because researchers cannot adequately monitor national trends or evaluate prevention programs.

CDC launched an initiative in 2004 to improve the investigation and reporting of SUID, in collaboration with other federal agencies and organizations representing medical examiners, coroners, death scene investigators, emergency medical personnel, law enforcement officials, forensic nurses, SIDS researchers, infant death review experts, and SIDS parents. As part of this effort, in March, 2006, CDC released the Sudden, Unexplained Infant Death Investigation (SUIDI) Reporting Form for state and local use in infant death scene investigations. The SUIDI Reporting Form replaces the Investigation Report Form that accompanied the 1996 Guidelines for the Death Scene Investigation of Sudden, Unexplained Infant Death. The revised form can be downloaded from the CDC website at: http://www.cdc.gov/SIDS/PDF/SUIDIForms.pdf. Instructions on how to use the revised SUIDI Reporting Form can be found at: http://www.cdc.gov/SIDS/PDF/How%20to%20Use%20SUIDI%20Forms.pdf.

In collaboration with a steering committee and a team of national experts, CDC developed a comprehensive training curriculum and materials for infant death scene investigations. Currently, there are no national training materials on the conduct of an infant death scene investigation. CDC will use these materials to train investigators and death certifiers in how to consistently collect data at the death scene and accurately report their findings on the death certificate. CDC will conduct five regional train-the-trainer academies over the next two years. The first regional train-the-trainer academy will be held in St. Louis, Missouri, on June 12 – 15, 2006, and the second academy will be held in Atlanta, Georgia, on September 18 – 21, 2006.

CDC has developed a promotional campaign to advance the new form and training materials among its partners and stakeholders. A thorough understanding of the importance of accurately collecting and reporting infant death-scene data is crucial to the eventual widespread and consistent use of these tools. These efforts will allow improved surveillance and research aimed at preventing infant deaths.

For more information on CDC’s SUID Initiative, please contact Terry W. Davis, Ed.D., National Training Coordinator, ORISE Fellow, Maternal and Infant Health Branch, CDC, Phone: (770) 488-6259 or via E-mail at tdavis5@cdc.gov. Readers may also visit the website at: www.cdc.gov/SIDS.

AAP Revises SIDS Recommendations on Pacifier Use, Safe Sleep

In an November, 2005 policy statement, “The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk,” the American Academy of Pediatrics (AAP) reaffirmed previous recommendations and stirred up a bit of controversy with the release of new recommendations.

To recap the AAP’s amendments, side-sleeping should no longer be recognized as a reasonable alternative to fully supine (lying on back) sleeping. It has been determined that this position may increase the chances for the infant to roll onto the stomach and place themselves at risk for SIDS.

While infants may be brought into bed for nursing or comforting, the AAP recommends they be returned to their own crib or bassinet when the parent is ready to sleep; bed sharing is not recommended during sleep. Some evidence supports room sharing (infant sleeping in a crib in parent’s bedroom) as being associated with reduced risk for SIDS, therefore the AAP recommended a ‘separate but proximate’ sleeping environment.

A recommendation promoting the use pacifiers at naptime and bedtime throughout the first year to reduce the risk of SIDS, has been the cause of some controversy. Breastfeeding advocates expressed concerns about pacifier use impeding breastfeeding but the evidence suggesting pacifier use inhibits breastfeeding or causes later dental complications was not deemed compelling enough to discredit the recommendation.

Pacifier introduction for breastfed infants should be delayed until one month of age to ensure the skill is firmly established and the recommendations do not suggest forcing babies to use a pacifier.

A slightly increased risk of ear infections is associated with pacifier use, but the incidence of ear infection is generally lower in the first year of life, especially the first six months, when the risk of SIDS is the highest. The protective effect may well outweigh the risk of ear infections.

For more information, visit the web at http://www.aap.org/ncepr/revisedsids.pdf.
Medicaid: What Now?

Federal Medicaid law has been changed; whether those changes are for better or for worse remains to be seen. What is clear is that state policymakers increasingly have the power to define child and family health policy and that local MCH leaders have important roles to play in the process.

The direction of the new federal policy is consistent with trends that began a decade ago with the State Children’s Health Insurance Program (SCHIP); that is, greater emphasis on family responsibility for costs, the opportunity to offer benefit plans similar to Blue Cross-Blue Shield, and more explicit options to subsidize coverage for children in families with higher incomes.

The Deficit Reduction Act of 2005 (DRA) was signed into law in early February. While final regulations have not been released by the federal Center for Medicare and Medicaid Services (CMS), the consensus among expert analysts points to the following changes.

Family Cost Sharing: Under prior law, children were exempt from cost sharing (with possible exceptions under waiver programs). Similarly, pregnant women in Medicaid were exempt from cost sharing for pregnancy related services.

The DRA makes significant changes, giving states the option to charge families for: premiums (e.g., monthly payments for coverage); co-payments (e.g., $10 per visit); and/or co-insurance (e.g., 10 percent of the cost of a visit or a hospital stay). While DRA offers some protections such as upper limits on the amount low-income families may be required to pay, informing and empowering families will be essential.

Benefits in Benchmark Plans: Prior Medicaid law required that child health benefits, as defined by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, include all of the services available under Medicaid, even if these services were not covered for adults in the state. In most states, children had effective coverage of the full range of screening, diagnostic, and medically necessary treatment services.

Under DRA, states have the option to offer coverage through so-called “benchmark” benefit plans. The federal employee, state employee, or typical BlueCross/Blue Shield plans are examples. The legislation does not however appear to eliminate the requirement for states to cover the broader range of services defined in EPSDT. As with managed care, states may offer certain benefits under a benchmark plan but they also retain the residual obligation to pay for additional services as necessary.

Targeted Case Management: Under prior law, states were employing various types of case management. Some were considered administrative support (e.g. prior authorizations, out-stationed eligibility workers) and qualified for 50 percent federal matching. Other types were considered medical assistance (e.g. certain home visits or counseling and referrals for pregnant women) and qualified for federal matching at the states medical assistance rate — typically above 50 percent.

Addressing Healthy Weight to Improve Birth Outcomes

In February of 2005, CityMatCH and the Association of Maternal and Child Health Programs (AMCHP) developed the Women’s Health Partnership (WHP) to promote safe motherhood and enhance women’s health before, during and after pregnancy. During the next several years, areas of concentration will be developed to address key concerns.

As a first area of concentration or focus, the Women’s Health Partnership has chosen to promote healthy weight in women of reproductive age. This was selected based on CityMatCH and AMCHP’s mutually identified priorities. Membership from both organizations expressed concern about adverse perinatal outcomes and about rising rates of obesity in women and children. With support from the Centers for Disease Control and Prevention (CDC), the WHP has spent the past year working to build the knowledge base, to gather promising strategies, and to develop new approaches to promoting healthy weight in women of reproductive age.

(Continued on page seven)
Find Your Place on the CityMatCH Board

Nominations are currently being solicited by the CityMatCH Central Office to fill upcoming vacancies on the Board of Directors. Current eligibility regulations require that nominees be the designated CityMatCH representative from a member health department located in the region for which the vacancy exists.

Up for election in 2006 are Marilyn Seabrooks, M.P.A. (representing North East #1), Ann Sayler Caldwell, M.P.H., RD/LD (South Central #1), Kathy Carson, R.N. (West #1), and Kimberlee Wyche-Etheridge, M.D., M.P.H. (At-Large). The regions listed represent the following states: **North East** (Delaware, West Virginia, Maryland, Maine, Vermont, New Hampshire, New York, Pennsylvania, Massachusetts, Rhode Island, Connecticut, New Jersey, The District of Columbia, Ohio); **South Central** (Arizona, New Mexico, Kansas, Oklahoma, Texas, Missouri, Arkansas, Louisiana); and, **West** (Hawaii, California, Nevada, Utah, Washington, Oregon, Idaho, Montana, Alaska).

Any designated CityMatCH representative is eligible for nomination and election at or to-large positions on the Board of Directors. Eligible individuals may nominate themselves or be nominated by another member representative.

Once elected, new Board Members will assume office during the annual CityMatCH conference this August, 2006, in Providence, RI and serve a three-year term. For more information, contact Mark Law, M.S., at (402) 561-7500 or via E-mail at mlaw@unmc.edu.

Ask-A-Colleague

CityMatCH has simplified the which can now be initiated, de- Responses will also be collected and access the AAC service to quickly and efficiently query their colleagues around the country on MCH concerns.

The new process is simple: First, the member accesses the AAC section of the CityMatCH website and posts their questions; staff work with the member to refine the questions. Next, the query is posted on a web-page available only to other CityMatCH members. Members are alerted to the AAC via E-mail and given an individualized link to participate.

The online AAC process walks users through tool options, i.e. Likert scale, yes-no, checkbox, qualitative response, etc. After submitting a response, members may view other responses. A complete E-file is sent to the requesting member and responses archived for ninety days. For more information, contact Maureen Fitzgerald, M.P.A., at (402) 561-7500 or via E-mail at mfitzger@unmc.edu.

Service Now Online

Ask-A-Colleague (AAC) service, developed and completed online, posted online. CityMatCH members will implement preconception health care practices using community-based participatory research. A request for applications to participate in the ALC will be sent to all AMCHP and CityMatCH members in July, 2006.

To learn more, please contact Jennifer Skala, M.Ed., Managing Coordinator for Education and Training at (402) 561-7500 or via E-mail at jkskala@unmc.edu.

Check Your E-Mail: The CityMatCH Membership Assessment

CityMatCH will shortly launch the biennial 2006 Membership Assessment. Members will receive an announcement via E-mail with a weblink to complete the questions online.

Member responses provide a clear and current description of urban MCH programs and leaders. This assessment was first initiated in 1989 and remains an important tool for checking the pulse of urban MCH.

Reviewing priority MCH issues over the years can draw attention to persistent concerns and identify new issues. Responses influence CityMatCH planning and direction. Additionally, member demographics, health department structure, funding and staffing demonstrate the changing dynamics of urban MCH and shifts in budgets and priorities. For more information, contact Mark Law, M.S., at (402) 561-7500 or via E-mail at mlaw@unmc.edu.

CityMatCH Members Approve By-Laws Amendments

After an annual by-laws review process led by the CityMatCH Organizational Effectiveness Action Group, the Board of Directors proposed significant changes, which recently were approved by a vote of the membership. These changes include restructuring the CityMatCH Regions served by the Board.

The Board had been organized around ten Federal Regions, which over the years were less effective at assuring equal representation. Some Board members represent regions with more than 35 member health departments; others represent regions with less than 10.

The new structure establishes five geographically balanced, “Super Regions” – North-East, South-East, North-Central, South-Central, and West. Each Region will be represented on the Board by two elected members. Four “At-Large” positions and the permanent position for the CEO/Senior Advisor round out the 15 members of the Board. For more information, contact Mark Law, M.S., at (402) 561-7500 or via E-mail at mlaw@unmc.edu.

Women’s Health Partnership Spotlights Healthy Weight

A National Scientific Advisory Group (NSAG) has been convened to inform the WHP. NSAG is comprised of the National March of Dimes Birth Defects Foundation; the American College of Obstetricians and Gynecologists; the Association of Women Health’s Obstetrics and Neonatal Nurses; CDC; the Health Resources and Services Administration/Maternal Child Health Bureau; USDA, America on the Move, and state and local health departments across the country.

During the next two years, the WHP will assist local and state MCH professionals and their partners by: providing documentation (practices, measurement, monitoring, research and evaluation) on how achieving or maintaining healthy weight in women can improve birth outcomes and maternal health; offering tools to raise awareness and increase health literacy among consumers and stakeholders; making training and technical assistance available to MCH professionals to build relevant competency/capacity, and creating partnerships and collaboration between local, state, and national level public health agencies to promote healthy weight in women of reproductive age.

Currently, AMCHP and CityMatCH are planning a Healthy Weight Action Learning Collaborative (ALC) which would include up to five city/state teams who will implement preconception health care practices using community-based participatory research. A request for applications to participate in the ALC will be sent to all AMCHP and CityMatCH members in July, 2006.

To learn more, please contact Jennifer Skala, M.Ed., Managing Coordinator for Education and Training at (402) 561-7500 or via E-mail at jskala@unmc.edu.
Nashville Campaign Seeks to Reduce Infant Mortality

Over a year ago, Project Blossom, Nashville’s (TN) local infant mortality coalition, began preparations to stage a billboard campaign designed to improve community awareness around infant mortality and create greater understanding of ways to reduce the rates. The vision for this campaign is the belief that Nashville will become the healthiest city for infants and children. Unfortunately, funds were not available to support the campaign at that time and the campaign was placed on hold.

Project Blossom’s patience was rewarded this year when the State Commissioner of Health personally committed to decreasing infant mortality. Now, with funding set aside for educational materials as part of a state home visiting grant, the billboard campaign has gone from preparation and planning to execution. The whole series of billboards was on display by National Public Health Week, April 3-9, 2006. The theme for Public Health Week seemed especially appropriate: “Designing Healthy Communities: Raising Healthy Kids.”

Kimberlee Wyche-Etheridge, M.D., M.P.H., Maternal Child Health Director at the Nashville-Davidson County (TN) Health Department and a member of the coalition, stated that, “Through our CityMatCH PPOR experience, we had learned that preconception health, and prematurity were the areas we must focus our efforts to reduce fetal and infant deaths. By creating a SOCO (single overriding communication objective) that emphasized these issues, we hoped to educate a large number of community folk.”

Taking the identified communication objective and translating it into straightforward, high-impact billboard messages was accomplished during the course of several Project Blossom meetings and an intern was selected to design the boards. Dr. Wyche-Etheridge and an assistant decorated and photographed gravestones at a local monument company; the assistant took pictures of empty classrooms. Several designs were tested among coalition members and stakeholders, and the top designs selected for production. Two examples are shown with this story (See images above right).

Home-visiting clients living in the areas where the boards are displayed will be queried as part of the evaluation component. These clients will be asked questions concerning where the boards are located, which one they might have seen, what they remember from the billboards, and if they felt the messages had been effective. For further information, please contact: Kimberlee Wyche-Etheridge by phone at (615) 340-5614 or via E-mail at kimberlee.wyche@nashville.gov.