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## Viewed through the Lens: Urban MCH and the Life Course

Many readers are familiar to varying degrees with "Life Course" models or perspectives which generally propose that unique combinations of biological, behavioral, psychological, and social protective and risk factors can impact health outcomes during the lifespan and perhaps even across generations.

The September 2008 CityMatCH Urban MCH Leadership Conference has been framed around this bold set of ideas. We hope many of our members will have taken the opportunity to join us in Albuquerque for "A Life-Course Perspective: Pathways for Improving Practice in Urban MCH." For those who were not able, we have put together a short list of select resources to perhaps pique your interest or help you become more informed about the unique ways this perspective can illuminate public health problems. Some of these written resources can be found inside, or you can visit the CityMatCH website at: [http://www.citymatch.org/conf\\_lifecourse.php](http://www.citymatch.org/conf_lifecourse.php) for the direct links. And of course, key conference presentations will be featured in the upcoming CityLights Conference edition. Relevant session materials and additional resources will be posted to our website.

**Consider Teen Pregnancy** Recent events in the national news have brought teen pregnancy back into the limelight and hopefully are a wake-up call on the importance of science-based approaches to prevention. Consider the potential impact of pregnancy upon a teen, her partner, their families and their social networks, if she chooses to continue the pregnancy. Visualize the life trajectory for most children born to an adolescent mom as a result of an unplanned pregnancy. CityMatCH is providing leadership to urban health departments on this important public health issue, from education and training to resources. In this edition of CityLights, we feature adolescent reproductive health issues, particularly teen pregnancy, and provide related data on entrenched disparities in adolescent reproductive health, which add another layer of complexity to public health approaches.

CityMatCH has frequently collaborated with the National Campaign to Prevent Teen and Unplanned Pregnancy. The Campaign has examined teen pregnancy as a life course issue. Their series, "Why It Matters," available online,<sup>1</sup> provides data on the relationships and intersections between teen pregnancy and educational attainment, marriage, poverty, healthy relationships, substance abuse and other risky behaviors. We encourage our urban health department members to review the series. Consider the life course implications thoughtfully in your public health efforts to develop effective, science-based programs and make a meaningful difference in your community.

**In This Issue...** We remember the late Julius Richmond, so instrumental in helping children have better life outcomes through such initiatives as Head Start. We discuss training on science-based approaches to teen pregnancy prevention, and spotlight one of the AMCHP/CityMatCH Teen Pregnancy Prevention Roundtable collaborative teams. The adolescent reproductive health data section offers timely information, including sexual activity, use of birth control and pregnancy. Read about a very special training of trainers experience led by skilled facilitators for the Healthy Teen Network. Selected AMCHP, CityMatCH, and NACCHO staff had the opportunity to strengthen organizational capacity to educate our members about science-based approaches to teen pregnancy prevention. Finally, our partner, the American Academy of Pediatrics, has provided a great overview of autism spectrum disorders and the role of public health in helping children with autism achieve better outcomes across the lifespan.

We hope this CityLights leaves you inspired and reenergized in your professional and personal public health mission.

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*"Each person's health and well-being reflects the cumulation of their own unique prior history."*

Milton Kotelchuck, PhD, MPH

Maternal and Child Health Journal, Vol. 7, No. 1, March 2003 (© 2003)

<sup>1</sup> Why It Matters, <http://www.thenationalcampaign.org/why-it-matters/>, accessed August 8, 2008.

# Invisible Hero: Dr. Julius Richmond



By Magda Peck, ScD  
CityMatCH Senior Advisor

*Where were you when Martin Luther King announced to the world “I have a dream”? When the Berlin Wall fell? On 9/11?*

*“Where were you when (WWYW)”* moments are about “events singed on your memory.”<sup>1</sup> Internet sites abound with historic lists, everything from the Beatles on Ed Sullivan, Apollo 11’s man on the moon to JFK’s assassination.

WWYW moments aren’t always global or public. The recent passing of revered mentor made me ask a similar question on a personal scale: *where was I when* I first met Julius Richmond, who died this past summer at age 91. Answer: Spring, 1982, in a crowded third floor conference room, Harvard School of Public Health.

Dr. Richmond, former U.S. Surgeon General under the Carter Administration and Head Start’s co-founder, was giving a seminar to MCH students on making public policy for children. What he imparted, in his understated way in just 90 minutes, became a cornerstone of my public health practice. He drew a circle partitioned into three equal parts on the blackboard. “First you need research and data to support your work,” he explained, labeling one of the sections **knowledge base**. Then he emphasized having well-designed, evidence-based, and evaluated programs and services in the field; the words **social strategy** labeled the second section. Drawing arrows between these sections, he challenged: *what’s missing?* Why don’t well designed, data-supported, soundly managed programs always succeed?

We ventured beyond traditional boundaries of rational planning in the Reagan era. Funding cuts. Shifting priorities. Failed leadership. Politics. With a deliberate hand, Dr. Richmond wrote in the remaining unlabelled section: **political will**. He declared that a strong knowledge base and proven programs are necessary but insufficient for durable systems change, and then added connecting arrows among all three sections.

This elegant, simple tripartite model advanced by Dr. Richmond with

then junior colleague Dr. Milt Kotelchuck, has been dead-on accurate and hugely useful across the life course of the public health endeavors I have championed. It influenced how we designed CityMatCH’s infrastructure to integrate data, practice and policy. It was the precursor to our Data Use Triangle model, whose concepts support many CityMatCH products and services. It drove the design of the DaTA Institute and team composition of practice collaboratives.

I last saw Dr. Richmond in 2004 in his Harvard Medical School office. He had agreed to be part of my “Invisible Heroes” project on elder champions of social justice. During our lengthy conversation, I asked him about the model. He cited bringing national Head Start up to scale as a good example of how it worked. *“When Betty Caldwell and I were developing our program in child-care for low income children and families in Syracuse, which formed the basis for the development of Head Start, we thought of how one could apply this on a wider scale... As a consequence of the civil rights revolution and the establishment of the... war on poverty, it became possible then to think on a large scale about how one could apply that knowledge base. Without that [political will], it wouldn’t have been possible to go from having groups of 75 children that we did programs for in Syracuse to 500,000 in 27 communities across the county in five months in the summer of 1965.”* Dr. Richmond was convinced the program would work. It was evidence-based, it had all the right programmatic ingredients, and fairly simple to explain. It followed the model.

In *The New York Times* obituary<sup>2</sup>, Harvard Dean Allan Brandt described him as a giant figure on three major health fronts: tobacco control, national benchmarking, and early child development. As more states and communities pass smoking bans, the FDA is on the verge of overseeing tobacco, we recall his groundbreaking advocacy. As we wrestle over indicators in Healthy People 2020, let us remember he was instrumental in the inaugural Healthy People for 1990. As yet another cohort of preschoolers nationwide enters Head Start programs this Fall, their lives will



Image source: www.hms.harvard.edu/.../richmond\_rhein2003.jpg

be touched by the program he shaped in the 1950s and transformed into the national educational day care that has served over 20 million U.S. children.

When Julie Richmond accepted the Ed Ehlinger Award from CityMatCH (with Dr. Kotelchuck) at its 2003 national leadership conference, he spoke of the tripartite model, and how it guided their development of Project Head Start. Afterward, a long line of leaders queued up in front of him; each waited patiently to shake his hand.

*“I wouldn’t be here today as an MCH leader if it weren’t for Head Start,”* said a woman from the South of middle age.

*“I was a Head Start kid, too”* said another, extending his young hand with gusto.

*“I just wanted to thank you for making it possible for me to be who I am,”* said a senior local health leader who embraced Dr. Richmond, her eyes brimming with tears. *“I just never knew who to thank.”* He received each one with a warm, knowing smile.

A few weeks ago after he died, I read the transcripts of our 2004 interview and listened again to his sage words. *“I often get challenged by people who are incensed when they hear that someone has taken the credit for having developed Head Start...”* he said matter-of-factly. *“They say to me, ‘Why don’t you say something?’ and I say, ‘Well, it’s in the public domain, and the more people who take the credit, the better we are. I don’t particularly want to focus on whether I get credit or not.”*

**Julius Richmond: Servant Leader. Invisible Hero. Singed in blessed memory.**

Footnotes:

<sup>1</sup> *Where Were You When Moments*, <http://www.slate.com/features/bracketologist/wherewere/index.html>, accessed August 8, 2008.

<sup>2</sup> *The New York Times*, July 30, 2008, pC14.



## SpotLight on Local Public Health: Teen Pregnancy Prevention in Pennsylvania

Pennsylvania is taking Teen Pregnancy prevention to a higher level as a public health issue in their state through participation in the CityMatCH / AMCHP collaborative Teen Pregnancy Prevention Roundtable. When these two national organizations developed their collaborative effort, nine teams were selected to participate – including Pennsylvania.

**Intent of the Roundtable:** To achieve two-way learning – and to increase collaboration among and between local and state representatives – including coalitions. (See related story for more information about the Roundtable) Each of the teams has made significant strides. To illustrate their efforts, we selected Pennsylvania's effort for a closer look.

**Team Composition:** Pennsylvania's team included state, local, and community representatives from the Pennsylvania Department of Health, the Allentown Health Bureau, and the Pennsylvania Coalition to Prevent Teen Pregnancy (PCPTP). Long-time CityMatCH member, Belle Marks, RN, ND, MPH, is the Associate Director for Personal Health Services at the Allentown Health Bureau, and in that capacity worked directly as

a member of the Pennsylvania Roundtable team.

**Team Interaction:** First of all, the Department has been collaborating with Ten County and/or Municipal Health Departments to provide direct health services and education in the areas of Maternal and Infant Health, Child Health, and Children with Special Health Care Needs. PCPTP, a unique coalition which provides resources, training and on-site technical assistance to communities seeking to raise awareness about teen pregnancy, has a recognized and well-established relationship with the Department as well.

The PCPTP has provided a natural bridge between the State and Local levels, encouraging informed dialogue about adolescent sexuality and providing a unified voice on the need for state-wide prevention efforts through advocacy, education and support for community initiatives.

Therefore, for Pennsylvania, putting together a team for the Roundtable was not beyond the realm of possibility. However, this was the first time this type of collaborative effort to address



prevention was assembled in Pennsylvania.

The Pennsylvania team worked hard to create an action plan for the implementation of a science-based teen pregnancy prevention program at the local level.

**Addressing Challenges:** The team was particularly challenged to identify funding for their effort. Performing a thorough needs assessment and developing a logic model were important steps along the way, and necessary to help Pennsylvania's team determine which science-based approach would be most efficacious and effective for the population to be served.

Pennsylvania's Department of Health demonstrated their commitment to the team by providing funding for a program to be located in Allentown. The Pennsylvania Coalition to Prevent Teen Pregnancy was entrusted with lending a hand to the Allentown Health Bureau with the program plan. Although there have been challenges along the way, state and local collaboration has been positive, and barriers are addressed as they arise.

If you would like to learn more, AMCHP and CityMatCH will present the overall Roundtable, and the Pennsylvania team will showcase their experiences in the session, "State and Local Health Departments Collaborate to Prevent Teen Pregnancy" at the American Public Health Association (APHA) Annual Conference in San Diego (CA), Wednesday, October 29, 2008 at 9:00 am.

For more information, contact:

♦ **Allentown Health Bureau**, Belle Marks, by phone: 610-437-7725 or E-mail: [marks@allentowncity.org](mailto:marks@allentowncity.org)

♦ **Pennsylvania Coalition to Prevent Teen Pregnancy**, Joe Fay, by phone: 717-761-7380, ext 3100, or E-mail: [jfay@fhccp.org](mailto:jfay@fhccp.org) web: [www.pcptp.org](http://www.pcptp.org)

♦ **Pennsylvania Department of Health**, Kelly Holland, by phone: 717-772-2762 or E-mail: [kholland@state.pa.us](mailto:kholland@state.pa.us)

♦ **CityMatCH**, Sarena Murray, by phone: 402-561-7500 or E-mail: [smurrayp@unmc.edu](mailto:smurrayp@unmc.edu)

### Assuring Local/State Connections: The AMCHP-CityMatCH Teen Pregnancy Prevention Roundtable

To assure that the best science-based programs to reduce teen pregnancy rates with the best outcomes reach the state and the local public health level, AMCHP and CityMatCH collaborated to produce the Teen Pregnancy Prevention Roundtable.

The Roundtable is based upon the assumption that building a stronger relationship between state and local/urban MCH departments can help develop sustained teen pregnancy prevention efforts. In September 2007, AMCHP and CityMatCH convened a two-day training and meeting facilitated by Healthy Teen Network, "Science-Based Approaches to Teen Pregnancy Prevention; What Are They and How Can We Promote Their Use?"

Training teams consisting of representatives from state and local maternal and child health and community and/or coalition members convened in the Roundtable. The following states were selected to participate: Arizona, Missouri, Montana, Nebraska, North Carolina, Ohio, Pennsylvania, Tennessee, Washington. Pennsylvania's team effort is featured above.

In May 2008, the AMCHP "Pulse," featured all nine Roundtable teams. Read the online archive at: [http://www.amchp.org/member\\_center/Pulse/5-16-08/feature2.html](http://www.amchp.org/member_center/Pulse/5-16-08/feature2.html).

See Page Eight for More on Science-Based Approaches to Teen Pregnancy Prevention

# Urban Adolescent Reproductive Health Disparities

by Carol Gilbert, MS,  
CityMatCH Health Data Analyst

## Background

Not only is teen pregnancy strongly associated with increased risk of future economic, mental and physical health problems for both the mother and her child<sup>1,2</sup> it also carries a high public cost<sup>3,4,5</sup>. Though some problems of women who became mothers as teens are the result of factors in the mother's childhood that increase the likelihood of both the teen pregnancy and the associated problems, evidence is building that teen pregnancy actually increases the risk of future economic and other disadvantages<sup>6,7,8</sup>.

A key question in public health is: "What interventions will improve the outcome of interest?" The *life course perspective* adds an important dimension, changing the question to: "**What actions . . . need to be taken at what age across the life span of individuals to prevent disease and enhance health?**"<sup>9</sup> Research indicates that teen pregnancy prevention can have a large impact because both the mother and her infant are at stages of life when exposures are particularly influential.

## In this Article

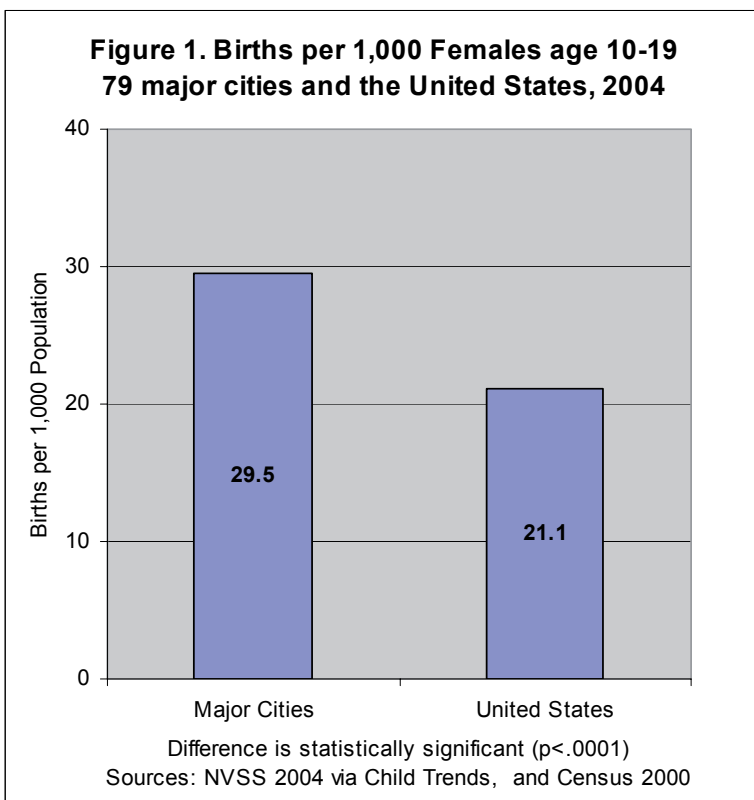
As part of our series on adolescent health disparities, this issue of *CityLights* examines data on adolescent reproductive health, including sexual activity, use of birth control, and births to teens. We discuss differences between large urban areas and the nation as a whole, as well as urban and national racial disparities. While national data and a few city-specific illustrative examples are included in the article, detailed city and county tables are found on the CityMatCH web site <http://www.citymatch.org/citylights.php>. We also direct the reader to the data sources, where additional information can be found.

## Methods: Births to Teen Mothers

CityMatCH utilized data from two sources (National Vital Statistics System and the Census) to estimate teen birth rates in major US cities. Since the US Census Bureau does not provide intracensal estimates of population for cities by age and race, 2000 Census population of females age 6-15 was used to estimate the 2004 population of females age 10-19.\* Numbers of births to teen mothers in 79 major cities were compiled by Child Trends from the 2004 Natality Detail File (CD Series 21) [http://www.childtrends.org/Files//Child\\_Trends-06\\_26\\_2007\\_FG\\_2007FactsAtAGlance.pdf](http://www.childtrends.org/Files//Child_Trends-06_26_2007_FG_2007FactsAtAGlance.pdf). The list of 79 cities selected by Child Trends

includes the largest city from each state and the District of Columbia, with the exception of Wyoming where the largest city had too small a population for analysis, and 29 of the next most populous U.S. cities.

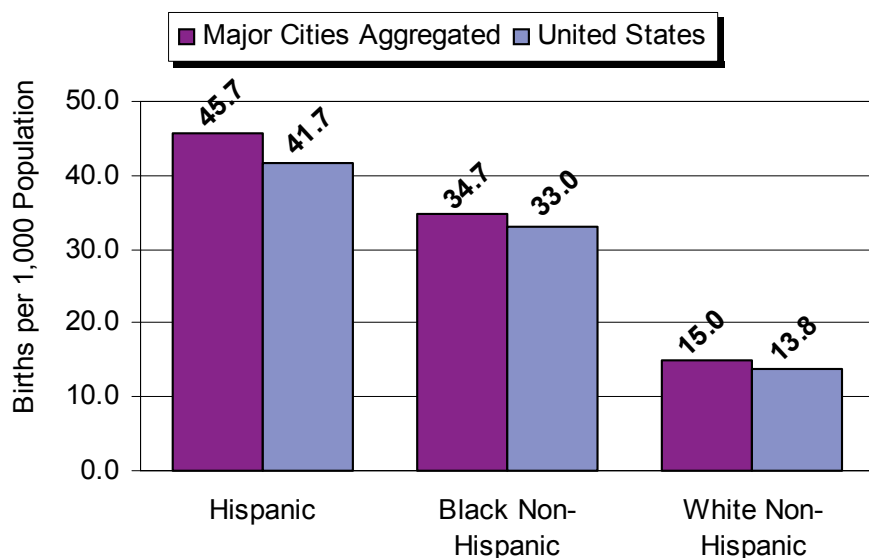
**Note:** \*Girls who were age 6-15 in 2000 will be age 10-19 in 2004. However this is only an estimate because if a city's population increased because of migration during that time, overall or in a subgroup, there will likely be more actual 10-19 year olds in 2004 than we are estimating. In other words, we would be underestimating the population, and therefore overestimating the rate. Conversely, if the population decreased due to migration or mortality, the rate given here will likely be an underestimate.



## Results: Births to Teen Mothers

The teen birth rate for the United States was 21.1 births per thousand girls age 10-19. The selected major cities had *higher* teen birth rates overall (29.5 per thousand) than the United States (See Figure 1). Teen birth rates for 63 of the 79 major cities exceeded the US rate; they ranged from just over 10 births per 1,000 in San Francisco (CA), Fargo (ND), and Seattle (WA) to over 50 births per 1,000 in Tampa (FL), Columbia (SC), and Las Vegas (NV).

**Figure 2. Disparities in Birth Rates  
Among Teens (Age 10-19)  
79 major cities and the United States, 2004**



Differences are statistically significant  
Sources: NVSS 2004 via Child Trends, and Census 2000

Significant racial/ethnic disparities were found in the US and in its major cities (See Figure 2). Birth rates among non-Hispanic Black teens were more than double non-Hispanic whites rates, and birth rates among Hispanic teens were nearly triple those of non-Hispanic White teens ( $p < .0001$ ).

To assure reliability, rates are calculated only for racial/ethnic subpopulations with at least 20 births. For this reason, rates for all three subpopulations are only available in 61 of the 79 major cities. The racial/ethnic pattern described above (i.e. Hispanic > Black > White) was found in 55 of the 61 cities.

- ◆ Birth rates among Hispanic teens exceeded 100 births per 1,000 (or one birth for every 10 girls) in ten of the 72 cities with at least 20 Hispanic teen births. Rates among Hispanic teens were below 30 per 1,000 in Virginia Beach (VA), Boston (MA), New York City (NY), and San Francisco (CA).

- ◆ Birth rates among non-Hispanic Black teens ranged from under 18 per 1,000 in San Jose (CA) and Anchorage (AK), to over 50 per 1,000 in Omaha (NE), Tampa (FL), Columbia (SC), and Las Vegas (NV).

- ◆ Birth rates among non-Hispanic

White teens ranged from under 5 per 1,000 in San Jose (CA), Seattle (WA), and Los Angeles (CA), to over 30 per 1,000 in Tampa (FL), Detroit (MI), Las Vegas (NV), Sacramento (CA), and Birmingham (AL).

## Risk Factors Related to Teen Reproductive Health (YRBS)

### Methods: Sexual Risk Factors Among High School Students

Data on sexual behavior among high school students were obtained from the Youth Risk Behavior Survey online tool "Youth Online" which provides easy access to YRBS summary data from local (city, borough, or county) surveys as well as state and national results, <http://apps.nccd.cdc.gov/yrbss/>. This web site provides data on eight outcomes related to reproductive health (See Table 1)

The Youth Risk Behavior Surveillance System (YRBS) is a biennial, school-based survey developed by the

CDC to provide information on behaviors which may lead to bad outcomes such as teen pregnancy, injury, illness, and death. More information on YRBS methods are available at <http://www.cdc.gov/HealthyYouth/yrbss/index.htm>.

The twenty-one cities or counties participating in 2007 were: Baltimore (MD), Boston (MA), Broward County (FL), Charlotte-Mecklenburg County (NC), Chicago (IL), Dallas (TX), DeKalb County (GA), Detroit (MI), Hillsborough County (FL), Houston (TX), Los Angeles (CA), Memphis (TN), Miami-Dade County (FL), Milwaukee (WI), New York City (NY), Orange County (FL), Palm Beach County (FL), Philadelphia (PA), San Bernardino (CA), San Diego (CA), San Francisco (CA). There are other cities participating in YRBS, and data for these cities may be available, but it may not meet criteria for inclusion on the CDC web site. Local survey results for only three racial/ethnic groups are discussed. This is because data for the fourth group, "Other," are available for very few cities (due to small numbers), and because comparisons for "Other" have little meaning since it is actually a different population in each city.

**YRBS Technical Notes:** Local YRBS surveys are stratified and data are weighted to produce valid results that represent particular subgroups and the whole population. The CDC does not report results based on fewer than 100 respondents. While percentages based on the national survey are generally accurate to within  $\pm 3\%$ , results of local surveys can have confidence intervals larger than  $\pm 10$  percentage points. Therefore, for local results, only the largest differences are likely to be statistically significant.

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Table 1: National YRBS 2007 Results for Reproductive Health Risk Factors, Overall and by Race/Ethnicity *	Total	non-Hispanic White	non-Hispanic Black	Hispanic	Other
Percentage of students who ever had sexual intercourse	47.8 (45.1–50.6)	43.7 (40.5–47.0)	66.5 (63.0–69.9)	52.0 (48.3–55.6)	35.2 (28.6–42.4)
Percentage of students who had sexual intercourse with at least one person during the 3 months before the survey	35.0 (32.8–37.2)	32.9 (30.3–35.5)	46.0 (42.3–49.7)	37.4 (33.8–41.1)	23.9 (19.2–29.3)
Percentage of students who had sexual intercourse for the first time before age 13 years	7.1 (6.2–8.1)	4.4 (3.4–5.7)	16.3 (14.7–18.0)	8.2 (7.1–9.3)	6.7 (5.0–8.9)
Percentage of students who had sexual intercourse with four or more persons during their life	14.9 (13.4–16.5)	11.5 (9.6–13.7)	27.6 (24.8–30.6)	17.3 (15.2–19.5)	10.5 (7.8–14.0)
Among students who were currently sexually active, the percentage who reported that either they or their partner had used a condom during last sexual intercourse	61.5 (59.4–63.6)	59.7 (56.8–62.5)	67.3 (62.6–71.6)	61.4 (56.7–65.9)	61.5 (52.2–70.0)
Among students who were currently sexually active, the percentage who reported that either they or their partner had used birth control pills to prevent pregnancy before last sexual intercourse	16.0 (14.2–17.9)	20.8 (18.5–23.3)	9.1 (6.6–12.5)	9.1 (7.1–11.5)	14.0 (8.5–22.3)
Among students who were currently sexually active, the percentage who drank alcohol or used drugs before last sexual intercourse	22.5 (20.7–24.5)	24.8 (22.3–27.5)	16.4 (13.4–20.0)	21.4 (18.2–25.1)	23.4 (18.0–29.8)
Percentage of students who had ever been taught in school about AIDS or HIV infection	89.5 (88.1–90.7)	91.1 (89.6–92.4)	90.3 (88.6–91.8)	85.0 (82.9–86.8)	85.6 (78.8–90.5)

\*Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS), 2007, accessed via <http://www.cdc.gov/HealthyYouth/yrbbs/index.htm>

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## Results: Sexual Intercourse among High-School Students

Nationwide, 47.8% of students reported ever having sexual intercourse (See Table 1). Percentages in participating cities and urban counties varied around this average, ranging from 26.4% in San Francisco to 67.1% in Baltimore (Figure 3).

Similarly, the national percentage of students who reported being currently sexually active (having had intercourse in the past three months) was 35.0%, with local survey results ranging from 17.5% to 49.7%. Nationally, the percentage of students who reported having early sexual intercourse (before age 13) was 7.1%, with local survey results ranging from 3.9 to 18.6%. Nationally, the percentage of students who reported having four or more sexual partners was 14.9%, with local survey results ranging from 6.5% to 29.6%.

Racial disparities were evident *nationally* in all four sexual intercourse outcomes (See Table 1). In every case, non-Hispanic Black students had the highest percentage, non-Hispanic White

students had the lowest, and Hispanic students' percentage fell between the two.

In local surveys, percentages among urban teens often followed the national pattern (i.e. Black>Hispanic>White). Among non-Hispanic Black students, the percent who reported ever having sexual intercourse ranged from 48.9% to 69.1% in 20 local surveys. Among Hispanic students the percentage ever having had sexual intercourse ranged from 40.9 to 63.4% in 19 local surveys. Among non-Hispanic White students, the percentage ranged from 32.4% to 47.6% in the 17 localities reporting results for that group. Exceptions to the rule may prove instructive: For instance, non-Hispanic Black students in Palm Beach County Florida have *lower* rates of "ever having sex" and "being currently sexually active" than any other group. (Tables of local survey results are available at <http://www.citymatch.org/citylights.php>.)

## Results: Using Contraceptives

Nationally, the percent of students reporting the use of birth control pills

to prevent pregnancy during their last sexual intercourse was 16%. Use of the pill was *less* prevalent in cities, with the exception of San Diego, California at 16.9%.

The percent of students reporting that they used condoms to prevent pregnancy during their last sexual intercourse was much higher than the percent using the pill, at 60.5% nationally. In 17 of the 21 city and county surveys, the percent of students using condoms was *higher* than the national average (range= 57% to 74%).

There was some evidence of a pattern of racial disparities in use of contraception to prevent pregnancy. Nationally, non-Hispanic White students were *more than twice* as likely to report using the pill (20%) as non-Hispanic Black and Hispanic students (both 9%). However, non-Hispanic Black students were *more* likely to report using condoms than non-Hispanic White students (67.3% and 59.7%, respectively).

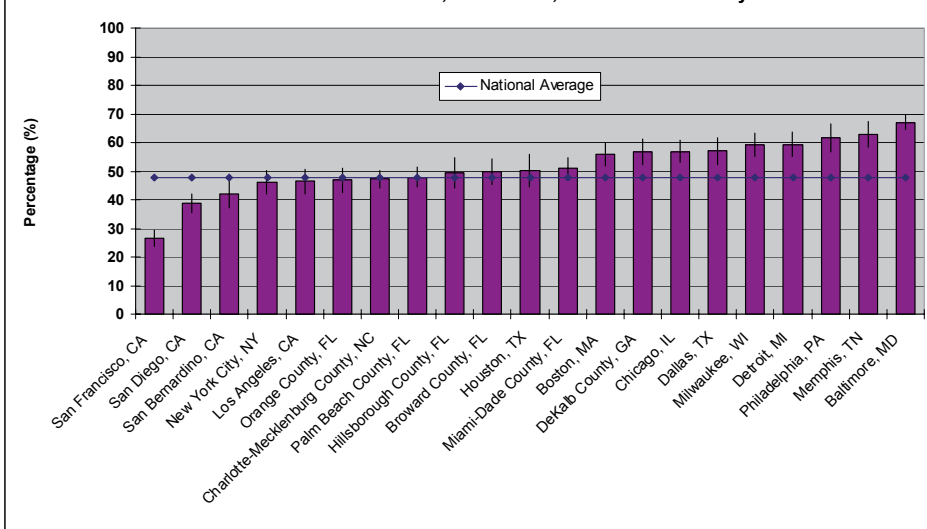
Because only students who are sexually active answer questions about pregnancy prevention, the precision of local survey estimates by race/ethnicity is poor (confidence intervals are wide) and fewer subgroups meet the minimum 100 respondents requirement to be reported. In all six local surveys with results for non-Hispanic White students, use of the pill was *more* prevalent among that group than among the others. In all 11 local surveys for which comparison was possible, non-Hispanic Black students were *more* likely to report using condoms than Hispanic students. Though most of these local disparities were not statistically significant, the consistency of the pattern indicates that the underlying racial disparities among students in these cities mirror the significant disparities seen nationally.

## Results: Other Reproductive Health Risks

Use of alcohol or drugs before sexual intercourse was reported for 22.5% of students nationally. In 20 of 21 local surveys, this prevalence was *lower*, ranging from 12.2% to 25.5%. Nationally and in all six local surveys for which comparison was possible, non-Hispanic White students were *more* likely than

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Figure 3. Percentage of students who ever had sexual intercourse, with 95% Confidence Intervals; YRBS 2007, US and Local Surveys



non-Hispanic Blacks or Hispanics to have used alcohol or drugs before engaging in sexual intercourse.

Nationwide, the percentage of students who reported having been taught in school about AIDS or HIV was 89.5%. In 18 of 19 reporting cities and counties, the percentage was *lower* than the national percentage, ranging from 76.7% to 92.3%. Nationally, the percentage among Hispanics (85.0%) was significantly *lower* than the percentages among non-Hispanic Whites and non-Hispanic Blacks (91.1% and 90.3%, respectively). In 12 of the 16 cities and counties with Hispanic data reported, the percentage among Hispanics was the *lowest* of the three groups.

## Summary

Teen birth rates have been dropping nationally, but, in 2004 rates were significantly higher in cities overall and for each of the three racial/ethnic groups studied (non-Hispanic White, non-Hispanic Black, and Hispanic). Generally, urban Hispanic teen birth rates were *highest*, followed by non-Hispanic Black. Rates among non-Hispanic White were the *lowest* of the three. YRBS data indicate that sexual intercourse among high school students in the 21 large urban areas reported was NOT more common than in the US as a whole.

YRBS results seemed inconsistent with birth rates, in that sexual activity was most prevalent among non-Hispanic Blacks nationally and in many urban areas, while the birth rate was

highest among Hispanics. This could be partly explained by racial disparities in use of condoms, which indicate that nationally and in many urban areas, non-Hispanic Blacks were *more* likely than other groups to use condoms. Use of the birth control pill was less prevalent, and non-Hispanic Whites were *more* likely than other groups to report using this method. Urban teens were *less* likely to report using drugs or alcohol before having sexual intercourse, and non-Hispanic Whites nationally and in the six urban areas studied were *more* likely than other groups to report this behavior. Hispanics were less likely than other groups to have been taught in school about HIV and AIDS nationally and in most local surveys.

## Conclusions and Next Steps

These data clearly demonstrate that teen birth rates are higher in urban counties than in the nation as a whole. In addition, within urban areas there are substantial racial/ethnic differences in both birth rates and high risk behaviors, some of which are similar across many urban areas. These facts emphasize the need for interventions that are tailored to racial/ethnic and cultural subgroups within cities. That is, since the underlying problems are truly different, we cannot expect one-size fits all solutions to be effective. Urban health departments may benefit from additional training on programs that have been proven to work - the

Science Based Approaches to Teen Pregnancy Prevention. Examples of efforts already underway are the Teen Pregnancy Prevention Roundtable training described on page 3, along with the resources listed on page 8. For its part, CityMatCH will continue to develop strong national partnerships, seek additional resources, and provide data along with education and training opportunities for our urban membership.

## Data Sources

1. Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS), 2007, accessed via <http://www.cdc.gov/HealthyYouth/yrebs/index.htm>.

2. Source for Births (numerator) 2004 Natality Detail File (CD Series 21) Compiled by Child Trends [http://www.childtrends.org/Files/Child\\_Trends-\\_26\\_2007\\_FG\\_2007FactsAtAGlance.pdf](http://www.childtrends.org/Files/Child_Trends-_26_2007_FG_2007FactsAtAGlance.pdf).

3. Source for Population (denominator): Census 2000 Summary File 1 (SF 1) 100-Percent Data, with advice and assistance from David Drodz, Center for Public Affairs Research, University of Nebraska Omaha.

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<sup>1</sup> Young Maternal Age and Depressive Symptoms: Results from the 1988 National Maternal and Infant Health Survey – Deal LW, Holt VL – American Journal of Public Health FEB-1998 88(2) pp 266-270.

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<sup>5</sup>Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy – Rebecca A. Maynard, Washington, DC: The Urban Institute Press; 1997.

<sup>6</sup> Age at first childbirth and later poverty – Moore KA, Myers DE, Morrison DR, Nord CD, Brown B, Edmondston B—Journal of Research on Adolescence 1993, 3 pp 393-422.

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## Science-Based Approaches to Teen Pregnancy Prevention: Training of Trainers & Key Resources

CityMatCH would like to thank the Healthy Teen Network (HTN) for recently leading a four-day "Training of Trainers in Science-Based Approaches to Teen Pregnancy, HIV and STI Prevention." We applaud the commitment of AMCHP and NACCHO staff in traveling to Omaha (NE) to join with CityMatCH staff for the training. This exceptional experience has augmented each organization's capacity to provide cutting-edge technical assistance in this critical issue.

As part of their Weaving Science and Practice project<sup>1</sup>, HTN facilitators Mary Martha Wilson, MA, Director of Training and Technical Assistance and Deborah Chilcoat, BS, Training Coordinator, utilized an interactive mix of education and training activities, modeling adult learning practices while walking participants through the training experience.

Participants learned how to: identify adult learning principles and how they are used in training design and implementation; describe facilitator preparation needed to conduct trainings and technical assistance on content areas; and increase confidence



and comfort in facilitating trainings and technical assistance in content areas.

**Resources:** Readers considering science-based approaches should be aware of the following resources:

1. "A Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs (TAC)," from Healthy Teen Network/ETR Associates and available for download at <http://www.healthyteenetwork.org/vertical/Sites/{B4D0CC76-CF78-4784-BA7C-5D0436F6040C}/uploads/{5E990359-FF6E-4845-A55D-90C54F913D72}.PDF>

2. "Science and Success, Second Edition: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections," from Advocates for Youths

new and available at <http://www.advocatesforyouth.org/programsthatwork/toc.htm>

3. "Little (PSBA) GTO: 10 Steps to Promoting Science-Based Approaches (PSBA) to Teen Pregnancy Prevention using Getting To Outcomes (GTO) – A Summary," April 2008. (Adapted from Wiseman S, Chinman M, Ebener P, Hunter S, Imm P, Wandersman A (2007). *Getting to Outcomes: 10 Steps for Achieving Results-Based Accountability*. No. TR-TR101/2. Santa Monica, CA: RAND Corporation) <http://www.cdc.gov/reproductivehealth/adolescentreprohealth/PDF/LittlePSBA-GTO.pdf>

The training was a huge success for these organizations and CityMatCH looks forward to future collaborations.

For more information, contact Kathleen Brandert at 402-561-7500 or via E-mail at [kbrandert@unmc.edu](mailto:kbrandert@unmc.edu)

Footnotes:

<sup>1</sup> Healthy Teen Network: Weaving Science and Practice Project Frequently Asked Questions about Science-Based Approaches, funded by the CDC # U58/CCU324964, Healthy Teen Network in partnership with ETR Associates: 2005. <http://www.healthyteenetwork.org/vertical/Sites/{%7BB4D0CC76-CF78-4784-BA7C-5D0436F6040C%7D}/uploads/{%7BC4AC9E3C-F7C5-4F72-BF6A-867A953849A6%7D}.PDF>, accessed September 5, 2008

## CDC Promotes Science-Based Approaches to Prevent Teen Pregnancy

The CDC has championed efforts to reduce teen pregnancy through cooperative agreements advocating for science-based approaches to preventing teen pregnancy. They are working to increase the capacity of local organizations to select, implement, and evaluate science-based approaches to prevent teen pregnancy, HIV, and STDs in their communities. This has important implications for urban member health departments.

Starting in 2002, the CDC funded "Coalition Capacity Building to Prevent Teen Pregnancy" – a three year cooperative agreement funding selected national organizations and state teen pregnancy prevention coalitions to build capacity through the use of science-based approaches to prevent teen pregnancy and promote adolescent reproductive health, including abstinence, and prevent STDs and HIV.

Grantees built capacity to understand and advocate for science-based approaches, developed logic models for program planning and evaluation, and increased the number of youth participating in programs shown to successfully delay sexual debut and reduce teen pregnancy, HIV, and STDs.

A five-year cooperative agreement was funded in 2005. This Cooperative Agreement provides training and technical assistance to state coalitions and local organizations to increase their ability to use science-based approaches. Second, dissemination of lessons learned and science-based information to organizations working with youth on the national, state, and local levels is now underway.

Three national organizations, Advocates for Youth, the National Campaign to Prevent Teen and Un-

planned Pregnancy, and the Healthy Teen Network are funded to provide technical assistance on implementing, translating, and disseminating science-based teen pregnancy prevention programs to state and local organizations. CityMatCH has worked with these groups to promote their efforts for greater impact and significance to the local level. The training of trainers described on this page is just one example how CDC's commitment is reaching out across the country.

Nine state coalitions are working with state and local teen pregnancy prevention organizations to enhance their capacity to plan, implement and evaluate science-based approaches. Visit CDC's website: <http://www.cdc.gov/reproductivehealth/adolescentreprohealth/ScienceApproach.htm> for a list of grantees and links to their websites.

# Autism Spectrum Disorders: Overview and Public Health Implications

by Charlotte O. Zia, MPH, CHES, American Academy of Pediatrics (AAP), and Maureen Fitzgerald, MPA, CityMatCH

**A** Autism spectrum disorders (ASD) have emerged as a major public health concern in the past decade.

ASD comprises a spectrum of clinical characteristics, with wide variability in the presence and intensity of symptoms that define autism, including autistic disorder, Asperger's syndrome and pervasive development disorder (as described in DSM-IV and DSM-IV-TR).<sup>1</sup> Public health plays an essential role in early detection and screening, surveillance, prevention, and response.

Previously, ASDs were thought to be quite rare. According to a 2004 study, 44 percent of primary care pediatricians reported having at least 10 children with ASDs in their practice.<sup>2</sup> The best estimate of current prevalence of ASD in the United States is approximately six or seven per 1,000.<sup>3,4</sup> A more precise estimate of ASD prevalence is difficult because changes in prevalence for autism and ASDs are closely linked to changes in the clinical criteria and diagnostic codes, and also may be related to both increased public awareness and increasing professional proficiency in recognizing and diagnosing ASD. It was not until the passage of the Individuals with Disabilities Education Act (IDEA) in 1990 that children with a diagnosis of "autistic disorder" were eligible to receive special education services.<sup>5</sup> After this change, in addition to newly-diagnosed children, those children who had been eligible for services under a different label were then categorized under ASD, reflecting an increase in prevalence. Given these factors, current prevalence estimates have been controversial.<sup>6</sup>

Despite intensive and increasing research to determine the underlying causes for ASD, researchers remain baffled as to the specific etiologies.<sup>7</sup> Though ASD may be genetic in origin, some environmental factors may exacerbate or influence expression or severity of this condition. Advanced paternal and maternal age, has been shown to be associated with increased



risk of having offspring with ASDs.<sup>6A</sup> Environmental factors, such as exposure during the first and second trimesters of pregnancy to teratogens, such as thalidomide and valproic acid, or maternal illness, may play a role.<sup>6B</sup> Findings for these environmental issues are based on studies with relatively small numbers and further investigation is required before the results can be generalized to the population at large. Although there has been much media attention about a possible link of ASD to measles-mumps-rubella (MMR) vaccine and other vaccines that combined preservatives with mercury (thimerosal), a number of studies have been conducted that found no evidence of a causal association between the MMR vaccine and autism.<sup>6C</sup>

**Research and Funding:** Over the past few years, efforts to understand and address ASD have ramped up significantly. The **Combating Autism Act of 2006** authorized nearly one billion dollars in expenditures over five years beginning in 2007, to combat the autism spectrum disorders including autism, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, and PDD-NOS through screening, education, early intervention, prompt referrals for treatment and services, and research.

**The CDC's Autism Information Center**<sup>8</sup> provides an overview of ASD, frequently asked questions, and is a warehouse of information. Selected examples of CDC's intensive research efforts to understand and address ASD include the following:

- ◆ **Early Autism Spectrum Disorders Surveillance:** In September 2006, CDC funded the California Department of Health, Florida State University, and the University of Utah to develop and test methods to identify the number of children under four years of age with an ASD.

- ◆ In October 2006, CDC awarded \$5.9 million to five sites—the Kaiser Foundation Research Institute in California, the Colorado Department of Public Health and Environment, Johns Hopkins University in Maryland, the

University of North Carolina at Chapel Hill, and the University of Pennsylvania—to help identify factors that might put children at risk for ASDs and other developmental disabilities. These sites make up the **Centers for Autism and Developmental Disabilities Research and Epidemiology (CADDRE) Network**. CDC participated in the study, which included children and their parents from the metropolitan Atlanta area. About 2,700 children ages 2–5 and their parents were expected to participate.

- ◆ CDC is currently putting together a report to verify the data that have been collected as a part of **Validation Study of the Metropolitan Atlanta Developmental Disabilities Surveillance Project (MADDSP)**, which served as the basis for Autism and Developmental Disabilities Monitoring (ADDM) methodology (2008).

- ◆ **Autism and Biopsy Study** (June 2007) This study looked at whether the Measles, Mumps, Rubella (MMR) vaccine might lead to autism by causing persistent measles virus infection in the intestine. Researchers are studying the intestinal tissue of children with autism to see if the measles virus is present.

- ◆ **Thimerosal and Autism Study** (September 2008) Using the Vaccine Safety Datalink, CDC is comparing thimerosal exposure in children with and without autism. Certified specialists are using the most up-to-date, standardized diagnostic tests to evaluate children with autism. Review of medical records and interviews with parents are also included.<sup>9</sup>

**HRSA/MCHB has defined ASD as a priority area and it is the focus of significant attention.**

- ◆ **A few examples of their efforts include** grant funding by the **MCH Research Program for Early Detection of Autism: Comparison of Three Screening Instruments** to the University of Connecticut's Department of Psychology. This study involves the comparison of three parent checklist screening instruments for 24-month-olds: (1) The Checklist for Autism in Toddlers (CHAT)-Parent Report section (Baron-Cohen,

(Continued on next page)

## Policy&Practice

Allen, & Gillberg, 1992; Baron-Cohen et al, 1996), (2) The Modified Checklist for Autism in Toddlers (M-CHAT; Robins, Fein, & Barton, in press), and (3) the Yale Autism/PDD Screener.<sup>10</sup>

◆ HRSA/MCHB announced two autism intervention research networks that are starting as of this reading. HRSA-08-142, Autism Intervention Research Network on Physical Health (AIR-P Network) will be limited to \$4 million per year for up to 4 years; HRSA-08-143, Autism Intervention Research Network on Behavioral Health (AIR-B Network) will be limited to \$2 million per year for up to 4 years.<sup>11</sup>

**The M.I.N.D. Institute** (Medical Investigation of Neurodevelopmental Disorders) at the University of California Davis has been the focus of recent national attention. An international, multidisciplinary research organization, the MIND Institute is striving to understand the causes and develop better treatments and ultimately cures for neurodevelopmental disorders. Within this Institute, families, scientists, physicians, educators, and administrators work in concert to 'unlock the mysteries of the mind.' Their Autism Phenome Project (APP) is described as "the largest and most comprehensive assessment of children with autism ever attempted."<sup>12</sup> The APP is working to distinguish among recognized subgroups, or phenotypes, of



autism. It will link these different forms of autism with distinct patterns of behavior and biological changes.

Significant research and study is underway. In the meantime, what can local public health practitioners do? First, those practitioners providing services to children, can assist in developmental surveillance, including: early screening and referral, eliciting and listening to concerns, maintaining a developmental history of that child; making accurate and informed observa-

tions, including identification and documenting of risk and protective factors and findings.

Screening, as identified by the AAP clinical report, *Identification and Evaluation of Children with Autism Spectrum Disorders*, should occur with children at the specific intervals, especially the 18-month preventive care visit. The report provides detailed information on signs, symptoms, as well as an algorithm for surveillance and screening at the individual level.

**AUTISM: Caring for Children with Autism Spectrum Disorders - A Resource Toolkit for Clinicians** was developed on CD-ROM to assist health care professionals in the identification and ongoing management of children with ASDs in the medical home. For sample tools and resources available in the toolkit, visit: <http://www.aap.org/publiced/autismtoolkit.cfm>.

If an ASD is indicated in initial surveillance and screening, AAP suggests the following activities be conducted simultaneously:

1. Parental education: provide parents with reading materials, as it is better to be informed with appropriate materials than taking a "wait and see" attitude.
2. Comprehensive evaluation of the child with a team of child specialists. Pediatric sub-specialists (child neurologist, developmental pediatrician, psychiatrist), child psychologists, speech-language pathologist, pediatric occupational therapist, and social workers with expertise in ASDs can assist in the diagnostic process.

3. Immediate referral to early intervention program or special education department in the school district. Intervention is important and can be effective even if it is generic until a more detailed diagnosis is made.

4. Audiology evaluation for all children with language delays, including those with ASDs.

5. Schedule follow-up. It is important to coordinate care for this child and their family to allow for appropriate care and integrated services.

From a public health perspective, it is important to understand the role of the primary care practitioner in this surveillance, screening and follow-up

process. Public health departments work with limited budgets and staff. One important challenge for public health departments is to work with primary care practitioners and specialists to improve collaboration and coordination of services to provide the appropriate screening, and follow-up services. Public health staff providing service delivery can assist in encouraging families to talk about their child's developmental progress and provide them with education using correct information about ASDs. Finally, linking children who have been identified as having an ASD diagnosis to early intervention programs is clearly a role that both public health staff and other community practitioners should actively support.

Additional resources for many of the concerns raised here, can be found in the *ResoureInfo* online compendium at [www.citymatch.org](http://www.citymatch.org).

### Footnotes:

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2 Dosreiss S, Weiner CL, Johnson L, Newschaffer CJ, Autism spectrum disorder screening and management practices among general pediatric providers. *J Dev Behav Pediatr*. 2006; 27:588-594.

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7 Autism: an emerging public health problem. Newschaffer, Craig J, Curran Laura K, *Public Health Rep*. 2003 Sep-Oct; 118(5): 393-399.

8 <http://www.cdc.gov/ncbddd/autism/>

9 [http://www.cdc.gov/ncbddd/autism/documents/FACTSHEETAutismGeneral%20February7\\_2007%20\\_2\\_.pdf](http://www.cdc.gov/ncbddd/autism/documents/FACTSHEETAutismGeneral%20February7_2007%20_2_.pdf) Accessed May 15, 2008.

10 [http://mchb.hrsa.gov/research/project\\_info.asp?ID=1](http://mchb.hrsa.gov/research/project_info.asp?ID=1)

11 [www.grants.gov](http://www.grants.gov)

12 <http://www.ucdmc.ucdavis.edu/mindinstitute/research/app/index.html>



## Selected Life-Course Resources

The following citations are just a few examples of resources and tools related to Life-Course that are currently available. We invite you to familiarize yourself with these and others.

### **Application of a Lifecourse and Multiple Determinants Framework to Improve Maternal Health.**

Holly Grason, MA, Dawn Misra, MSH, PhD. 2006. Baltimore, MD. Women's and Children's Health Policy Center. Johns Hopkins Bloomberg School of Public Health.

### **Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective.**

Michael C. Lu, MD, MPH, and Neal Halfon, MD, MPH. Maternal and Child Health Journal, Vol. 7, No. 1, March 2003.

### **Building on a Life-Course Perspective in Maternal and Child Health.**

Milton Kotelchuck, PhD, MPH. Maternal And Child Health Journal 2003 Mar; Vol. 7 (1), pp. 5-11.

**The Life Course Model and Maternal, Child and Adolescent Health - An Overview.** Contra Costa Health Services – Family, Maternal and Child Health Programs, [http://www.cchealth.org/groups/fmch/pdf/life\\_course\\_fact\\_sheet.pdf](http://www.cchealth.org/groups/fmch/pdf/life_course_fact_sheet.pdf), 2005

### **Integrated Perinatal Health Framework: A Multiple Determinants Model with a Life Span Approach.**

Dawn P. Misra, PhD, Bernard Guyer, MD, Adam Allston, MPH, American Journal of Preventive Medicine, Volume 25, Number 1. 2003.

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website often!  
New Programs  
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## E-MCH OCTOBER: Life Course Health Development Model

NACCHO and CityMatCH jointly present "Emerging Issues in MCH" (E-MCH) webinars, offering our memberships cutting-edge research, policy and practice strategies on critical public health issues. Registration is FREE, space is limited, and free CEU's are offered for each E-MCH session.

Join us for the E-MCH October 16th webinar at 3:00 pm Eastern, where **Neal Halfon, MD, MPH**, Director, UCLA Center for Healthier Children, Families, and Communities in Los Angeles, CA, **Jody Hatz** from the National Conference of State Legislatures in Denver, CO and **Cheri Pies, MSW, DrPH**, Director, Family, Maternal, Child Health Programs in Contra Costa County Health Services Department, Martinez, CA will discuss the **Life-Course Health Development model**. **Brenda Thompson, MPH**, Public Health Prevention Specialist Assigned by CDC to CityMatCH, will serve as moderator. **Register online at: <http://webcasts.citymatch.org/>**



## Partnership to Eliminate Disparities in Infant Mortality

CityMatCH, the Association of Maternal and Child Health Programs, and the National Healthy Start Association are pleased to announce the "*Partnership to Eliminate Disparities in Infant Mortality*," an initiative made possible through generous support from the W. K. Kellogg Foundation.

The project aims to eliminate racial inequities that contribute to infant mortality within urban areas in the United States. Training and technical assistance in current research, best practices, and systems-building will be provided to selected State, local, and community collaborative teams. These teams together will network across state and other categorical lines, strategize to break down barriers in addressing inequities in infant mortality, and design new and innovative solutions tailored to their individual communities.

Team applications have closed as of September 2008, To find out more, contact Brenda Thompson by phone at 402-561-7500 or via E-mail at [brendathompson@unmc.edu](mailto:brendathompson@unmc.edu). Additional information about the project will be available on the CityMatCH website at [www.citymatch.org/](http://www.citymatch.org/).

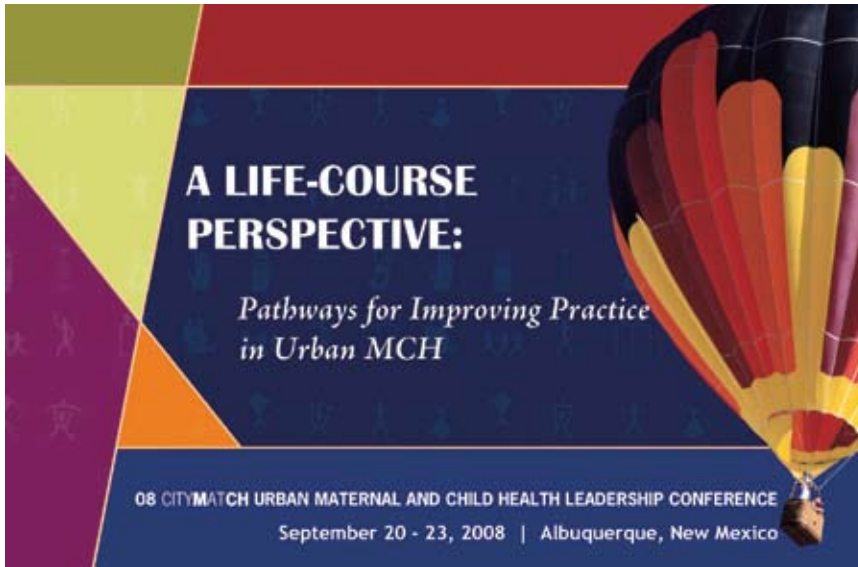
## Give It a Try! The "Ask-A-Colleague" Service

To build capacity and enhance peer-to-peer support, CityMatCH offers the "*Ask-A-Colleague Service*" (AAC). This select tool, available only to member health departments, can be used to quickly and efficiently query your colleagues around the country on MCH program, policy, practice and data use concerns. The AAC process is typically initiated, developed and completed online. Responses are also collected and posted online. If your health department is tackling an issue, struggling with a programmatic solution, wondering about resources and capacity or want to see how other health departments have dealt with similar concerns, the AAC is a great to get the information you need.

To get started, visit the CityMatCH website. Click on "Membership," and then click on "Ask-A-Colleague." You'll fill out an online form in a simple step-by-step process that walks users through tool options, (e.g., Likert scale, yes-no, check-box, short or descriptive responses, etc.) If you prefer, you can send your questions by E-mail or contact the CityMatCH office. Your query will be posted on a web-page available only to other CityMatCH members. An E-mail is sent to members to alert them to your query. It includes the link for their response. Online responses are archived and available for ninety days following submission. Additionally, if you would like to follow up with a health department for greater detail on their response, you may receive contact information from the respondents.

What a great way to get real-time assistance from fellow urban MCH leaders! For more information, contact Maureen Fitzgerald, MPA, at (402) 561-7500 or via E-mail at [mfitzger@unmc.edu](mailto:mfitzger@unmc.edu)





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**The 18th Annual CityMatCH Urban MCH Leadership Conference  
 Albuquerque, New Mexico, September 20-23, 2008**



**NOTE: Highlights and Conference materials and resources will be available online following the event. Visit the CityMatCH website: [www.citymatch.org](http://www.citymatch.org)**

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