Leader's Tools and Tips: Leveraging, Obtaining, and Sustaining Dollars for MCH (Continued from page seven)

meets their state's needs. Federal rules say that local health agencies should be involved in the development of the state needs assessment and application, so local agencies can have some influence on the spending plan. Some states allocate the Block Grant to their local public health agencies in a similar way, asking for an application that reflects the needs of the local area. In addition, cities may have capacities that state health agencies lack and may be able to do work for the state as a contractor. That can be a win-win collaboration if it allows expertise to be maintained in the system as a whole.

Temporary Assistance for Needy Families (TANF) Contracts

Each state has to meet goals in their economic assistance program to reduce the number of people on welfare and increase the numbers who are working. States have a great deal of flexibility in how they are doing this, so how public health can work with them varies significantly. But the vulnerable populations they serve are a focus of public health assurance activities as well, and there are many ways creative partnerships between welfare and public health can benefit these families. The Oldest home-visited model has shown significant reductions in months spent on welfare. Assessments of children for special needs that require parental care or parenting classes that help prepare families for working outside the home can be strategies for partnerships. Working with childcare providers both to increase the supply and so they can better care for special needs children are also areas of mutual interest. There are cultural and system barriers that make these partnerships between welfare and public health difficult, but much is to be gained for the families and for the agencies themselves.

Do you have a practice strategy that has worked for you? Your colleagues would like to hear it! Contact Maureen Fitzgerald at CityMatCH and she will help you get your story into CityLights.

CityMatCH at the University of Nebraska Medical Center
982170 Nebraska Medical Center
Omaha, Nebraska 68198-2170
Phone: (402) 561-7500
Fax: (402) 561-7525
http://www.citymatch.org

CityMatCH Staff:
Magda G. Peck, ScD, CEO/Executive Director
mpeck@unmc.edu
Michelle Cee, Staff Secretary
mcco@unmc.edu
Diana Fisaga, Staff Secretary
dfisaga@unmc.edu
Maureen Fitzgerald, MPA, Coordinator
mfitzger@unmc.edu
Vera Haynatzka, PhD, Health Data Analyst
vhaynatz@unmc.edu
Jeanette Leeper, Staff Secretary
jleeper@unmc.edu
Kelly McNichol, Project Assistant
kmnichol@unmc.edu
Matthew Newland, PhD, Project Assistant
mnewland@unmc.edu
Janet Rogers, Office Manager
jmrogers@unmc.edu
Jeff Rabey, MA, Project Coordinator
jrabe@unmc.edu
Jennifer Skala, MEd, Managing Coordinator for Education and Training
jskala@unmc.edu
Patrick Simpson, MPH, Director of Operations
psimpson@unmc.edu

CityView....................2
CityPractice...................3
CityIssues....................5
CityMatCH News..............7
E-Roundtable of MCH Leaders
Perinatal Transmission of HIV/AIDS
Leveraging, Obtaining, Sustaining Funding for MCH

Inside this Issue...

CityMatCH
Promoting communication and collaboration to improve the health of urban women, children and families
Volume 11, No. 1 Summer 2002
Published by CityMatCH
Summer 2002

From Loss to Resilience

It has been a roller coaster decade of drama and change for public health, and many who champion mothers and children are acutely feeling changes that are real and significant: direct services suspended, Medicaid reimbursement and core funding diminished, social justice commitments to the vulnerable seemingly set aside. In the last year, and post 9/11, losing ground has become more urgent for some who fear the core mission of public health is being absorbed by biodefense. Others are reeling with more pragmatic daily constraints: restricted travel, layoffs, rounds of budget cuts, shifted resources, and competing priorities between health, safety, and security.

If we are resourceful and resilient, we who bear responsibility for the health and well-being of women and children in America’s cities, where there is the greatest magnitude of change, can seize opportunities to strengthen our public health work even in times of doubt. The key is to cultivate partnerships and leverage resources outside the often narrow boundaries we have come to define as “MCH.”

This Summer CityLights edition features two prominent urban public health concerns in which MCH has not always been a main player: Bioterrorism preparedness and HIV. Yet both have special impact on and unique implications for women and children. We also offer tips and tools from the field for those who are crying about where the money is. We offer this CityLights late summer harvest of ideas to invoke and inform.

In August 2002, CityMatCH hosted an E-Roundtable of selected leaders in urban public health who share common roots in MCH. Selected highlights from their responses provide personal and professional insight on the impact of increased attention and resources toward local Bioterrorism Preparedness (BT), amid the current economic downturn and funding cuts in general local public health budgets on MCH.

(Continued on page three)
Grace say grace.

Grace Abbott: shaped by the legacy of her family of abolitionists and activists in the underground railroad, and by the convictions of her mother, a staunch suffragist who worked to assure Nebraska’s women’s right to vote as far back as 1882, in whose home Susan B. Anthony once came for tea.

Grace Abbott: influenced by her outspoken father, a Civil War soldier in Lincoln’s army, who relished the law, and who spurred with his Grace on matters of principle, assuring she learned to hold her own ground.

Grace Abbott, who left for Washington in 1912 to work for the first Chief of the new Children’s Bureau, emerged in 1921 as Julia Lathrop’s successor; who was among the first to use radio to broadcast public health messages about safeguarding their babies; who was the first woman ever nominated to Cabinet for Secretary of Labor, but refused to compromise her pledge to the women and children she served.

She was, in her sister’s words, “a pioneer in the new social frontiers of the 20th century.” What would we say as we begin the 21st with signs of misfortune and threats to security, women and children still in danger? New mothers serve face a hostile reception at our borders and airports and malls. Amidst a shortage for routine childhood vaccinations, smallpox vaccine is manufactured with urgency. A new cabinet level agency to pressure states in the “name of homeland security. If Grace Abbott were among us today, what she would make of the odd array of challenges urban and women and children are facing at the dawn of an invisible war?

She who helped pioneer immigrant rights, those she worked with Jane Adams atop of Chicago’s Hull House would argue for welcoming the stranger. She who fought two Presidents to keep the Children’s Bureau alive, would argue vehemently against the dismantlement and absorption of public health into other federal agencies. Those who named for messages to stop violence to a child who along with her whole family, died from diphtheria, would advocate effectively for sufficient children’s immunizations first and foremost.

Grace Abbott would not take kindly to our whining and perceived public health losses. She would see and seize opportunities to align mothers and children with health professionals who were the first to lay down their lives for the nation’s health. She would encourage us in every community to blend advocacy and science to persuade those in charge.

So, what did Grace say?

“...if I have said again and again that the only time we can save the babies who are going to die this year is this year. If we wait until next year they will be dead.”

Perhaps a better question we might ask is: What would Grace say?

And what, pray tell, must we do?

The answer is: Most of us have responsibilities in our work, leading several lives at once. One of my too many jobs is President of a new statewide philanthropy, the Nebraska Children and Families Foundation. It was in that capacity that I boarded a single engine aircraft from Island to Island to speak at the re dedication of a city park. Fifty years ago Grace Abbott Park had been named, for a woman of whom I had first heard in a Harvard School of Public Health requisite MCH core course. Who would have predicted that two decades later I would be in Nebraska, to always be asked to name one of public health’s unsung but most significant women, right in her own home town? In this most peculiar time of economic craziness, pitifully low funding, rising health and competing priorities, Grace Abbott’s idealism seems quite relevant once again. This CityView is adapted from my remarks.
In October 1999, CityMatCH entered into a cooperative agreement with the National Center for HIV, STD, and TB Prevention at the CDC. This partnership seeks to prevent perinatal HIV transmission in US cities by building capacity and data into effective practice in urban communities with the highest rates of perinatal HIV infection. CityMatCH focuses on the application of research and best practice through its Urban Learning Cluster Approach for prevention of perinatal HIV transmission, specifically in terms of addressing the social barriers: the often conflicting relationships among the researchers, policymakers and target populations.

The AIDS epidemic is best viewed within the larger context of the social and cultural experiences that shape the lives of those most at risk. While, consequently, have high rates of perinatal HIV transmission among urban poor women. This is because AIDS is “in much an organizational issue as it is a biological one” (Hall, 2002:13). Although there are indeed many organizations that deal with AIDS (both public and private) they often resemble as “tasks and services in the tool of diverse interest groups...perform very poorly in coping with AIDS” (Hall, 2002). Researchers who study and make policy recommendations about preventing the AIDS epidemic often experience varying degrees of equipoise among the target populations’ communities. This is largely due to policymakers recommending strategies without regard to a community’s culture, language, and worldview. Some community members feel frustrated because they feel policymakers have historically ignored their needs.

Prominent field researchers such as Michael Burawoy (1998:13) argue that the AIDS epidemic offers a unique opportunity for researchers, which the researcher includes reflexivity. Burawoy argue that reflexivity is important because, “we wish to deepen the foundations of sociology by recognizing our own place within the field...it elevates the dialogue.”

A perfect example of the importance of reflexivity in HIV prevention within urban poor communities is described in an article by Krauss, Goldsamt, and Sember (1997). They found that the greatest barriers to HIV infection in urban multicultural settings are often the social barriers, namely, the stereotypes of researchers, the target population, and the world’s differences between them. In their experience with community interventions, they found that successful interventions required simultaneous social interaction, dialogue and adapting to the needs of the community instead of treating AIDS prevention as an isolated issue.

While HIV prevention was the researchers’ encompassing theme/goal, it was crucial to incorporate HIV prevention into other community concerns, including drug treatment, food, housing, employment and other needs. This approach demonstrated a key to the community that the researchers were indeed aware of the community’s needs and took measures to adapt appropriate culturally. Furthermore, interventions stationed at or including these areas had more success because they reached more people and gained more attention.

Researchers also found a thirst for information in urban poor communities about HIV and prevention. Community members provided crucial information to the researchers on how to implement more effective strategies - an example of the strengthening relationship between researchers and local communities.

Los Angeles’s County is a member of the CDC-CityMatCH HIV Urban Learning Cluster. Their Perinatal Social Marketing Campaign seeks to reach the “hardest to reach women,” including women of color, incarcerated and recently released women from prison and women and women experiencing a variety of social problems (violence, drug use, lack of health insurance), by using social marketing campaigns is an awareness strategy that encourages pregnant women who may not be in prenatal care to seek and wait for prenatal care or biological plumb, or other such emergences.

Rob Fulton: MCH public health leaders should know who is planning and coordinating public health responses in their communities; what the implications of a bioterrorist incident may be; how MCH staff and resources can assist response efforts; who/what has been identified as a local high-risk target; how the public health response integrates with other emergency response activities; training programs and resources; communication networks and tools; need/capacity assessments; and public-provider education strategies.

Len Foster: Public health leaders should understand their organizational and community assets, as well as vulnerabilities. The events of 9/11 propelled what was viewed by many of us as merely theoretically possible to the new reality of the day. We must view our unique role in a new way. We must build or restore basic public health infrastructure to defend against bioterrorism, as well as traditional public health issues, including infectious disease outbreaks. BT really is a “population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that could be formed in the context of BT Preparedness that would be strengthened with public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their partners is the opportunity to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other arenas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise, and the media promotes vaccination, vaccine delivery, and administration. The American Red Cross is critical for shelter management. School systems are the largest number of children and should be a key partner. Special consideration for children and pregnant women must be emphasized, given the differences in medication and doses and long-term effort.

Lynn Frank: MCH practitioners have all the essential skills needed to be part of a Bio-Defense team. During our anthrax attacks, MCH staff provided assistance to over 1000 postal workers, provided risk assessment services, and “maned” an information line.

Lawrence Sands: A key focus area for the CDC grant is the development of an extensive Health Alert Network to cover every community and establish “connectivity” between all the major players involved with detecting and responding to public health emergencies. The purpose of the system is to facilitate rapid notification of emergencies and dissemination of critical information. In addition to traditional electronic messaging modalities, distance-learning modalities are a component of this system. Once established, these systems have the potential to strengthen the public health infrastructure for MCH and other programs. Imagine what DU and other CityMatCH services could be like utilizing this new asset.

What are the unique issues for women, children and adolescents in pandemics that need to be raised and addressed in current and future...
Global Best Practices for Prevention Perinatal Transmission of HIV

Today forty million people worldwide are infected with HIV/AIDS. In 2001, there were five million new infections, over six million people died from HIV, and three million people died from AIDS complications. With hope for a vaccine in the future, but a cure nowhere in sight, sharing global best practices and lessons learned is key to addressing the prevention of HIV transmission.

In the 1990’s the United States perinatal HIV infection declined by more than 80 percent. The Centers for Disease Control and Prevention (CDC) estimates that perinatal HIV transmission was passed to the schools and via their parents, school drivers, teachers, etc. Improved relations among these sectors can produce significant dividends in other areas. Improved relations between local physicians and the local health department could result in anything from improved accuracy of birth certificate data, improved reporting of diseases, greater participation in community wide immunization campaigns, and a host of other areas.

Stephanie C. Bailey: We developed and implemented a program called the Perinatal Health Practice “to strengthen infrastructure, equip staff with competencies needed to address emerging health issues, enhance ongoing collaboration and coordination among health professionals, improve the accuracy and timeliness of data reporting, and increase the use of healthcare repositories. As a result, the Perinatal Health Practice program had a significant impact on improving the quality and effectiveness of care for mothers and their newborns.”

The Diaphragm for HIV Prevention?

In Zimbabwe 33 percent of women are infected with HIV. A study in 1999 found that 99 percent of HIV cases were among women of reproductive age. Fifteen percent of AIDS cases were in children under the age of five. However, there are very few HIV prevention methods associated with a lower desire for pregnancy. Women have a 44-year life-expectancy rate, which is declining due to AIDS. There is desperation for female control over their bodies and for barrier-controlled methods. The cervix is a hot spot for HIV, and so researchers are exploring the possibility of the diaphragm as a barrier method in the prevention of HIV. The diaphragm is more acceptable than condoms, and women could use this method without their partner’s knowledge.

Female Condoms for HIV Prevention and Female Empowerment

The female condom is the first barrier method to help prevent HIV infection available for women. In South Africa, demand for female condoms is high as women seek some control over their bodies. Men seem more receptive to this method because of perceived benefits to their partners.

In Brazil, HIV positive women report having less unprotected sex when given the option of the female condom, and describe feeling comfort and power with this method. Due to the comparatively high cost of female condoms, researchers have focused on cost when the risk is removed and placed in a 1-to-2 ratio bleach solution for two to five minutes, the female condom can be reused and still be considered safe, a maximum of five times. However, concerns exist regarding accessibility of bleach and clean water, and potential confusion with male condoms, which cannot be cleaned and reused.

For more information, visit the conference website at: http://www.aids2002.com.

"Today we all go forth with a fresh chance – to build a great and global alliance – to find a vaccine, discover a cure, prevent new infections, treat the sick and care for the orphans. If we can see ourselves in those who suffer and find our freedom in their release, we will not change the course of this epidemic but the course of history."

For more information, visit the conference website at: http://www.aids2002.com.
The Scope of HIV/AIDS

Today forty million people worldwide are infected with HIV/AIDS. In 2001, these were five million new infections. In 1990, HIV and three million people died from AIDS complications. With hope for a vaccine in the future, but a cure nowhere in sight, sharing global best practices and lessons learned is key to addressing the prevention of HIV transmission.

In the 1990's the United States period of HIV infection declined by more than 80 percent. The Centers for Disease Control and Prevention (CDC) estimates that 372 HIV vaccinations were developed between 1981 and 2000. The most commonly missed prevention in the period of primary HIV in the United States today happens annually. Fifty-six percent of HIV-infected infants were born to their mothers with missed opportunities for perinatal prevention. (See Future Spec. of Douglas, 1996:2003)

Hamper Prevention Efforts

Women experience poor treatment by physicians in some countries in the quest to prevent perinatal HIV transmission. In Australia, there is a concern that doctors are so “pro-treatment” in their use of antiretroviral drugs in the prevention of perinatal HIV transmission, that they neglect to listen to women’s concerns about possible side effects to their babies. In Brazil, HIV-positive women who are of reproductive age reportedly hold “three Cs” in front of a mirror (cash, cell phone, and condom) inequalities are widespread and unemployment is 60 percent, all of which contribute to the complexity of this problem.

The Diaphragm for HIV Prevention?

Women who are infected with HIV. A study in 1999 found that 67 percent of HIV cases were among women of reproductive age. Fifteen percent of AIDS cases were in women under the age of five. However, research has shown that the diaphragm is not associated with a lower desire for pregnancy. Women have a 44-year lifetime risk of infection, which is declining due to fewer infections. There is a desire for female control over their bodies and for barrier-controlled methods. The cervix is a hot spot for HIV, and so researchers are exploring the possibility of the diaphragm as a barrier method in the prevention of HIV. The diaphragm is more acceptable than condoms and women could use this method without their partner’s knowledge.

Female Condoms for HIV Prevention and Female Empowerment

The female condom is the first barrier method to prevent HIV infection available for women. In South Africa, demand for female condoms is high as women seek some control over their bodies. Men seem more receptive to this method because of potential protective benefits.

In Brazil, HIV-positive women report having less unprotected sex when given the option of the female condom, and describe feeling comfort and power with this method. Due to the comparatively high cost of female condoms, researchers have focused on the need for affordable and affordable boric acid formulas to replace breastfeeding. Because of diarrhea, babies who are not breastfed have a higher mortality rate than breastfed babies who are breastfed by an HIV-positive mother. Researchers are conducting studies to see if there is a benefit to breastfeeding (up to four months) can decrease the chance of the baby becoming infected.

In Uganda the maternal aunt, “Sister,” is a crucial link to her niece. She may inform her niece that it is taboo to deny a man “live” sex (sex without a condom). The niece may still learn that refusal of sex with her husband could result in a beating or rape. Myths in Uganda continue to circulate. Female condoms hold fluids that transmit AIDS.

In Zimbabwe, there is concern about intergenerational sex among adolescents. A growing number of older men are seeking out young girls because they are seen as “AIDS free.” Twenty-five percent of girls now have HIV/AIDS. Teenage girls are intrigued by the older men because of what they refer to as “the three Cs’: cash, call phone, and condom. Gender inequalities are widespread and unemployment is 60 percent, all of which contribute to the complexity of this problem.

Global Best Practices for Prevention Perinatal Transmission of HIV

"Today we all go forth with a fresh chance – to build a great and global alliance – to find a vaccine, discover a cure, prevent new infections, treat the sick and care for the orphans. If we can see ourselves in those who suffer and find our freedom in their release, we will not change the course of this demonic but the course of history."
Breaking Social Barriers to Reduce the Transmission of HIV/AIDS

In October 1999, CityMacH entered into a cooperative agreement with the National Center for HIV, STD and TB Prevention at the CDC. This partnership seeks to prevent perinatal HIV transmission in US cities by developing local STD and data into effective practices in urban communities with the highest rates of perinatal HIV infection. CityMacH focuses on the application of research to best practices through its Urban Learning Cluster Approach for prevention of perinatal HIV transmission, specifically in terms of addressing the social barriers: the often conflicting relationships among the researchers, policymakers and target population.

The AIDS epidemic is best viewed within the larger context of the social and cultural experiences that shape the lives of those most at risk. Consequently, high rates of perinatal HIV transmission among urban poor women. This is because AIDS is “an attack on the core of community life, and an attack on the heart of a biological one” (Hall, 200-13). Although there are indeed many organizations that deal with AIDS (both public and private) they often resemble as “caring services” or “tools in the service of diverse interest groups that perform very poorly in coping with AIDS” (Hall, 2002).

Researchers who study and make policy recommendations about preventing the AIDS epidemic often experience varying degrees of anxiety about providing people among the target populations’ communities. This is largely due to policymakers recommending strategies without regard for the community’s culture, language, and worldview. Some community members feel frustrated because they feel policymakers have historically ignored their needs.

Prominent field researchers such as Michael Burawoy (1998:13) argue that “the most effective means of achieving social change is through which the researcher includes reflexivity. Burawoy argues that reflexivity is important because, “we wish to deepen the foundations of sociology by recognizing our own place within the field... it elevates the dialogue.”

A perfect example of the importance of reflexivity in HIV prevention within urban poor communities is described in an article by Kraus, Goldsamt and Sember (1997). They found that the greatest barriers to HIV infection in urban multiracial settings were often the social barriers, namely, the stereotypes of researchers, the target population, and the sexual differences between these groups. In their experience with community interventions, they found that successful interventions required sustained social interaction, dialogue and adapting to the needs of the community instead of treating AIDS prevention as an isolated issue.

While HIV prevention was the researchers’ encompassing theme/goal, it was crucial to incorporate HIV prevention into other community needs, including drug treatment, food, housing, employment and other needs. This approach demonstrated its value to the community that the researchers were indeed aware of the community’s needs and took measures to adapt appropriate strategies. Furthermore, interventions stationed at or including these areas had more success because they reached more people and gained more attention.

Researchers also found a thirst for information in urban poor communities about HIV and prevention. Community members provided crucial information to the researchers on how to implement more effective strategies - an example of the deepening relationship between researchers and local communities.

Los Angeles’ County is a member of the CDC-CityMacH HIV Urban Learning Cluster. Their Social Marketing Campaign seeks to reach the “hardest to reach women,” including women of color, incarcerated and recently released women from prison and women and women experiencing a variety of social problems (violence, drug use and lack of health insurance). The social marketing campaign is an awareness strategy that encourages pregnant women who may not be in prenatal care to seek and maintain antenatal counseling and treatment.

An important component of this strategy is the Promotores Training and Community Outreach program that trains existing promotora in their own communities. Relying heavily on established networks, these promotora are well-connected to other promotora and high risk/pregnant women, this model seeks to improve the health of community members by actively supporting and engaging them in prevention efforts. The campaign works to ensure that hard-to-reach, at-risk, and HIV positive pregnant women have a credible peer to a continuum of care they might otherwise access or utilize.

For more information, contact the CityMacH Central Office.

CityResources

Preventing Perinatal HIV Transmission


Sember (1997). They found that the issues of a biostatistic incident may be; how much an organizational problem as it is a community needs/capacity assessments; and public/private provider education strategies.

Lawrence Sands: Becoming knowledgeable of and active with local emergency/biostatistic preparation processes can lead to new many opportunities to partner with an altogether different segment of your community and gain access to other community assets. Find out who is leading preparedness efforts within your agency and your particular governmental unit (city, county, etc.), especially individuals responsible for organizing and directing CDC’s Public Health Preparedness funds. Find out how funds are being invested at the local level. Planning and decision-making processes are being carried out, and how and when you and your program can provide input. By participating in planning and advisory groups, you will have opportunities to assure MCH needs are incorporated into response plans and also to learn of systems, strategies and assets being developed that could benefit the community.

Researcher: What are the unique issues for women, children and adolescents in your community that need to be raised and addressed in current and future reports and their role. Leaders should have contact numbers for each staff member. Every role or person should have backup.

Leaders should be educated to answer staff questions concerning their safety and security as the top priority in the agency. Plans should be practiced and drilled to the point of comfort.

The events of 9/11 propelled what was viewed by many of us as merely theoretically possible to the new reality of the day. We must view our unique role in a new way. We must build or restore basic public health infrastructure to defend against biostatistic, as well as traditional public health issues, including infectious disease outbreaks. BT really is a “population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

The American Red Cross is critical for shelter messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.

Moatti and Souteyrand. (2000) “Recalcitrant tools as population-based approach.” Just as BT agents respect no geographic borders, they do not respect age or gender.

What are essential relationships and partnerships that can be forged in the context of BT Preparedness that would be beneficial and strengthen public health infrastructure for MCH?

Len Foster: Of particular benefit to local health departments and their research partners is the ability to establish new relationships with the medical community. Local health departments have the opportunity to establish new relationships to local practitioners and others, with significant benefits in other areas, including MCH.

Stephanie C. Bailey: MCH partnering with internal providers of clinical services and health promotion for health messages, combining their expertise and assets.
When life folds back on itself again over time, like kneading bread across the rise, we must take notice. For in the repetition, the return of conditions, there is a chance of earlier mistakes, and to learn from the masters who overcame what looms insurmountable. Now is one of those times, for the worry of one of Nebraska’s greatest women are again upon us. We need her wisdom and her words.

As was a century ago, all of our children need championing. They need to be able to blow out the first candle atop the cake. They need to awaken unafraid of the dark, or of the stranger atop the cake. They need to awaken the children who overcame what looms insurmountable. Is there a chance to leapfrog over earlier light-years?

Grace Abbott, who left for Washington in 1912 to work for the first Chief of the new Children’s Bureau, emerged in 1921 as Julia Lathrop’s successor; who was among the first to use radio to broadcast public health messages about safeguarding their babies; who was the first woman ever nominated to Cabinet for Secretary of Labor, but refused to compromise her pledge to the women and children she served.

She was, in her sister’s words, “a pioneer in the new social frontiers of the 20th century.” What would we say as we begin the 21st with signs of misfortune and threats to security, women and children stand together: New immigrants we still left behind? New immigrants we threaten as�� destruction. They are those in charge.

So I ask you to bravely consider a question amidst an often angry, uncertain nation on the brink of war, enveloped in an epidemic of fear. Four short words to ponder, to weigh: What would Grace say?

Grace Abbott: shaped by the legacy of her family of abolitionists and activists in the underground railroad, and by the convictions of her mother, a staunch suffragist who worked to assure Nebraska’s women’s right to vote as far back as 1882, in whose home Susan B. Anthony once came for tea.

Grace Abbott: influenced by her outspoken father, a Civil War soldier in Lincoln’s army, who relished the law, and who spurred with his Grace on matters of principal, assuring she learned to hold her own ground.

Grace Abbott, who left for Washington in 1912 to work for the first Chief of the new Children’s Bureau, would argue vehemently against the dismantlement and absorption of public health into other federal agencies. She was named for a message about the child who along with her whole family, died from diphtheria, would advocate effectively for sufficient children’s immunizations first and forever.

Grace Abbott would not take kindly to our whining and mourning perceived public health losses. She would see and seize opportunities to advocate and strengthen children’s protections with Biedefence and homeland security. She would encourage us in every community to blend advocacy and science to persuade those in charge.

So, what did Grace say?

“If I have said it again and again that the only time we can save the babies who are going to die this year is this year. If we wait until next year they will be dead."

Perhaps a better question we might ask is: What would Grace do?

And what, pray tell, must we do?

Postscript: Most of us have responsibilities in our work, leading several lives at once. Of my too many jobs is a President of a new national hospital organization, the Nebraska Children and Families Foundation. It was in that capacity that I boarded a single engine aircraft from Grand Island to speak at the rededication of a city park. Fifty years ago Grace Abbott Park had been named for a woman of whose deeds seem exquisitely relevant once again. This year, Region I, V, IX and two At-Large seats were up for reelection.

In Region I, Barbara Ferrer, PhD, MPH, Deputy Director for the Boston (MA) Children’s Hospital, will serve a term from 2002-2005.

In Region V, Carolyn Slack, MS, RN, Director, Family Health Center, Columbus Department of Health, will serve a term from 2002-2005.

In Region IX, Cheri Pies, MSW, DrPH, Director, Family, Maternal & Child Health Programs, Contra Costa County (CA) Health Services Department, will serve a term from 2002-2005.

The two At-Large seats were won by Vicki Alexander, MD, MCAH Director for the Berkeley (CA) Public Health Department, who will serve a term from 2002-2005; and Marilyn Seabrooks, MPH, MCAH Director, Washington, DC Department of Health, who will serve out the remainder of Larry Sand’s term from 2002-2005.

What would Grace say?

"If I have said it again and again that the only time we can save the babies who are going to die this year is this year. If we wait until next year they will be dead."

Perhaps a better question we might ask is: What would Grace do?

And what, pray tell, must we do?

Postscript: Most of us have responsibilities in our work, leading several lives at once. Of my too many jobs is a President of a new national hospital organization, the Nebraska Children and Families Foundation. It was in that capacity that I boarded a single engine aircraft from Grand Island to speak at the rededication of a city park. Fifty years ago Grace Abbott Park had been named for a woman of whose deeds seem exquisitely relevant once again. This year, Region I, V, IX and two At-Large seats were up for reelection.

In Region I, Barbara Ferrer, PhD, MPH, Deputy Director for the Boston (MA) Children’s Hospital, will serve a term from 2002-2005.

In Region V, Carolyn Slack, MS, RN, Director, Family Health Center, Columbus Department of Health, will serve a term from 2002-2005.

In Region IX, Cheri Pies, MSW, DrPH, Director, Family, Maternal & Child Health Programs, Contra Costa County (CA) Health Services Department, will serve a term from 2002-2005.

The two At-Large seats were won by Vicki Alexander, MD, MCAH Director for the Berkeley (CA) Public Health Department, who will serve a term from 2002-2005; and Marilyn Seabrooks, MPH, MCAH Director, Washington, DC Department of Health, who will serve out the remainder of Larry Sand’s term from 2002-2005.

This year, 90 ballots were returned for an overall response rate of 48.6%.

CityMatCH anticipates a Board for their exemplary service, and salutes these outgoing Board Members for their years of dedication:

CityMatCH: Agatha Lowe, RN, PhD, Peter Morris, MD, MPH, Larry Sands, DO, MPH, Betty Thompson, RN, MSN. Their hard work has been outstanding.

For more information on how one is nominated to serve on the board and what qualifications are necessary, contact the CityMatCH offices at 402-561-7200.
Leader’s Tools and Tips: 
Leveraging, Obtaining and Sustaining Dollars for MCH

(Continued from page seven)

meets their state’s needs. Federal rules say that local health agencies should be involved in the development of the state needs assessment and application, so local agencies can have some influence on the spending plan. Some states allocate the Block Grant to their local public health agencies in a similar way, asking for an application that reflects the needs of the local area. In addition, cities may have capacities that state health agencies lack and may be able to do work for the state as a contractor. That can be a win-win collaboration if it allows expertise to be maintained in the system as a whole.

Temporary Assistance for Needy Families (TANF) Contracts

Each state has to meet goals in their economic assistance program to reduce the number of people on welfare and increase the numbers who are working. States have a great deal of flexibility in how they are doing this, so how public health can work with them varies significantly. The vulnerable populations they serve are a focus of public health assurance activities as well, and there are many ways creative partnerships between welfare and public health can benefit these families. The Olas home-visiting model has shown significant reductions in months spent on welfare. Assessments of children for special needs that require parental care or parenting classes that help prepare families for working outside the home can be strategies for partnerships. Working with childcare providers both to increase the supply and so they can better care for special needs children are also areas of mutual interest. There are cultural and system barriers that make these partnerships between welfare and public health difficult, but much is to be gained for the families and for the agencies themselves.

Do you have a practice strategy that has worked for you? Your colleagues would like to hear it! Contact Maureen Fitzgerald at CityMatCH and she will help you get your story into CityLights.

CityMatCH at the
University of Nebraska Medical Center
982170 Nebraska Medical Center
Omaha, Nebraska 68198-2170
Phone: (402) 561-7500
Fax: (402) 561-7525
http://www.citymatch.org

CityMatCH Staff:
Magda G. Peck, ScD, CEO/Executive Director
mpeck@unmc.edu
Michelle Cee, Staff Secretary
mccee@unmc.edu
Dana Fisaga, Staff Secretary
dfisaga@unmc.edu
Maureen Fitzgerald, MPA, Coordinator
mfitger@unmc.edu
Vera Haynatzka, PhD, Health Data Analyst
vhaynatz@unmc.edu
Jeanette Leeper, Staff Secretary
jleep@unmc.edu
Kelly McNichol, Project Assistant
kmcnichol@unmc.edu
Matthew Newland, PhD, Project Assistant
mnewland@unmc.edu
Janet Rogers, Office Manager
jrogers@unmc.edu
Jeff Rabey, MA, Project Coordinator
jrabe@unmc.edu
Jennifer Skala, MEd, Managing Coordinator for Education and Training
jskala@unmc.edu
Patricia Simpson, MPH, Director of Operations
psimpson@unmc.edu

Volume 11, No. 1 Summer 2002
Published by CityMatCH
Summer 2002

Inside This Issue...
CityView......................2
CityPractice....................3
CityIssues........................5
Perinatal Transmission of HIV/AIDS
Leveraging, Obtaining, Sustaining Funding for MCH

From Loss to Resilience

It has been a roller coaster decade of drama and change for public health, and many who champion mothers and children are acutely feeling changes that are real and significant: direct services suspended, Medicaid reimbursement and core funding diminished, social justice commitments to the vulnerable seemingly set aside. In the last year, and post 9/11, losing ground has become more urgent for some who fear the core mission of public health is being absorbed by biodefense. Others are reeling with more pragmatic daily constraints: restricted travel, layoffs, rounds of budget cuts, shifted resources, and competing priorities between health, safety, and security.

If we are resourceful and resilient, we who bear responsibility for the health and well-being of women and children in America’s cities, where there is the greatest magnitude of change, can seize opportunities to strengthen our public health work even in times of doubt. The key is to cultivate partnerships and leverage resources outside the often narrow boundaries we have come to define as "MCH."

This Summer CityLights edition features two prominent urban public health concerns in which MCH has not always been a main player: Bioterrorism preparedness and HIV. Yet both have special impact on and unique implications for women and children. We also offer tips and tools from the field for those who are crying about where the money is. We offer this CityLights late summer harvest of ideas to invoke and inform.

E-Roundtable of MCH Leaders
BioDefense 2002:
Seizing Opportunities for MCH

In August 2002, CityMatCH hosted an E-Roundtable of selected leaders in urban public health who share common roots in MCH. Selected highlights from their responses provide personal and professional insight on the impact of increased attention and resources toward local Bioterrorism Preparedness (BT), amid the current economic downturn and funding cuts in general local public health budgets on MCH.

(Continued on page three)

Promoting communication and collaboration to improve the health of urban women, children and families

(Continued on page five)