Over the past year, CityMatCH leaders have worked with members to examine and enhance its stated mission. One proposed change is to add an explicit focus on the health of women in urban communities. This reflects our commitment to a broader definition of "MCH" and our understanding of current and future MCH practice and policy. Our move toward women’s health parallels that of many of our partners.

CityLights Summer 2001 features a range of local and national efforts to address women’s health through best practice, applied research, and advocacy efforts that foster awareness, illuminate policy issues affecting women, and promote problem resolution.

CityMatCH members seek opportunities to build upon the best practices of other health departments efforts around women, children and families in cities. CityLights spotlights selected urban health departments’ women’s health programs. Interest and activism devoted to women’s health issues has risen significantly within the past decade.

Over the past decade or so, federal offices of women’s health have been designated including HRSA’s Office of Women’s Health (OWH), which coordinates women’s activities across more than 80 HRSA programs. MCHB established the Division of Perinatal Systems and Women’s Health in 1999 to underscore it’s commitment to explore and provide for women’s health.

CDC’s Office of Women’s Health provides leadership, guidance, and coordination on policy, program planning, and development of CDC activities related to women’s health. Philanthropic organizations such as the Commonwealth Fund, the Kaiser Family Foundation, and National Partnership for Women & Families strive to increase awareness of women’s health issues in a sociocultural context. Academic-based Women’s Health Policy Centers draw attention through a variety of mechanisms and perform needed research.

Together these health departments, policy centers, federal offices of women’s health, and philanthropic organizations study, stimulate, and propagate needed changes in women’s health care. This edition provides a strategic assortment of available resources for public health departments and their partners in urban communities. Our aim is to highlight the opportunities and challenges in women’s health.
An academic sabbatical calls for leaving daily work and obligations behind to actively pursue professional growth and development.

First sabbatical Abat: “Sabbatical” is an oxymoron.

Most thesaurus synonyms are misleading. “Vacation,” “furlough,” “holiday,” and “respite,” are simply off the mark. Sabbatical is derived from the seventh day of rest. Six days into mine, I needed just that. Week one in D.C. was for immersion at Grantmakers in Health to gain a foundation on foundations. I paddled it with a trek to Baltimore, a Data Use plenary at an NCI conference to help pay for both, plus a handful of CityMatCH duties. I headed back to Omaha for 24 hours of family embrace, plus clean clothes and a few hours in the office to swap old files for new. Untangling from David’s second goodbye hug sounded like Velcro ripping. I went off to Pittsburgh on Sunday, wondering why I wanted to do this mini-sabbatical in the first place, and why I arranged two-months of weekdays away with some weekends at home.

There is another synonym closer to truth: Leave. Personal or family medical “leaves” demand that we stop to heal ourselves or another, often without warning. Somehow we just do it: we leave the e-mail, meetings, projects and patients in the hands of others who understand that life gets in the way. An academic sabbatical calls for leaving daily work and obligations behind to actively pursue professional growth and development. It means daring to put yourself at the front of the line.

In the daily juggle of kids and spouse and parents and home, of too many jobs, professional and volunteer, most women put themselves at the end of the day, rarely center stage. Master logicians of daily life, we find time for others first, sometimes at our own expense. Most of us who have dedicated our professional lives to improving the health and well-being of women and children and their families, are the women at the back of the line.

Sabbatical is choosing to leave. Truth is, I am not very good at it. An airport spectacle, I am a pack mule with laptop and satchel, schlepping files of things I must take along. My e-mail and voice mail explain that I’ve left, but I still check them both without fail. I need practice putting daily things down, in lightening the load to learn more.

I have tried to explain to Sam and to Dave what sabbatical means, that learning is fuel for life. They have seen their father or me go off to workshops and conferences every year since birth. They witnessed my year of intense Jewish learning and heard me chant Torah last May. But this time is different. I had considered taking the boys with me on the road when a six month sabbatical was the plan. But the timing was wrong, so I cut back to two, and I’ve scheduled ‘me’ morning ’til night. The cell phone I swore I’d never really use keeps them virtually closer instead. I sing Dave his lullaby at a quarter past nine, and check in with Sam twice a day.

This year’s CityMatCH Urban MCH Leadership Conference focuses on “Moving Women's Health Center Stage,” an apt parallel to my summer journey. When I see you in Music City, ask me how the sabbatical is going, or if I have synonyms to share. The best one I’ve come up with so far is choice. This mini sabbatical that the University of Nebraska Medical Center’s Department of Pediatrics is supporting has put choice into my hands. Nobody died, no surgery awaits, no dark call has come in the middle of the night. I have chosen to embrace my own well-being, to go to the front of the line, to choose learning. May I forgive myself for this radical act so essential to every woman's health.

E-ROUNDTABLE 1:
Urban MCH Leaders Assess Women's Health

Historically, women’s health needs have been categorized as “reproductive” and “other,” with reproductive needs assumed to be the only “unique” health needs of women. Not surprisingly, fragmented systems of health care emerged.

Urban public health departments strive to meet the needs of women, including women of diverse cultural and ethnic backgrounds with different beliefs about health care, in a system that is often fragmented and underfinanced.

Our first E-roundtable features selected responses to a recent E-mail query of several CityMatCH members about women’s health care in urban America.

CityMatCH: Are women's health issues a priority in your health department?

Agatha Lowe: Women’s health issues are one of the priorities in the Chicago Department of Health. It is the main reason why the MCH Division was changed several years ago to the "Division of Women and Children's Health Programs.” The change allowed for the inclusion of a men's health program. This does not mean that we are free from challenges. We are handicapped by categorical funding and multiple...

The biggest issue is developing an understanding of and a sensitivity to the needs of women as they transition from one culture to another.

-Agatha Lowe (continued on page 3)
E-ROUNDTABLE 1: Urban MCH Leaders Assess Women's Health

(continued from page 2)

managers or divisions that are responsible for these funds.

Vicki Alexander: In the health department, women's health issues are status quo - they retreated about twelve years ago when prenatal care was discontinued. Strong programs in HIV/AIDS, smoking cessation address women's issues but are somewhat scattered.

Linda Hook: Most recently, San Antonio Metropolitan Health District's Director of Health presented an overview of the importance of women's health in relationship to the family's health, physically, socially, and economically, to the elected City Council. Fortunately, strides are being made on breast health, and organizations like Susan G. Komen are helping efforts at local levels.

CityMatCH: Is anyone treating women as a whole being, rather than "parts?"

Deb Hendricks: St. Paul-Ramsey County (MN) Department of Public Health has structured its Title X Family Planning Program to look at the woman as a whole, providing a more comprehensive clinical service than many private providers. The Family Planning Program's priority is the provision of voluntary contraception; in addition, the program offers women the opportunity to become involved in a myriad of additional women's health and public health activities and services such as STD/HIV prevention and testing, immunization, broad range serum testing for cholesterol, thyroid, sickle cell, and diabetes. It was at the request of breast and cervical cancer screening users that our Department offers fee for service Expanded Women's Health services which are broad-based and non-categorical. The Department is also working to create a holistic, asset-based approach with young women between the ages of 12 and 18 with targeted state and federal funding.

Linda Hook: At the San Antonio Metropolitan Health Department (SAMHD) during the last year, the nursing division has made great strides at creating one nursing record used in all programs serving women. The record is a comprehensive history including assessments for nutritional status and mental health. This is our first step in trying to treat women as a whole.

CityMatCH: What cross-cultural lessons can be learned as new populations of women grow in our communities?

Agatha Lowe: The biggest issue is developing an understanding of and a sensitivity to the needs of women as they transition from one culture to another. It is essential that we understand their concept of health care and health care providers, family decision-making with respect to health, and past and present experiences with health services. In addition to the transition to an American culture, many families may also be learning to function for the first time in an urban environment. We can use this information to determine the types and mechanisms for providing services.

Deb Hendricks: Because of the significant Hmong population in St. Paul, we have learned much specific to that population. We are experiencing the arrival of many new Somali and other African refugees and immigrants. Issues around violence, pregnancy planning, divorce and mental health continue to challenge as a variety of cultures become a part of our community.

Culture, age, ethnicity, and religion have tremendous influence on the acceptability, tolerance, and utilization of some contraceptives. Consequently, we have tailored visits to reduce barriers and increase utilization.

CityMatCH: What can CityMatCH do to help your health department enhance women's health in your jurisdiction?

Vicki Alexander: CityMatCH should advocate for cultural humility and continuous learning, regarding the multiple cultural influences in this country.

Deb Hendricks: It would be helpful to have a readily accessible, internet site that shares the successes and challenges of other providers, as well as existing educational and outreach resources. We need materials translated and depicted with culturally sensitive information and pictures on a variety of health issues.

Linda Hook: Provide the latest research information about women's health and keep a pulse on the national agenda.

- Agatha Lowe

Roundtable Participants

- Vicki Alexander, MD, MPH, MCH Director, Berkeley City (CA) Health Department
- Linda Hook, RN, MSHP, Assistant Nursing Program Manager, San Antonio (TX) Metropolitan Health District
- Agatha Lowe, RN, PhD, Director, Women & Children Health Programs, Chicago (IL) Department of Public Health
- Deborah Hendricks, RN, MPH, Manager, Healthy Families Section, St. Paul-Ramsey County (MN) Department of Public Health

We speak of women's health, yet programs focus on illness ... perhaps what we need is a change in our mind set

- Agatha Lowe

CityMatCH could provide the latest research information about women's health and keep a pulse on the national agenda.

- Linda Hook
**CityFocus**

**THE URBAN INFANT AND MATERNAL MORTALITY STORY:** Tales from Two Cities

Maria: 42-year-old Maria Saint Vil, a recent immigrant from Haiti with no legal papers, is a home health provider. Her days are long: 12 hours, 6 days a week, providing care for an older invalid woman. 34 weeks pregnant, she is aware of the need for prenatal care. Her fear of "being turned in" to Immigration, her long work hours and the shame of another pregnancy in a foreign country makes prenatal care an impossible luxury. Her husband and three children are in Haiti; there is no family near by and few supports. This difficult pregnancy, complicated by headaches and "swelling" face, hands and feet, has made her late for work. She's afraid of losing her job.

At 36 weeks, the headaches worsen. She calls a friend who must first take a subway and a bus, to lend assistance. By the time her friend arrives, she is unconscious on the floor and EMS is called. Since she lives in a poor neighborhood, the response is slow. Maria is taken to the local public hospital, where they try to revive her. After 70 minutes of CPR and resuscitative measures, she is pronounced dead.

Shaneequa: 21-year-old Shaneequa Jackson hasn't seen much of the world, just her small part of Brooklyn. Her universe? Two children and pregnant again. We've all heard her story: high-school dropout, single-parent household, urban poverty. The media usually portrays these women badly, but they're our daughters, nieces, sisters or cousins, and their life-style puts them at risk.

Few understand her daily life in a fourth floor walk-up. Rude comments from clerical staff, headaches and 'swelling' face, hands and feet, has made her late for work. She's afraid of losing her job.

Shaneequa's vaginal cultures are positive for gonorrhea; she has refused HIV testing. Shaneequa: "The doctors didn't understand that I was really sick. You never see this in the media."

"You never see this in the media."

Since 1992, the California Department of Health Services with a Title V block grant funding a Fetal-Infant Mortality (FIMR) Review Project to identify causes and contributing factors related to the deaths of babies and to find ways to reduce the number of preventable deaths. After three years, the project shifted its focus to maternal mortality. It reviewed all identified pregnancy-related maternal deaths of Los Angeles County residents that occurred during 1994-1996. The report: "Maternal Mortality in Los Angeles County 1994 -1996" is the product of that study.

The DOH revised its Maternal Mortality Review committee as an adjunct to the Infant Mortality Initiative. This committee will review every maternal death in NYC in a calendar year, (~26-50 deaths per year), highlighting the need for accurate reporting of all deaths, and the need to include the medical examiner in all maternal death reviews. This peer-review, confidential committee will provide recommendations and suggestions for future similar situations, and share its findings appropriately to communicate the need for policy change and/or changes in the delivery of care to pregnant women.

The NYC Department of Health (DOH) recently selected infant mortality as its 'crosscutting' initiative. A task force was created and preliminary findings reveal multiple 'gaps' in areas of need. Proposed programs will focus attention on interventions to heighten the awareness of women's health before, during and after pregnancy.
preventable pregnancy-related deaths.

Each maternal death must be considered a sentinel event. For every woman in Los Angeles County who died of pregnancy-related causes, many more had serious complications of pregnancy and many were hospitalized for conditions related to pregnancy. Key causes of pregnancy-related deaths were hemorrhage, embolism and hypertension. Maternal mortality ratios in the LA review were higher for women over thirty years of age; African Americans; women with little or no prenatal care; and women with higher numbers of previous live births. According to the report, three-quarters were potentially preventable deaths with a host of contributing factors cited.

LA’s FIMR review panel made a number of recommendations for reducing maternal mortality, from improved women’s health care and preconceptual counseling to postpartum education and follow-up.

The impact of infant and maternal mortality is far reaching and cuts across race, economic and cultural lines. As public health policy makers, we must be cognizant of our power to persuade governments to ‘do the right thing’ and categorize maternal and infant mortality not as a condition that Blacks, Latinos and ‘those poor people’ bring upon themselves, but as a strong barometer of our health and social condition in this country and in the world.

H.L. Mencken said, “For every problem there is a solution that is simple, neat and wrong.” There is no simple solution to the problem of maternal mortality. The causes and contributing factors are diverse, which makes finding effective solutions challenging.

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THE NATIONAL SAFE MOTHERHOOD SUMMIT:
An Opportunity for a National Talk to Protect Women’s Health

Have some memories about women’s health in the 20th century? Is it the photograph of the midwife helping an immigrant family? Perhaps the chapter of a book describing labor and delivery practice in the 1920’s? Maybe a memory of an event that changed women’s lives? Or, perhaps you remember sitting in a meeting. Did the speaker talk about a “Women’s Health movement” or how a career in public health could change your life? If so, you are ready to answer these questions: What is Safe Motherhood? How can we make it a reality for all women in this nation? Why are we still facing challenges we hoped to overcome in the 20th century?

CDC will ask more than 300 people to answer these same questions during the National Summit on Safe Motherhood in September. Participants represent organizations and institutions like yours, and know how to harness the best of science and practice for women’s health. They understand the complexities of the health care system, the workplace, and the community, and will help shape a common vision of Safe Motherhood in the 21st century. CDC will ask them to begin the national “conversation” on Safe Motherhood to protect the health of a woman before, during and after pregnancy.

During the Summit, participants will hear how pregnancy can affect a woman’s health long after labor and delivery, develop a clear picture of the changing face of American women, and hear personal stories about pregnancy and the challenges faced during and after pregnancy. Journalists and authors of popular books on women’s lives and motherhood will attend and discuss what they’ve learned and what can be done to make Safe Motherhood a reality.

The hard work begins after the Summit: attendees must return to the offices, clinics and communities where women die or face the threat of death each day. The dialogue must include others who care for and about women’s health. That is why you and your organization are important. Be ready when the talk hits your office, clinic, community or home. Consider the questions and the vision. Consider making the 21st century known as the one where Safe Motherhood became a reality in families and communities all over the nation.

CityMatCH has been a partner in Safe Motherhood Summit planning from the beginning. Having CityMatCH “at the table” helped bring new insights and information to planning the Summit. Patrick Simpson and Vicki Alexander joined CDC and others last February to plan the meeting. At this pivotal meeting representatives of about 20 MCH, women’s health, and minority health organizations worked to develop a vision and a framework for the Summit. Several “partnering” options were available to organizations. Some provided financial support and are known as Summit co-sponsors. Others, like CityMatCH, provide the important in-kind assistance needed to strengthen activities before and during the Summit. CityMatCH will continue to be a strong partner in post-Summit activities, particularly in getting information to those who are unable to attend the meeting.

CityFocus

National Summit on Safe Motherhood: Investing in the Health of Women September 5-7, 2001 Atlanta, Georgia

Information about the conference is available at: <http://www.cdc.gov/nccdphp/dhr/events.html#Summit on Safe Motherhood>
Or, send an email to: safemotherhood@cdc.gov, or call: 404-325-8109.

At least eight or nine women will die from pregnancy-related complications while the Summit is in session and approximately 9,000 women will experience serious complications due to pregnancy during the same period.
Chicago, IL: “Stop the Hurt! Stop the Pain!”

A conversation between Neopolitan Lighthouse and the Chicago Department of Public Health (DPH) led to the inception of this domestic violence project. Neopolitan Lighthouse (a non-profit organization dedicated to promoting the emotional, educational, and practical needs of abused and/or unmanned women and their children) and the Health Department were both aware of a lack of domestic violence services in the medical community.

Together they determined that this particular population could be reached at the Women, Infant and Children's (WIC) Clinics. The two organizations drafted an assessment tool to aid in the screening of clients in need of domestic violence services.

An advocate from Neopolitan Lighthouse is now stationed at designated WIC clinics to meet clients, complete the assessment tool, discuss domestic violence and the Illinois Domestic Violence Act, and answer any questions. Staff training and identification of site locations for the project was accomplished by the WIC Program and Neopolitan Lighthouse. Between November 1, 1996, and December 31, 1999, approximately 3000 women were screened. Three hundred thirty three women were identified as victims of domestic violence. A Medical Advocate provided these women with over 430 hours of individual counseling and more than 240 hours of Illinois Domestic Violence Act (legal) counseling.

Some difficulties presented themselves during the phase-in of this project. Although clients are screened and identified as being a victim of domestic violence, many women failed to show up for their follow-up counseling sessions. Many of these clients rescheduled but still didn’t come in, requiring advocates to make repeated contacts to encourage the women to seek follow-up counseling and to provide them with tokens to attend.

Another barrier to the project was that some women were not screened with the assessment tool because they were escorted to the WIC Program by husbands or boyfriends. Medical advocates would only approach these women if they could speak to them alone during the appointment.

Bringing Women's Health to the Local Level

Local urban health departments face unique challenges to develop women’s health initiatives which fit the needs of their populations. Chicago (IL), San Antonio (TX), and Evansville (IL) share stories of their efforts to enhance women’s health and well-being. Columbia (SC) describes the integration of many of its clinical services.

Evansville, IN: Office Outreach for Breast Cancer

Through a grant from Susan G. Komen Breast Cancer Foundation to provide education and awareness of breast cancer, the Vanderburgh County Department of Health has reached out to women in WIC/MCH clinics, staff and to women in other offices in the Civic Center Complex where the health department is located.

The program has been taken to numerous city and county offices. The program strategy includes teaching breast cancer awareness, educating clients and employees on the importance of breast self-exams and mammograms; providing an educational program with incentives to be taken to local MCH/WIC and hypertension clinics; encourages health department employees to take this disease seriously and to promote education for breast cancer awareness; and developing a booth on breast cancer information for use in numerous community health fairs.

By December 1, 2000, the health department had provided ten breast cancer awareness informational booths to various city and county offices, encouraging women to learn about breast cancer and early detection methods. Information booths at the WIC/MCH and Hypertension clinics promoted breast cancer awareness among the nearly 1000 clients seen. Ten breast cancer booths were displayed in conjunction with various church and agency health fairs.

Possibly due to community awareness of the high incidence of breast cancer and the greatly publicized Susan G. Komen "Race for the Cure," no significant barriers have been encountered in the implementation of the project. All government offices that were contacted agreed to have the information booth and to educate women on staff.

Various divisions in the health department have been instrumental in working with the health educators to have displays in waiting rooms and personal one-on-one education with female clients seen in clinic. As of July 1, 2000, five hundred women had been reached, and a goal to reach of two thousand women by the end of the year 2000.

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Fax: 312-747-8799 Phone: 312-747-9706 For more information, contact: Thomasine Johnson-Partlow Women & Children’s Health Program Chicago (IL) Dept. of Public Health Fax: 812-435-5418 Phone: 812-435-5871 E-mail: partlow.thomasine@cdph.org...
San Antonio, TX: *Every Woman, Every Day*

In late 1999, South Central Texas March of Dimes awarded San Antonio Metropolitan Health District a grant to create a folic acid education and multivitamin distribution project entitled "Every Woman, Every Day."

Cooperation and coordination among the divisions of Health Education and Promotion, Nursing and WIC was necessary to achieve the goal of increasing patients’ knowledge about the relationship between consuming folic acid and prevention of birth defects and increasing the proportion of women who consume folic acid daily.

The project works with staff to assure a strong knowledge base, surveys clients of the clinics in both Spanish and English about their knowledge, attitudes and use of folic acid, provides culturally appropriate print materials (such as brochures, reminder magnets and keychains), and provides a 90-day supply of multivitamins containing 400 mcg. of folic acid. Reminder cards are also sent out offering another free 90-day supply of multivitamins.

Four key objectives anchor the project: 1) to provide 2000 women with multivitamins (containing 400 mcg. of folic acid) and education regarding the importance of folic acid in their diet; 2) to survey, in Spanish and English, at least 25% of the 2000 target population on their knowledge, attitudes and behaviors regarding folic acid use; 3) to increase the target population’s knowledge that 400 mcg. of folic acid daily can help prevent birth defects and that it should be taken prior to becoming pregnant; and 4) to include folic acid education as standard care to women accessing SAMHD clinics.

With 14 different clinic locations, and multiple staff responsibilities, implementing the project consistently in all the clinics and maintain communication among all groups was a great challenge. The health department and its different divisions are actively involved in planning, implementing and evaluating the folic acid project.

Project highlights include dispensing over 2000 bottles of multivitamins, and more than 300 surveys distributed. The project has not gone without its share of difficulties: some clinics did not return adequate numbers of surveys, and others had vitamin packs remaining in boxes long after the project had been underway.

The next interdivision project will learn from these lessons and include an increased focus on communication. *Every Woman Every Day* was well received, and efforts to educate women on the importance of folic acid will continue within the clinics of the San Antonio Metropolitan Health District and the community of San Antonio.

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Putting the Pieces Together: Integrated Women’s Health Services

South Carolina Department of Health and Environmental Control - Palmetto Health District, Columbia, (SC) has gone through a process that led to the integration of health clinics for Family Planning, STD, HIV, some maternity and family support services and immunizations. These services are provided to both men in women in one clinical setting. Though the department has clearly come a long way, Susanna Watson, Family Planning/Maternity Nursing Supervisor, describes the present integrated clinics as an "ongoing process." They have made remarkable strides to integrate services while navigating the murky waters of multiple funding streams, accountabilities and patient populations.

How did this come about? Several years ago, the South Carolina State Deputy Commissioner mandated that these health services be integrated. South Carolina has a rather unique situation in that all health departments are within one jurisdiction, using the same standing orders, the same system of administration, etc. (The counties are grouped into districts, and Palmetto Health District, located in the State’s Capital, is the largest in population.) The transition was not without conflict. Many felt that the health department was doing a good enough job of providing services already. A number of nurses left and found other employment, rather than expand their predictable cluster of responsibilities.

It has not been easy to make the transition; having a clear mission and sense of purpose has helped a great deal. The physical location of clinics changed; new staff were hired to replace those who had left.

Many issues cloud clinical service integration, including separate funding streams, and these "background details" can cause a lot of difficulty. Recently, the health department was able to combine medications, which are funded separately. Integration of clinical services is a work in progress, and issues around administration, billing and coding concerns remain.

Recently a charge nurse was hired to oversee these clinics. Patients at the integrated clinics can receive family planning services, STD testing, prenatal screening and more. While prenatal exams are not provided, the clinics do serve as a ‘system bridge’ connecting expectant mothers with Medicaid, WIC, and referrals to private physicians for care. This “one stop shopping” is of great benefit for patients, allowing them to receive a range of services without all the complications that multiple appointments present: additional time away from work, transportation concerns, accessing child care, etc.

The Palmetto Health District suggests building staff consensus first, if your health department is considering integrating some or all of your women’s health and or STD/HIV related services. Talk to your staff about the mission. Help them to understand and agree that integration of clinical services is better for the populations they serve. As public health practitioners, the patient should be the first priority.

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CityMatCH recently E-interviewed selected public health leaders about changes in the Women’s Health landscape. Featured below are selected highlights.

CityMatCH: What are some of the key opportunities and challenges to make a difference in urban women’s health?

Renee Brown-Bryant: A real challenge is working with new Americans living in urban areas. When a woman who is a recent immigrant struggles with the differences between her traditional values and a new culture, what can we do to provide her safe and appropriate passage? The migration of families from small towns and rural areas continues. We must remember the threats to a woman’s health in a urban setting may be very different from those in a rural community.

Holly Grason: Welfare policy changes present both opportunities and challenges. More women are in the workforce, and this presents opportunities to enhance both economic self-sufficiency and social independence, with the potential to improve women’s well-being overall. Achieving this will require persistent system advocacy, and support for individual women who interface with public health programs. Attention needs to be given not only to ensuring that their health (and that of their children) can be optimized, but also that they are provided opportunities in employment situations to earn a living wage and adequate employee benefits. Child care adequacy also needs to be assured.

Prior and new provisions in S-CHIP allowing for family insurance coverage can be important generally, and with specific regard to women involved in TANF. Research documents important links between a mother’s and her children’s health status and health services use. Public health professionals need to bring this information to light and be staunch advocates for S-CHIP enhancements and full enrollment of eligible women and children.

Rashidah Hassan: Women are more aware and interested in matters of their health. It is critical to use the media, including radio, television, public media displays, cable, internet. These are not traditional methods to accessing health information, but with so many women lacking knowledge of health care, it is critical to think beyond tradition.

CityMatCH: What kind of political will needs to be generated to create a stronger women’s health agenda at the federal, state, and local level? What is the current political landscape?

Renee Brown-Bryant: As a Federal agency, our responsibility is to conduct research and make findings available so it benefits the public’s health. We view ourselves as helping people obtain the tools and evidence needed to make sound policies, guidelines, and personal choices. We will continue to help women understand how public health policies affects their lives. We hope women will recognize that these tools are available and understand how to use them to affect the political process.

Holly Grason: In order to avoid some controversial issues, many in the political arena who seek to promote women’s health choose to focus exclusively on noncontroversial health concerns such as chronic disease. While these health problems are important, comprehensively addressing women’s health from a life-span perspective would likely move the field further along. If women’s and perinatal health advocacy groups could move beyond the political barriers, efforts to build political will for greater attention and resources for women’s health might yield better results.

Rashidah Hassan: The first step is to have an agenda with specific goals and objectives brought to each level of government based on ability or responsibility to address them.

A cross-section of women should be organized to train participants to access their representatives, and then move out specific times, i.e., Lobby Days. Plan actions that can occur throughout the year to highlight issues.

We let politicians off the hook by not regularly pushing our needs and demanding action. When women take action, things happen, regardless of the landscape.

(continued on page 9)
National Voices on Women’s Health in Urban America

(continued from page 8)

CityMatCH: Any additional “words of wisdom” which you would like to share with readers?

Renee Brown-Bryant: Be aware each day brings something new to women’s health: a discovery, a controversy, or a new approach to prevent disease. We must remember a new generation of women will soon enter their reproductive years. Soon, they will become our colleagues and our clients. They will challenge us to pay attention to their needs, will have values, beliefs and behaviors shaped by the massive use of technology, and demand more evidence before making decisions.

Holly Grason: Be open, bold, and creative in identifying partners and opportunities for enhancing women’s health...think broadly, keeping in mind the interrelationships among health concerns over the course of a woman’s lifetime.

Rashidah Hassan: Women are the only ones truly capable of determining the health needs we face. We alone can best articulate those needs to those with the power and resources to make a difference in our health. We must be fierce and unrelenting in addressing change as we see the need.

National Program Teaches Girls Healthy Behaviors

Girl Neighborhood Power! Building Bright Futures for Success (GNP) is a program designed to help 9-14 year old girls make responsible and healthy choices that will affect the rest of their lives. GNP uses a preventative health promoting approach which is designed to "enable girls and young adolescents to become successful adults by exercising responsible reproductive health, achieving gender-specific empowerment, and maturing as skilled navigators toward productive adulthood and responsible citizenship."

GNP is made possible through a cooperative agreement between the Department of Health and Human Services (DHHS)/Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), and the National Healthy Mothers, Healthy Babies Coalition (HMHB). HMHB serves as the National Consortium providing technical assistance to four federally funded local GN sites: Crispus Attucks Association, York, PA; Youth and Family Services, Inc., Rapid City, SD; Girls Incorporated of Memphis, Memphis, TN; and the City of Madison, Madison, WI.

The Girl Neighborhood Power! Program was developed to support special projects that demonstrate how states, local agencies, organizations, businesses and communities can work together to improve the health, and well-being of girls and young adolescents. The four sites were selected on a competitive basis by the Maternal and Child Health Bureau as community-based partners. HMHB will be helping additional communities to establish new GNP programs using local funding mechanisms.

The Department of Health and Human Services (DHHS) challenges America’s communities to become active partners in assisting girls and young female adolescents to develop their maximum potential. GNP is a collaborative partnership between America’s communities and the DHHS.

For more information contact:
Development Office
National Healthy Mothers,
Healthy Babies Coalition
121 N. Washington St., Suite 300
Alexandria, VA 22314
Phone (703) 836-6110
Internet: http://www.hmhb.org/
Committees/Girlpower/girlpower.html

SPOTLIGHT: Madison Girl Neighborhood Power

Madison (WI) was selected as one of the four Girl Neighborhood Power! sites. The project uses the Atwood Middle School Empowerment Program as its model and created a partnership with the Department of Public Health (a CityMatCH Member Health Department), Briarpatch, and the City of Madison’s Office of Community Services. Each partner contributes expertise to the project, which serves more than 150 girls in four neighborhoods across the city. The girls are involved in youth leadership, adolescent health issues, and community service.

Madison GNP staff are able to establish links between GNP efforts and preventative women’s health. In one instance, as one presenter spoke to GNP participants in her group about the changes of puberty, questions arose about breast cancer. In response, a mother/daughter tea was planned to create an opportunity to talk specifically about breast health. Since the risk of teen girls for breast cancer is low, the focus was on developing good health habits and encouraging mothers to become more knowledgeable about breast health.

The mothers and daughters in this group were of Hmong origin. A Hmong co-worker spoke to the moms and the GNP presenter spoke separately with the girls, as it is not culturally acceptable to discuss mothers’ health issues in front of the girls. GNP has made many similar positive strides with girls in Madison.

For more information on Madison’s effort, contact Madison Girl Neighborhood Power Director, Meme Kintner at 608-241-1574, ext. 18.

Summer 2001
The Changing Face of Women's Health

The current system of health care in the United States does not always meet the unique needs of women, therefore, health professionals and the public are calling for changes in the health care system. There are many other factors, i.e., socioeconomic status, demographic shifts, changing family structure and lack of insurance, contributing to the problem of women not receiving comprehensive health care. Research on a variety of fronts, and advocacy to promote the issues and stimulate the concern of the general population are what the policy centers, research centers and philanthropic organizations cited here strive to provide. There are many such organizations out there; CityLights describes a selected few.

SPOTLIGHT: The Women's and Children's Health Policy Center

The devolution of accountability for health policy, systems, and services presents pressing and complex challenges and opportunities for state-, county- and city-level child health policies and programs in a continuously shifting social and political context for maternal and child health in the United States. That's where the Women's and Children's Health Policy Center (WCHPC) at the Johns Hopkins University Bloomberg School of Public Health fits in. "As a state MCH director, I have found the materials that WCHPC has developed have been very helpful in providing resources for us," commented Nan Streeter, Director of the Utah Department of Health's Maternal and Child Health Bureau. "The resources and printed materials that WCHPC develops and makes available to states (and others, such as city/county MCH programs) provide a comprehensive review of the literature and a thorough discussion of the relevant issues. These resources provide MCH public health professionals with the necessary background material useful in planning and policy development in the area of women's and children's health, that benefit MCH at all levels of public health," continued Ms. Streeter.

The WCHPC solicits consultation about critical issues currently facing Title V MCH and CSHCN programs. Input from State and national MCH leaders and experts in its State Cluster Group assists the Center in its specific approaches to policy research project and product development. Direct input from individual state or local agencies and others interested in the development of primary health care services and systems is welcomed and encouraged.

In April 1999, the WCHPC published a two-volume compendium entitled Charting a Course for the Future of Women's and Perinatal Health. In these volumes, Center faculty reviewed the current state of women's and perinatal health, and invited experts to help develop recommendations addressing health policy, quality assurance, organization and financing of services, education, workforce development, and research concerns. Volume I presents the scope and guiding principles of the initiative and background on the field of women's health, summarizes key findings from the literature, and outlines recommendations. Volume II provides more in-depth documentation and discussion of key issues in women's and perinatal health, expanding on the material synthesized in Volume I.

Faculty with the WCHPC developed a new survey instrument designed to measure specific domains in women's health services that are not measured in sufficient detail or from women's perspectives in existing national data sets. The key contributions of the survey are the components that measure needs-based health care utilization and use of health care services. The key components of the survey are the components that measure needs-based health care utilization and use of health care services.
information – no other widely-fielded survey currently collects this information. The Center hopes to make this survey available in Fall 2001 for the use of state and local agencies, among others that might find one or more of the survey domains useful.


Other women’s health publications include several series of policy research briefs: Welfare Reform and Women’s Health: Opportunities to Advance the Public Response to the Health Needs of Women on Welfare through Collaboration; Welfare Reform and Women’s Health: Review of the Literature and Implications for State Policy; The Health of Homeless Women: Information for State Title V Programs; and Health Issues Specific to Incarcerated Women: Information for State Title V Programs.

Forthcoming is a research brief on women’s oral health issues.

Another recent WCHPC product is CAST5, Capacity Assessment for State Title V programs. Potential uses for the tool, as identified by state MCH leaders, include guidance in conceptualizing the public MCH mission in a changing health care environment and transitioning to core public health functions; as part of a strategic planning process; and as an adjunct to continuous quality improvement activities. While the tool was not designed with local-level MCH agencies in mind, it may be found to be useful for the larger urban areas.

Most of the Center’s publications can be downloaded in PDF format from the web site at http://www.med.jhu.edu/wchpc. Publications also can be obtained free of charge from the National Maternal and Child Health Clearinghouse at http://www.nmchc.org or (888) 434-4MCH.

The WCHPC was established in 1991 to address current policy issues found in national legislative initiatives and evolving health systems reforms that impact on the health of women, children, and adolescents. The Center as a whole and its individual studies are supported through an array of grants and contracts from private foundations, governmental agencies (federal, state, and local), and nonprofit independent research and consulting firms. The Maternal and Child Health Bureau (HRSA, Department of Health and Human Services) provides core funding for WCHPC activities.

For more information on the WCHPC, contact:
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City Focus

National Action Alliance: Building Data Capacity for the Health of Women, Children and Youth

...equipping our nation's public health agencies with the data tools necessary to make a measurable difference for future generations and the families that raise them...

Demonstrating their strong commitment to better equipping our nation's public health agencies with data tools necessary to make a measurable difference for future generations and the families that raise them, ten national public health organizations have joined together to form an 'alliance for action' to strengthen the data-related capacity of public health agencies.

The National Action Alliance began in 1997 as the National Action Agenda for Building Data Capacity for Maternal and Child Health. The initial leadership group consisted of the Association of Maternal and Child Health Programs (AMCHP), CityMatCH, HRSA, and CDC. Other national organizations soon joined the initiative. Together the group defined a mission and long-range vision for achieving MCH data capacity, and articulated well-defined short-term strategies. In June 2001, nine partners of the National Action Agenda met to assess the Agenda's impact, to determine the next steps, and to identify key successes achieved to strengthen public health agencies' data-related capacity. The meeting also resulted in updating and refreshing the Agenda's original mission, vision, goals and tenets.

The Agenda needed a new organizational structure that would encourage communication, coordination, and collaboration among the many partners. The National Action Alliance was launched to enable multiple organizations to maximize the impact of their related independent efforts.

The purpose of the National Action Alliance is to develop a clear national strategy to strengthen state, tribal and local public health agencies’ data-related capacity to carry out the core public health functions for women, infants, children, youth and their families, including those with special health care needs. Once developed, the Alliance will promote and advocate for this strategy; monitor implementation; and communicate, coordinate and collaborate on targeted activities where beneficial.

The Need:

State, local, and tribal public health agencies are responsible for assessing and monitoring the health of all people. Women, infants, children, youth and their families, including those with special health care needs, require targeted, focused attention to address the specific and unique needs of these developing and vulnerable populations. The health agencies identify, diagnose and investigate health problems and hazards affecting these populations. They inform and educate the public, and help mobilize community partnerships to solve health problems. They provide leadership for setting priorities, planning interventions, and developing policies to assure the health of families. They have responsibility for evaluating the effectiveness, accessibility and quality of health services across all sectors and populations. To best perform these essential public health services, governmental public health agencies and their partners must have adequate data-related capacity and infrastructure.

Effective performance of essential public health services focused on these special populations is critical given recent changes in the nation's health care delivery system including Medicaid, managed care and SCHIP.

Recent emphasis on performance, accountability and results-oriented budgeting and reporting requirements require expanded data-related skills at every level and a focus on better evidence-based decision-making. Large health disparities by race, ethnicity, geography and income call for public health action. Shifting social policies for education, welfare and immigration, plus continued devolution of responsibility to the state, tribes and local levels, present extraordinary opportunities and risks for these developing and vulnerable populations.

Any strategy to improve the data-related capacity of public health agencies must be part of a larger integrated approach within and among these agencies.

Why the Alliance:

The National Action Alliance Partners call for a national strategy with clear goals to strengthen the data-related capacity of public health agencies to improve the health of women, children and youth:

* Better data and information systems
* Increased opportunities for field-based capacity building
* Sufficient, well-trained people in the field
* Improve communication, coordination and collaboration; and
* Advance knowledge and evidence-based Practice.

For strategic activity beyond communication and coordination to occur, new sustainable funding for the Alliance is needed for planning, staffing, and targeted activities. At this infancy stage, National Action Alliance Partners are looking for organizations and individuals who are interested in investing to make a difference in strengthening the data-related capacity of public health agencies to improve the health of women, children and youth.

For further information, please contact:

Helene Kent, AMCHP: 202-775-0436 or hkent@amchp.org
Patrick Simpson, CityMatCH: 402-561-7500 or psimpsol@unmc.edu

National Action Alliance Partners

☆ Association of Maternal & Child Health Programs (AMCHP)
☆ Association of Schools of Public Health (ASHP)
☆ Association of State & Territorial Health Officers (ASTHO)
☆ Association of Teachers of Maternal and Child Health (ATMCH)
☆ Centers for Disease Control & Prevention (CDC)
☆ CityMatCH
☆ Council of State & Territorial Epidemiologists (CSTE)
☆ Health Resources & Services Administration (HRSA)
☆ National Association of County and City Health Officials (NACCHO)
☆ National Association of Public Health Statistics and Information Systems (NAPHSIS)
CityMatCH-March of Dimes Strategic Alliance
Advanced at National Meeting

Current joint activities and opportunities for greater future collaboration held the spotlight at a recent meeting between National March of Dimes Birth Defects Foundation (MOD) leaders and Magda Peck, ScD, Professor & Associate Chair, Section on Child Health Policy, UNMC Department of Pediatrics, CityMatCH CEO & Executive Director, and Bill Sappenfield, MD, MPH, Medical Epidemiologist, CDC, Adjunct Assistant Professor, UNMC Department of Pediatrics.

The National March of Dimes Birth Defects Foundation and CityMatCH have a history of shared goals and informal collaborations dating from shortly after the inception of CityMatCH over a decade ago. The “March of Dimes - CityMatCH Partnership for Urban Mothers and Babies,” formalized this relationship in 1998 with the following shared goals:

- Promote Effective Use of Data for Better Local Public Health Practice;
- Translate Applied Research into Best Practices for Urban MCH; and
- Strengthen Local Connections Between Public Health Agencies and MOD Chapters.

This landmark meeting, held June 6, 2001 at the National MOD headquarters in White Plains (NY), culminated in a grand rounds presentation by Drs. Peck and Sappenfield focusing attention upon current CityMatCH activities supported in part by the March of Dimes: Data Use Institute and Academies, the annual Urban MCH Leadership Conference, and most recently, the Perinatal Periods of Risk Initiative, a new community approach to reducing fetal and infant mortality.

Strategic opportunities for future March of Dimes-CityMatCH collaboration relative were discussed, based on common priorities of the two organizations. Both have significant interest and focus on prematurity research and prevention; they share a desire to reduce racial and ethnic disparities in birth outcomes, and they both strive to foster leadership for community impact.

“As we think through how to launch our next educational campaign on preventing prematurity, we need ...the right set of partners,” said Marion Greenup, Senior Vice President, Education and Health Promotion, MOD. She continued, “We believe CityMatCH is one of those critical partners whose association is needed by the March of Dimes to foster and assure strong local connections.”

CityMatCH Priorities 2004:
- Enhance leadership for maternal and child health in urban communities;
- Strengthen local capacity to use data effectively in public health practice;
- Translate research into effective action for urban women, children, and their families;
- Reduce racial and ethnic disparities in urban maternal and child health, and
- Focus on Urban Women’s Health.

March of Dimes Sets Goals for 2005

The National March of Dimes Birth Defects Foundation (MOD), a long standing partner with CityMatCH, works to create positive change through both research and advocacy. Recognizing the unique needs of every community, March of Dimes chapters are finding workable and creative solutions to such problems as premature birth or birth defects, across the nation, and internationally, through a medley of new and tried-and-true programs, as well as some $11.7 million in grants to local organizations.

On June 16, 2000 the Board of Trustees of the National March of Dimes Birth Defects Foundation unanimously approved the Strategic Plan for the Year 2005, the result of a new set of directions developed with the sustained involvement of volunteers and staff throughout the organization. This plan was later introduced to foundation leaders at the annual Volunteer Leadership Conference in September, 2000.

The plan establishes a number of key goals relative to the mission, including three of great importance not only to CityMatCH members but also to others who are interested in better health outcomes for mothers and babies:

- Invest in cutting edge research and prevention initiatives to improve birth outcomes. Selected strategies to meet this goal include the development of a multidisciplinary folic acid campaign to reduce neural tube defects by 30%; the expansion of research investments focused on gene therapy, tissue and organ regeneration and prematurity; and expansion of adequate birth defects surveillance to all states.
- Increase access to health care coverage for women of childbearing age, infants and children. Through advocacy efforts to improve and expand coverage within Medicaid and SCHIP, March of Dimes will be working to reduce the proportion of uninsured. The MOD will advocate strongly for the inclusion of preconception and perinatal care benefits and services in the public programs of all fifty states.
- Reduce racial and ethnic disparities in birth outcomes. The development and delivery of new products for low-income and minority women will coincide with efforts to decrease the rate of infant mortality by 25% in targeted communities through advocacy for federal and state funding of interventions.

LIFE AFTER CITYMATCH: Where DO Our Leaders Go Next?

Where do former Urban Health Department Maternal and Child Health (MCH) designees go when they aren’t MCH designees any more? CityLights editor Maureen Fitzgerald interviewed several former CityMatCH Member Representatives to find answers.

Linda Welsh was the Early Childhood Coordinator at the Austin/Travis County Health and Human Services Department in Austin, Texas. Last year, she became Associate Professor of Child Development at Austin Community College. As a full-time faculty member, she now fulfills both teaching and administrative responsibilities. She also oversees grants and community outreach.

Said Linda, “I had the opportunity (at Austin/Travis County Health and Human Services) to work closely with the community which prepared me to create programs that serve our students who are primarily women returning to school or first time in college after being in the workforce for a number of years. The wonderful training I have received has given me the skills to lead this organization and work effectively across disciplines.”

Welsh feels especially proud of the Early Childhood Program she developed for the City of Austin, with support and guidance from a city commission. Starting with $350,000 in funding, child care services annually receive almost $2 million. During that time, three child care facilities serving low income families were constructed. Her “biggest tangible accomplishment” was the creation of Connections Resource Center for Childcare Professionals and Parents. This vibrant community resource started as an idea – Welsh worked the inside and the Child Care Council worked the outside to get funding. They met in the middle to actually make this happen. She also helped start the Reach Out and Read program in the clinics, and helped create their perinatal coalition, from which developed a child abuse prevention coalition.

During her time with CityMatCH, Welsh served on the Board of Directors, Executive Committee, and Conference Co-Chair. She says that, “CityMatCH offered me a family of creative, inspiring colleagues, who helped me bridge the early childhood/child care world and the maternal/child health world to create stronger services for our community. The level of discourse and dialogue around important public health issues stimulated deeper thinking about needed community solutions to issues like racism and its impact on access to prenatal care or teenage pregnancy prevention.”

Len Foster spent 17 years as Deputy Director of Health (Adult and Child Health Services) with Orange County, California, in a jurisdiction that has a population of 2.8 million people. Foster’s responsibilities included Maternal and Child Health, Field Nursing, Oral Health, Health Care for Juvenile In-Custody and Dependent Children, CCS, Nutrition Services including WIC, and Special Projects. He left in 2000 to become Director of Health for Monterey County, California (population 401,000).

CityMatCH benefited from Foster’s active participation on the Board of Directors, the Executive Committee and numerous other activities.

Foster’s most notable contributions while in Orange County were the creation of a Perinatal Case Management program for women at high risk for substance abuse during pregnancy which significantly reduced (80%) the number of women giving birth to substance exposed infants, and infants requiring out of home placement; the institutionalization of the Countywide Health Needs Assessment as a partnership between the County’s Health Care Agency, local proprietary hospitals, and other community stakeholders to perform a comprehensive health assessment process every three years and to effectively utilize the data collected; the development of partnership between the Health Department and Latino Health Access; and implementing a computerized immunization registry that contains immunization records for over 500,000 patients.

Says Foster, “CityMatCH provided me with the opportunity to develop a set of skills essential in preparing me to make the transition from the principal deputy level within a local health department to director. It provided me with the chance to interact with federal officials at the policy level and to enhance my presentation and data skills. Additionally, CityMatCH linked me to a powerful network of health care professionals with whom I can exchange ideas and discover innovative approaches to commonly faced issues.”

Uniqua McIntyre, former CityMatCH representative from the New York City Health Department, is presently Senior Development Manager for the Community Health Care Network (CHN) in New York. This position involves conceptualizing new and existing program and funding needs to meet their mission and goals. Her last working day at the New York City Department of Health was June 29, 2001, so the transition is quite recent. She is busy identifying new RFP’s, writing proposals for new funding initiatives and preparing reapplications and reports for existing grants in collaboration with senior level and program staff.

Her previous position at the New York City Department of Health prepared her well for this position: as the Director of Research and Development, she designed qualitative and quantitative research projects, which contributed to developing new or enhancing existing programs for specially defined populations and the maternal and child health populations. In many cases, new funding was sorted through competitive processes such as applying for federal, state and local grants and contracts. She worked to...
LIFE AFTER CITYMATCH:
Where DO Our Leaders Go Next?
(continued from page 13)
establish community-based, academic and medical-based collaborations to implement new initiatives, and enhance existing ones.

Highlights from the New York City Health Department tenure are: participating in the CityMatCH Data Use Institute, enabling the Department of Health to further establish collaborative relationships with the Greater New York Chapter March of Dimes; establishing infant mortality as a priority for the Department and laying the foundation for a crosscutting work plan; developing reproductive health fact cards for Chinese-American women in New York City; co-developing the New York City’s Child Health Insurance Program; and co-writing the Department’s successful Healthy Start proposal.

Uniqua feels that her experiences with the Department of Health allowed her to translate academic education in public health into a broad description.

Liz Zelazek worked for the City of Milwaukee Health Department for over 33 years, before retiring in January, 2000. For the last 10 years of her career, she was Milwaukee’s representative to CityMatCH, where she served on the Board of Directors and Executive Committee, as well as in various other leadership capacities.

In her role of Public Health Nursing Director and MCH Program Manager in Milwaukee, Liz was responsible for the generalized public health nursing service in the agency, as well as specific MCH programs such as teen pregnancy prevention, immunization, intensive case management for HIV infected women, childhood lead poisoning, school nursing services.

Since her “retirement,” Liz has continued to use her MCH and public health skills by serving on several statewide public health committees in Wisconsin. She currently is a member of the Wisconsin Public Health Advisory Committee, a statewide committee that advises the administrator of the Wisconsin Division of Public Health on issues of public health importance. She represents the Wisconsin Nurses’ Association on the Wisconsin Council on Immunization Practices and on a committee dealing with access to oral health and dental care. A member of Wisconsin’s Turning Point Subcommittee on Financing and Funding for Public Health, Zelazek chaired a special work group on public health funding.

Zelazek serves as Project Manager for the Public Health Statute Modernization Project in Wisconsin. The Wisconsin Public Health Association is the recipient of this Robert Wood Johnson grant that, in collaboration with four other states and a variety of other national partners, seeks to develop a model state public health law intended to transform and strengthen the legal framework for the public health system.

According to Liz, “CityMatCH gave me the opportunity to represent MCH and local public health on a national level and learn from the experiences of all the national partners who work with CityMatCH. Initiatives within CityMatCH, such as the DUI, also provided a terrific learning experience for many of us in the Milwaukee Health Department. The friends I made through CityMatCH are still with me today. Most importantly, CityMatCH helped me develop skills in leadership that I continue to use today – even after "retirement!"
New DUI Teams Announced

With support from the Centers of Disease Control and Prevention and the National March of Dimes Birth Defects Foundation, seven urban communities have been selected to participate in the fifth CityMatCH Urban MCH Data Use Institute. The following are the 2001-2002 Data Use Institute cities and their projects:

- Chicago, IL—Chicago Communities’ Perinatal Periods of Risk Assessment Pilot Project
- Colorado Springs, CO—Child CARE: Childcare Assessment Response and Education
- Los Angeles, CA—Investing in Children and Families: The Los Angeles County Perinatal Health Programs Evaluation Collaboration
- Philadelphia, PA—An Analysis of and Intervention Strategies for Domestic Violence Among Immigrant Communities in Philadelphia: Determining Ways to Break the Silence
- Salt Lake City, UT—Analysis of Perinatal Outcomes for Program Evaluation
- Tucson, AZ—Pima County Perinatal Periods of Risk
- Waco, TX—Portrait of Health Issues: GIS in Monitoring Community Health Status

DUI Pearl #2:
Train teams, not just individuals

One of the Keys of the Data Use Institute is to develop successful teams. There are eight dimensions to high performing work teams:

- Clear, Elevating Goal
- Results-Driven Structure
- Competent Team Members
- Unified Commitment
- Collaborative Climate
- Standards of Excellence
- External Support and Recognition
- Principled Leadership