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

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Staying the Course

Our intense international Spring interlude in Iraq spilled over into Summer and threatens foreseeable seasons. Amidst continued casualties and unmistakable doubt, the nation has resumed social policy battles right here at home. Unpleasant solutions to serious state budget woes have left the social fabric of public services in tatters. Cuts made to the daily public “gifts” most take for granted – schools, libraries, the arts and parks – undermine access and diminish basic resources. Staff are laid off, hours are slashed, programs eliminated, doors closed. Those of us whose lives have been dedicated to the public’s health are navigating strange currents in which basic preventive health services for women and children are sinking while activities in the name of security stay fiscally afloat.

We usually frame the Summer CityLights edition with the assumption that we will soon be reunited with many of our members at our annual leadership conference. But the rules have changed for our constituents and for us. Gone are the days of federally subsidized participation; out-of-state travel and continuing education increasingly are unauthorized luxuries. Accordingly, in addition to a continued focus on women’s health and other usual fare, this issue of CityLights offers a taste of Confluence 2003 for those who will only be in Pittsburgh in spirit.

CityMatCH will continue to build capacity and to raise the bar of expectation for local MCH practice and policy. We will stay the course of effectiveness and innovation. There is no more important time for real learning and savvy doing than when things stay askew. May we continue to see and seize opportunities, together.


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Either you read Potter or you don’t. Odds are that some you have been curled up of late around a thick Hogwarts adventure.

According to Potter lore, fresh enrollees at wizardry school are placed in one of four houses by a magical witch’s hat which, once worn, reveals the true nature of every individual. Perched atop each new pupil’s head, it shouts out assignments according to his or her hardwired approach to facing danger and managing risk. Houses are declared ceremoniously after a rapid reading by the Sorting Hat. Bold bravery? Gryffindor! Shrewd cunning? Slytherin! Rational intelligence? Ravenclaw! Accommodating niceness? Hufflepuff!

I never wanted a dog; a decade of David’s persistence finally wore me down. “Scotch,” a two-year old abandoned cocker spaniel from the Humane Society, amplified our family some 18 months ago on Dave’s 11th birthday. Dog food, poop stains, obedience lessons, and an invisible fence augmented our daily lives. We adjusted as new routines were established, responsibilities parcelled out, and attachments grew.

Last month when I drove up to the house after work, something was wrong. Turns out that the dog had been missing for over an hour. Sam had let him out, but not back in, before going to work; both invisible fence and dog tag collars were not on the dog when he wandered away.

I found David first at the bottom of the front steps with outstretched arms weeping. His hoarse voice intermittently cried, “Scotch?” as if to bring him back by sheer will. He told me that his father already was in his car combing the neighborhood. Unsuccessful after an hour of looking, he angrily mowed the lawn, fuming at the boys and himself for not insisting the collars be worn.

After his dad stopped by the restaurant to ask Sam what he knew about the dog’s disappearance, Sam assumed that it was all his fault. Seized by angst, he abandoned the dirty dishes and walked home to comb the neighborhood on foot in search of his best friend. Meanwhile, David leapt into action once given clear instructions as to what to do: print a picture of Scotch we can use to report him missing; post flyers around the neighborhood where you think he might go. Defeated and soaked an hour later, Sam collapsing on the couch in self-incriminating rage. “It’s all my fault! What if he’s hurt, Mom? What if someone finds him and keeps him?” I sent him to the shower where sobbing can be muffled and tears washed away. Their dad had moved to the basement to attack the laundry.

Amid my guys’ drama, I problemsolved. After calling the Humane Society to find out what to do, I went there with a picture to report him missing. I called a series of neighbors who live at key intersections where Scotch might be more easily sighted or who are real dog lovers who would help us in the search. I designed compelling flyers for David to post, complete with a pleading photo of this cute but mournful cocker: “I’m lost! Can you help me get back home?”

I was doing dinner dishes when the call came from just five blocks away. “I think we found your dog! My son was playing up at Dundee School just now when he saw the flyer with his cute picture. I’m sorry but I already had your dog picked up about 30 minutes ago.” A call confirmed that indeed Scotch was being held at the Humane Society and we could pick him up in the morning. David shouted victory, and after a round of hugs, he moved on to something else. Sam called work to tell them he’d be back on time tomorrow; emotionally spent, he disappeared behind the TV curtain. Their Dad folded the laundry after extracting promises from the boys of better vigilance.

In a brief Summer evening interlude, each of our “houses” had been revealed. Our hardwired responses played out as they have and will as life gets in the way. We are so blessed. It has been an otherwise relatively calm year in Omaha, but harder stuff is just ahead. Our folks are in semisweet penultimate chapters. Adolescent drama is entering Act II. So many friends and colleagues are saying ‘bye’ to their parents or wrestling with their kids or doing battle with their own maladies. At work, the public health climate is persistently ominous against a backdrop of economic and political woes.

The Sorting Hat’s song in Potter V reminds us that the only way to defeat our foes is for our houses to stand united. It isn’t just about what any one of us does alone in the face of risk and adversity; it is what we can and must do together. As family and colleagues, and as wizards of public health, may we continue to discover the magical strength that comes from depending upon each other in the dark years ahead. And may what seems to be lost come home real soon.
Troubleshooting Your Own Thinking

Conversation is the way we humans think together. Real change begins with the simple act of people talking about what they care about. Talk is not cheap; it is the way we learn and plan and coordinate our actions.

Throughout time, people have gathered in circles, councils, support groups, around the campfire and the kitchen table to give voice to what matters, to consider how things might be better, to explore what first steps they might take. MADD, Women in Black, and CityMatCH began with one person reaching out, past denial, past isolation, past resignation to wonder out loud, to share a deeply held concern, to ask for help.

Every significant change initiative consists of a series of conversations. When we make the space to speak, to be heard, and to listen to others, we are able to:

- Make sense of our everyday experiences;
- Heal divisions and forge connections;
- Rediscover our human capacity for resourcefulness and resilience.

I have worked as an organizational strategist, a leadership coach, and a master facilitator in scores of organizations. I have come to believe that our ability to work on behalf of the changes we want to see in the world depends on the quality of our relationships, the quality of our conversations, and the stories we tell ourselves.

Leaders—of teams, initiatives, departments— have the ability to bring people together to do real work. Our choices from beginning to end help determine the impact our efforts will have:

- How do we frame powerful questions, ones that will identify emerging possibilities and build on what is working?
- How do we move beyond the usual suspects to engage diverse constituents and assure all voices will be heard?
- How do we set the space, arrange the seating, provide ground rules, encourage and model deep listening and genuine curiosity?

Making Ethical Decisions in Difficult Times

The Federal budget deficit is climbing. State surpluses have become deep deficits. Local governments are pressed to protect property taxes. The electorate both wants and fears change. Elections turn on small shifts in voter preference, if not hanging chads. Unemployment creeps upward. Retirees are squeezed as portfolios stagnate. Grants—particularly grants to sustain services—are scarce. Demand for services rises as the availability of resources falls.

It's that time again.

Time for what, though? Budget and service cuts, or entrenchment? Weeping and gnashing of teeth? Calls for bold leadership, or opportunities for advocacy?

An old friend and colleague called, inviting me to participate in a teleconference on ethical decisionmaking in tough times. Would I frame some questions, write a scenario, and facilitate an ethical discussion pitting the dilemma of growing needs against shrinking resources.

Been there, done that, got a drawer full of T-shirts. Cut to the chase. Wring your hands, sing for your supper, and go away hungry?

Not this year, not in Wake County and not in North Carolina.

Wake County’s elections brought a new avowedly conservative majority to the County Commission. State elections split the lower house of the General Assembly. Positions were taken, deep budget and service cuts proposed, and threatening headlines published.

When the votes were tallied, though, something extraordinary happened. Property taxes were raised. Income and sales tax increases were retained. Concern and compassion lead to historic leadership and compromise.

Why this time?

A few things seem clear: concern and compassion must be elicited and nurtured; leaders do learn not to repeat the past; and compromise is an art based in relationship and communication.

In Wake County, change was led by the County Manager even before the electoral shift. Why can't we, he asked, project our needs and plan our programs like we plan for our capital improvements? Why don't we, he asked, show how programs lead to improvements in outcomes and indicators? We described our clients and their (Continued on page nine)
Urban women’s health is a high priority issue for CityMatch members. Last Spring, (see CityLights Winter/Spring 2003) a lively discussion occurred at the Urban PIC Advisory Committee about improving urban women’s health. The conversation continues in this issue. Three members of the CityMatch Urban Women’s Health Subcommittee spoke with Helene Kent.* Excerpts follow:

What does the term women’s health mean to you?

CP (Cheri Pies) Women’s health is an umbrella term that includes physical, emotional, socioeconomic, political, cultural, and spiritual well-being. Above all, I believe that the broad range of issues that affect women’s lives influences women’s health.

ZH (Zenobia Harris) Women’s health is an integral part of maternal and child health. I see it as a symbiotic relationship. Women’s health incorporates a set of systems, services, and practices that lead to optimal physical and mental health of women. The MCH agenda is broader as it seeks optimal health for women, children, and families.

VA (Vicki Alexander) Women’s health to me has predominantly been about reproductive rights and health though my view now is shifting to a broader focus. If we define women’s health as only reproductive-based, it can leave out women who do not have children. We also miss opportunities to support health promotion.

Why is a focus on women’s health important within maternal and child health?

ZH Looking at women’s health allows public health professionals to build better systems of care to meet women’s needs. Women are the backbone of healthy families and their voices are often not heard. If we can strengthen their voices by giving them the tools and information they need to make good health decisions, we will not only improve their health, but their families’ health, too.

CP Traditionally, MCH has focused on the perinatal and postpartum periods. Women have many health experiences beyond pregnancy. Our role has been to work with women, to support and educate them so they will have a healthy child. Now we focus more of our efforts on keeping women healthy, not only to have a healthy child and to build healthy families, but for their own mental, physical, emotional, social, and spiritual health.

VA It is possible to integrate women’s health content beyond reproduction into MCH. We can help a woman understand that if she is not healthy, it is unlikely her family will be healthy. Integration of women’s health into a broader context helps us understand how strongly a woman’s health habits influence her family.

How does your practice reflect a women’s health focus?

CP Our MCH program does not have a specific women's health focus. However, our county health department has a strong community engagement approach. We ensure that community wants and needs are articulated, heard, and addressed by providing resources, skills and opportunities for engagement to promote better health for all. We are currently developing a Women’s Health Partnership, and have just launched Women’s Health Clinics in several county sites.

VA Our Health Department’s strength lies in public health activities and educational services. We still do not address women’s health as well as we could. Neither the agency, nor the MCH section, has a particular focus on women’s health. We are still in a “silo” pattern of providing services based upon funding sources and grant direction.

ZH Our agency is evolving towards having a greater focus on women’s health. We are creating women-friendly service delivery patterns and environments that make women feel welcome. We strive to be culturally and socially competent in how we provide care to women.

Our agency looks for ways to move from providing services according to categories to creating broader service delivery systems. For example, recently the family planning and STD services were combined. This integration has strengthened the services and health education opportunities for women and helped reduce fragmentation of care.

What are the most important issues affecting urban women’s health today?

VA I am concerned that we will see long term health consequences due to current socio-political changes. Urban women are more affected by issues of poverty and pollution, because women and these issues are more concentrated in urban areas. Health disparities are not being addressed and discrimination still exists. Reproductive rights are being lost. Environmental issues such as air quality and waste remain problems. The poor economy, compounded by funding cuts to local services, is affecting poor women and their families disproportionately.

CP Community and domestic violence are increasing, with violence often directed toward women and children. Budget cuts have reduced the ability of local police to respond to some domestic violence calls. Substance abuse, access to health care, and poor
access to affordable housing are also pressing concerns. We are seeing more food insecurity and lack of access to healthy and affordable food. The economy has a profound effect on the quality of women’s lives.

What suggestions do you have for improving women’s health?

VA It is important to focus on clinical services and community education. Women tend to focus on their families and not specifically on themselves. I find a family health-based approach that takes age into account to be effective.

ZH As public health providers, one of our roles is to educate the community about the health needs of women and to advocate for needed services. We need to increase our cultural sensitivity to women’s health and to find ways to provide comprehensive one-stop services. Decreasing fragmentation of care is also important. We also need policy development and service delivery approaches that take into account the cultural differences of people. Also, it is important to find out what women need and incorporate it into our services.

CP Our focus on women in the MCH arena has been driven by the federal guidelines of what maternal and child health should include. We need a broader definition of MCH to more comprehensively address women’s needs. I would like to see stronger emphasis on mental health assistance for urban women and mothers, programs that emphasize social and economic development, and clinic-based community-driven services. We need a coordinated, fully integrated approach to address health disparities. We also need to learn how to respond appropriately and train staff in linguistic and cultural competence.

Is there a role for data in improving the health of women?

VA Yes, we are still learning about the many things that affect a woman’s life and her health over time. We need more trend data and information about women’s health to enable us to draw conclusions. We need to ask the right questions: How has the community’s social and environment changes affected women’s health? What are the trends that should be investigated because of these changes?

Women’s Health USA 2002 is a new statistical report on the health status of America’s women that shows the disproportionate impact that certain health conditions such as osteoporosis, asthma, diabetes and lupus have on women.

Compiled by the Health Resources and Services Administration (HRSA), this report highlights current and historical data on some of the most pressing health challenges facing women and their families. Data are provided on health and health-related indicators in three categories: population characteristics, health status and health services utilization. The report includes the most recent federal data available from the Department of Health and Human Services (DHHS) and the Departments of Justice and Agriculture.

DHHS and its agencies are working to promote better health among women nationally. President Bush’s fiscal year 2003 budget plan would increase funding for HHS’ Office on Women’s Health by $2.1 million to $29.1 million to coordinate women’s health activities, programs and outreach throughout the federal government and through public-private partnerships. Under the plan, HHS’ National Institutes of Health would spend an estimated $4 billion on women’s health research.

The publication is available on-line at http://mchb.hrsa.gov/data/women.htm. Free hard copies are also available from the HRSA Information Center (Phone: 1-888-ASK-HRSA or visit the Center’s website at http://www.ask.hrsa.gov). Women’s Health USA 2002 is not copyrighted.

Women’s Health USA 2002.

Editor’s note: The preceding information was taken from a May 31, 2002 news release written and released by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

Selected Highlights:

- Women’s life expectancy reached a new record in 2000 — 79.5 years. While black females had the greatest life-expectancy gain (12.3 years) between 1950 and 2000, there was still a five-year difference in life expectancy between white (80 years) and black (75 years) females.
- More U.S. women than ever before are getting prenatal care in their first trimester of pregnancy. In 2000, 83 percent received early prenatal care, up from 75 percent in 1989.
- Nearly 87 percent of women had health insurance coverage in 2000. About a quarter of women between 18 and 24 were without insurance in 2000.
- In 2000, 10,459 AIDS cases were diagnosed in females 13 and older; 38 percent were exposed through heterosexual contact. Almost half of U.S. women under 45 have been tested for HIV.
Eliminating Perinatal HIV - A Women’s Health Issue

With the wealth of research, surveillance and prevention transmission of HIV from mother to child, a common danger has emerged – a tendency to lose sight of the woman. The outcome? Well, grantees wished for everything from HIV counseling and testing as a standard of prenatal care to the creation of a highly empowered taskforce of CDC, HRSA, CMS, clients and faith-based organizations to develop comprehensive surveillance and policy disciplines to form one regional wish list for implementation.

The cross fertilization by different areas of expertise was excellent.

Over the course of the last four years, the Centers for Disease Control and Prevention (CDC) has funded prevention, surveillance and policy grantees in an effort to reduce and eliminate the transmission of HIV from mother to baby. Each year these grantees have come together for an annual meeting. This year was no exception; however, the stakes at this year’s meeting were raised considerably.

After four years of funding, the CDC was curious, “What has been the return on this investment?” “What degree of collaboration exists among our prevention, surveillance and policy grantees?” Having attended InterCHANGE 2002 and seen firsthand how our network of MCH leaders share promising practices and forge partnerships together, project officers from the CDC decided to approach CityMatCH about assisting in the planning and delivery of this year’s grantees meeting – we were pleased to help.

The overall structure of the two-day meeting combined traditional scientific plenary sessions with participant exercises and Oprah-esque panel discussions. Participants were engaged in learning and doing around the foremost issues of perinatal HIV prevention, including HIV testing policies, strategies for reaching the hardest to reach women, how best to integrate complex and divergent systems and what exactly rapid intervention at delivery looks like.

In large measure, the conference was designed to reach its climax on the afternoon of the second day. It was here that participants were grouped into regional teams and provided meeting space to work through an exercise on systems integration. The exercise was grounded on the understanding that in order to further reduce the transmission of HIV from mother to baby, we must transcend medical science advances alone to consider the very way we go about the business of prevention. The exercise looked at the question, “What’s in the way?” It was hoped that, together, regional groupings of grantees would realize that we can do more together than any one of us can do alone.

To begin the regional exercise, grantees were asked to “put their cards on the table” by responding on a five-point Likert scale – strongly agree to strongly disagree – to the statement, “Mother to baby transmission of HIV/AIDS can be eliminated in this country by the end of the decade.” Following this revealing exercise, which demonstrated an overwhelmingly optimistic grantee population, regional teams self-divided into three working groups according to individual area of expertise – prevention, surveillance or policy. In these breakout groups, devised a list of barriers, comprised of all the stuff in the way of further prevention successes and then used these barriers to develop a “wish list” of three things they wished would happen in their region in the next one to three years. Then came the greatest challenge – merge the three subgroup wishes across prevention, surveillance and policy disciplines to form one regional wish list for implementation.

The outcome? Well, grantees wished for everything from HIV counseling and testing as a standard of prenatal care to the creation of a highly empowered taskforce of CDC, HRSA, CMS, clients and faith-based organizations to develop comprehensive policy to address and eliminate mother to child transmission. Bottom line: we asked them to shoot for the moon and they did.

Of course the ultimate outcomes are still pending. So, we ask you to stay tuned; the work is just beginning. In fact, CityMatCH has now been formally asked by the CDC to keep this collaborative momentum going through the facilitation of quarterly regional conference calls. As we explore this possible partnership with the CDC, we can clearly see the opportunity to convene and intermingle these groups to provide the continued energy that will aid in the process of turning regional wishes into national realities.
New CDC HIV Testing Policy – "Opt-Out" – Receives Support, Criticism

Successful prevention of perinatal HIV transmission depends, in large part, upon knowing the HIV status of soon-to-be mothers. Therefore, testing rates must be increased for prevention efforts to improve.

There are, essentially, three strategies for increasing HIV testing among pregnant women:

- **Opt-in Testing** – Women are provided counseling on the subject of HIV testing and given the opportunity to consent to an HIV test.
- **Opt-out Testing** – Women are notified that an HIV test will be included in a standard battery of prenatal tests and are given the choice to refuse this test.
- **Mandatory Newborn Testing** – Infants born to mothers whose HIV status is unknown are tested with or without the consent of the mother.

As you can imagine, there are zealous supporters and fervent opponents for all three of these approaches. Most recently, the CDC has come out in support of opt-out and mandatory newborn testing approaches, issuing the following recommendations;

…”The available data indicate that both “opt-out” prenatal maternal screening and mandatory newborn screening achieve higher maternal screening rates than “opt-in” prenatal screening. Accordingly, CDC recommends that clinicians routinely screen all pregnant women for HIV infection, using an “opt-out” approach, and that jurisdictions with statutory barriers to such routine prenatal screening consider revising them.

In addition, CDC encourages clinicians to test for HIV any newborn whose mother’s HIV status is unknown. Jurisdictions should consider whether a mandatory screening policy for these infants is the best way to achieve such routine screening…”

These recommendations have come with their fair share of controversy, to say the least. But without question, the greatest debate has emerged between the supports and critics of opt-out. Supporters claim that the new policy recommendations will increase testing rates, providing women with the critical information they need to make informed decisions that significantly impact their personal health and the health of their families. They see the new recommendations as consistent with historical recommendations affirming a voluntary testing approach that, they say, has never changed and never will.

Opponents agree that a policy shift to opt-out testing is one step closer to elimination. But the elimination is that of a woman’s right to make her own health decisions. They believe that the biggest threat of opt-out testing is that there really will be no “opt” about it; HIV testing will become standard practice and pretest HIV counseling, which provides women with the information they need, will begin to evaporate as a superfluous and time-consuming practice. They fear that women will receive a life-changing HIV diagnosis as, “oh, by the way, we performed an HIV test and, well…”

At the end of the day, responsible health practice and civil liberties affirm two truths:

1. Women should be counseled about the benefits of receiving a confidential HIV test prior to delivery.
2. Women have the right to make an informed decision as to whether to have an HIV test performed.

In principle, few would disagree with these two truths, and yet we find ourselves at odds over testing recommendations. And, without broad national consensus, it’s unlikely that any recommendations will be as effective in increasing testing rates. How will we reach consensus?

In coming months, CityMatCH is poised to serve as a national convener and facilitator for further discussions among proponents and opponents across the nation. The outcome of these conversations is far from certain, but the process promises to be a compelling and valuable one. Stay tuned.

**Did You Know...** As is true with adult AIDS, pediatric AIDS cases are overwhelmingly concentrated in urban areas: 85% (n = 7,700) of all U.S. cases were diagnosed in metropolitan areas with populations greater than 500,000. 9,074 pediatric cases were reported through December 2001. In 2001, 72% of pediatric cases were perinataley acquired (CDC, 2003).
The March of Dimes (MOD) has launched a five-year, $75 million research, awareness, and education campaign to help families have healthier babies. This campaign is targeted at raising awareness about the common and costly problem of premature births and its serious consequences.

CityMatCH is an Alliance Member in the Prematurity Campaign. Alliance members are organizations that have committed to work with the MOD in communicating the educational messages and assist in working toward accomplishing the goals and aims of the Campaign. In particular, the Perinatal Periods of Risk (PPOR) Approach (see page 10) can be very useful in demonstrating who is at risk for preterm birth.

Prematurity is the chief problem in obstetrics today, accounting for 70% of deaths in the perinatal period. Preterm birth is also a leading challenge in pediatrics — it is a major determinant of neonatal, infant, and lifetime mortality and morbidity, including mental retardation, cerebral palsy, vision and hearing problems, and chronic lung disease. Half of all neurological disabilities in children are related to prematurity.

### Urban Women’s Health: Dynamic & Changing

*(Continued from page seven)*

Community entities. We are creating more integrated and comprehensive care systems to better serve the community.

**CP** Our agency is a strong advocate for community-directed services. We are planning a community needs assessment to identify women’s health issues, and will hold several community forums where women can help us understand what issues they would like the county health department, including the MCH program, to focus on and address.

**Any final thoughts you would like to share on this subject?**

**ZH** There are many things we can’t control in public health, such as funding, but there are things that we can control. We can make a difference by helping women know what health practices are important. We can provide education to women about preventive health practices, so they can chose positive health practices. Women’s health is dynamic. Our challenge is to be flexible and meet changing needs. We can’t become complacent; we must be dynamic so that we won’t become irrelevant.

**VA** We shouldn’t look at health disease by disease, but must focus on leading edge health and socioeconomic issues. Yes, we must address key health issues, but we must also tackle the root causes of disease and poor health if we are to make a sustained difference. By root causes, I mean disparities in education, employment, and other things that shape a person’s ability to change.

**CP** We need to approach women’s health from a holistic perspective, to recognize the strengths of MCH programs to respond to women’s needs and health concerns. Using the lessons we have learned and the information we have gather from the women, we must design, implement, and evaluate programs and services that will enable us to eliminate health disparities, improve the social and economic conditions for omen, and improve the health of women in the years that stretch ahead.

We hope that this conversation will spark discussions about women’s health in your community. We invite you to take a short break from your busy schedule, grab a cup of coffee, find a colleague, and have your own conversation about the importance of women’s health to your agency and community.

*Helene Kent has worked in MCH for nearly 20 years. She was the Women’s Health Director for the Colorado Department of Public Health and Environment. More recently, she was the Director of Assessment and Assurance, for the Association of Maternal and Child Health Programs, Washington, DC. Kent is currently a Public Health Consultant in Denver (CO) where she works on a variety of projects focused on improving the health of women and children and enhancing public health workforce capacity.*

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**Conversation as Engagement Strategy**

(Continued from page three)

At this year's CityMatCH conference, I will lead a workshop on "Leader as Convener/Conversation as Engagement Strategy" on Tuesday morning, August 26. We will explore practical theories and useful tools to help MCH professionals convene and host conversations that engage people's best thinking and lead to learning and action! Most of us were trained to argue our point of view, to speak with certainty and confidence, and to disagree with those who think differently. But the world we live in is full of complexity and paradox, and our most significant challenges require new ways of thinking and working together.

The most powerful learning comes from our willingness to explore strategic questions for which we have no answers, to surrender our certainty, to admit what we don't know, and to endure the confusion and conflict we will inevitably experience on our way to new understanding.

So, along with practicing facilitation skills, we will also learn to trouble shoot our own thinking. We will examine the beliefs and assumptions we hold and inquire into the different ways others interpret the same "reality." We will learn to listen for what's new, what's different, what surprises us.

For more information, contact: Laura Peck, Claros Group, Albany (CA), Phone: 510-524-3150, lpeck@clarosconsulting.com, http://www.clarosgroup.com

**Making Ethical Decisions in Difficult Times**

(Continued from page two)

needs and our programs and their effects. We created business plans projecting needs and results into the future.

We met our new commissioners—and they met our clients and staff in a walking tour through our lobbies, call centers, clinics, and hallways. We also walked them through our business plans, describing our successes and speaking to our shortcomings.

Our board expanded committees, adding consumers, critics, and citizens. Our clients told their stories far better than we ever could. We admitted our weaknesses to our critics. We convinced our citizens of the quality and efficiency of our services.

We listened. We heard questions, concerns and visions from our manager, our commissioners, our clients, and our citizens. "Help me answer my constituents' concerns. Let me live as independently as I can. Keep us safe and protect our common interests."

We started from different places and different motivations, all of us. We had to move from our own prejudices and preferences to shared goals. We didn't always come to agreement, but we often came to understanding.

We challenged our assumptions and our approaches. The approved budget funded not school nurses but a Partnership for Educational Success—and school nurses were included. The Commissioners funded not MCH but Child Welfare—our most vulnerable children—and social services, mental health, and public health come together to integrate services and improve shared outcomes. We received staff for Community Health, not communicable disease control—and added health educators, special staff, and nurses.

Ethical principles tend to absolutes: Do unto others as you would have them do unto you; Do less harm to more people; Always act as if your concerns are least likely to be considered; The government that governs least, governs best.

Ethical decisionmaking moves beyond the absolute or underlying principle. We marshal the evidence, organize the facts, and acknowledge the rich and diverse faces behind—and in front—of the numbers and data.

Ethical decisionmakers come from all sides of the issues, with differing motivations and perspectives, each testing the data against the principle.

No one perspective owns the franchise on leadership, compassion, or compromise. We can all live with the consequences—or all own the results.

**From Margaret J. Wheatley**

**Turning To One Another, Simple Conversations To Restore Hope To The Future:**

Curiosity is a great help to good conversation. It's easier for us to tell our story, to share our dreams and fears, when we feel others are genuinely curious about us. Curiosity helps us discard our mask and let down our guard...When I'm in conversation, I try to maintain curiosity by reminding myself that everyone here has something to teach me. When they're saying things I disagree with, or have never thought about, or that I consider foolish or wrong, I silently remind myself that they have something to teach me. Somehow this little reminder helps me be more attentive and less judgmental. It helps me stay open to people, rather than shut them out.

In Wake County, our fiscal woes are not over. The picture looks even more bleak for the State. We're not intermittently arguing from budget to budget, but informing from projected and documented need and persuading with met outcomes and indicators, while listening to and becoming more responsive to commissioners, managers, consumers, citizens, and collaborators.

It's that time, always.

For more information, contact: Peter J. Morris, Medical Director/Policy Director, Wake County Human Services, Raleigh, NC, Phone: 919-250-3807, E-mail: pmorris@co.wake.nc.us

Editor's Note: Peter Morris will help kick off the CityMatCH Annual Conference on Sunday, August 24 with his presentation, "Summoning Moral Courage." See page 12 for the Conference 'At-A-Glance.'
On August 25, 2003, CityMatCH will graduate its sixth Data Use Institute cohort during the Annual Conference (see page twelve). All of these teams, 58 total after this year’s graduation, have come together from health departments, foundations and community organizations for the betterment of women and children in their communities. Here’s a sneak peak at what this year’s teams have been doing for the past 12 months:

- **Amarillo, TX:** Limited staff and little funding have not hampered the Amarillo team’s goal of using PPOR to reduce low birthweight in their community. The focus of the past year has been the identification of key community partners. The Amarillo team has been doing for the past 12 months:

  - Investigate and identify areas for community-level interventions to prevent fetal and infant mortality in their community.
  - Mobilize their community to use PPOR to examine fetal and infant mortality. The community engagement meeting was a success.

- **Jackson, MS:** The Jackson DUI team has created a referral system, based on PPOR data, for the Stork’s Nest, a program in Jackson designed to increase the number of women who get early and regular prenatal care.

- **Madison, WI:** Program evaluation is hard to do, but necessary. The team from Madison has been working hard to create a process to evaluate current perinatal case management services so that these resources may better serve the needs of their community.

- **Montgomery County, MD:** With data from FIMR, the team has been utilizing the PPOR approach to answer important questions about fetal and infant mortality in their community.

- **Pittsburgh, PA:** On June 6, 2003, the Pittsburgh team held a summit to mobilize their community to use PPOR to examine fetal and infant mortality. The community engagement meeting was a success.

**PPOR “How to Do” Workshop Planned for 2003 MCH Epidemiology Conference**

On Saturday, December 13, 2003, in conjunction with the CDC-sponsored MCH Epidemiology Conference in Phoenix, AZ, CityMatCH will present a day-long Perinatal Periods of Risk (PPOR) “How to Do” Workshop.

PPOR is a community-based tool increasingly being used in the U.S. to investigate and identify areas for community-level interventions to prevent fetal and infant mortality and promote maternal health.

Groups of individuals who desire hands-on training for using PPOR; maternal and child health practitioners in communities who plan to incorporate the PPOR Approach into their community’s work to promote women’s health, address racial disparities and mobilize partners to focus on infant mortality; Healthy Start sites and practitioners involved in FIMR, Child Health Review and other related initiatives are encouraged to participate. Participants should coordinate with their local health department to assure integrated learning for joint local action. For a list of CityMatCH member health departments, visit the website at “http://www.citymatch.org” and click on members.

Participate and learn how to assess and increase your community and analytic readiness for PPOR. Learn how to shift the focus from having feto-infant mortality data to using the PPOR Approach for greater systems change. CityMatCH welcomes learning teams from states and communities who want to incorporate this approach into their current work to improve the health of women and their families.

More detailed information is available at http://www.citymatch.org/PPOR or contact CityMatCH at 402-561-7500.
CityMatCH / NACCHO Launch MCH Teleconference Series

A fresh series of teleconferences has been launched in July 2003, the result of a partnership between CityMatCH and the National Association of City and County Health Officials (NACCHO). Entitled "Emerging Issues in Maternal and Child Health (E-MCH)," these teleconferences promise to be a catalyst for learning and change. CityMatCH members have expressed strong interest in hearing content information as well as promising practices in areas not necessarily in the traditional 'realm' of maternal and child health.

Planning began in early 2003. The CityMatCH Board was queried for issue areas, and with the generous support of the Health Resources and Services Administration’s Maternal and Child Health Bureau, the calls became a reality in the summer of 2003.

The first call, "Incorporating Mental Health Services in a Public Health Setting," took place on Wednesday, July 17, 2003. Frances Phillips, Health Officer, Anne Arundel County (MD) Department of Health offered a welcome and also introduced the speakers. Michael Faenza, President and CEO, National Mental Health Association, Alexandria (VA) set the stage by providing key background to the subject area. Speakers’ PowerPoint presentations were placed on-line to facilitate a more effective call.

Cynthia Farkas, Supervisor, Community Health Services, Jefferson County (CO) Department of Health and Environment, described how her health department has addressed the mental health needs in a client population currently served by clinics, nurse home visitation, WIC, and community outreach programs. Rebecca Rayman, Executive Director, East-Central District Health Department, Columbus (NE) shared her story of the long-term reconstruction of mental health services in her district, following a system collapse in 1991. Needs assessment led to the formation of a Behavioral Health Consortium comprised of multiple community agencies and the Health Department.

Second Bioterrorism Query Set for Fall

CityMatCH is monitoring how shifting focus on security and emergency preparedness impacts local MCH systems and status in urban communities, and how the needs of children and families will be addressed in case of disaster.

In February, 2003 CityMatCH members received the first Rapid E-Query “BT & MCH – Risk and Opportunity,” about seeing and seizing opportunity and managing risk for women and children in the push for Bioterrorism (BT) and Smallpox preparedness. Later this fall, CityMatCH will send the second query to the membership.

Initial query findings were reviewed in March by the UrbanPIC Advisory Committee, a group comprised of CityMatCH Board Members, federal partners and national peer organizations.

For more information, contact: Maureen Fitzgerald, Coordinator for Policy and Communication, by phone at 402-561-7500, fax 402-561-7525, or e-mail at mfitzger@unmc.edu.

CityMatCH Board Election Results

CityMatCH is happy to welcome several new Board Members as a result of summer elections. Region III, VI, X and one At-Large seat were up for reelection. 82 ballots were returned for an overall response rate of 56%. Thanks to all who expressed their choices by voting. Newly-elected Board Members will assume their responsibilities on August 23, 2003, and serve through 2006.

- **Region III**: Lisa Firth, Assistant Commissioner, MCH Division, Baltimore City (MD) Health Department
- **Region VI**: Ann Salyer-Caldwell, Division Manager, Tarrant County (TX) Health Department
- **Region X**: Kathy Carson, Administrator, Parent Child Health, Public Health - Seattle & King County (WA)
- **At-Large**: Kimberly Wyche-Etheridge, Maternal Child Health Director, Nashville-Davidson (TN) County Health Department

CityMatCH salutes these outgoing Board Members for their dedication:

- **Linda Hook**, Nursing Program Manager, San Antonio (TX) Metropolitan Health District
- **Marilyn Seabrooks**, MCH Officer, Washington (DC) Department of Health, Office of MCH

Three CityMatCH members were also elected to serve on the Nominating Committee. This committee is primarily responsible for developing the slate of potential candidates for the Board of Directors. Elected were:

- **Mary Balluff**, Chief, Health & Nutrition Community Services, Douglas County (NE) Health Department
- **Deborah Hendricks**, Manager, Healthy Families Section, St. Paul-Ramsey County (MN) Department of Public Health
- **Linda Hook**, San Antonio (TX) Metropolitan Health District

Upcoming E-MCH Calls

- **August 21**
  - Youth Obesity
- **September 18**
  - Oral Health
- **October 16**
  - Medicaid Funding
- **November 20**
  - Violence Prevention
- **December 18**
  - Men’s Health

Interest in incorporating mental health services in a public health setting was confirmed by participation on the call and by the intensity of questions following the presentations.

On-line registration is available at http://www.naccho.org/index.cfm Archived presentations will be available soon by visiting the NACCHO www.naccho.org> or CityMatCH <www.citymatch.org> websites. For more information, contact: Maureen Fitzgerald, phone 402-561-7500, fax 402-561-7525, or e-mail at mfitzger@unmc.edu.
CityMatCH Annual Urban MCH Leadership Conference, "Confluence 2003: Where Resilience, Results and Resolve Come Together"

**CityMatCH at the**
University of Nebraska Medical Center
Department of Pediatrics
982170 Nebraska Medical Center
Omaha, NE 68198-2170

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**Preliminary Conference Schedule At-A-Glance**

**Saturday, August 23 - Pre-Conference**
- 8:00 am – 12:00 pm Perinatal HIV Urban Prevention (*By Invitation*)
- 9:00 am – 11:00 am Urban Women’s Health Subcommittee (*By Invitation*)
- 8:00 am – 4:00 pm PPOR PAC Meeting (*By Invitation*)
- 1:00 pm – 4:00 pm CityMatCH Board Meeting (*By Invitation*)
- 4:00 pm – 5:00 pm CityMatCH Members’ Business Meeting
- 6:00 pm – 9:00 pm CityMatCH Networking Dinner

**Sunday, August 24 - Resolve**
- 8:00 am Navigation Team Leaders Meeting (**Team Leaders Only**)  
- 8:30 am Confluence Kickoff
- 8:45 am Summoning Moral Courage
- 9:30 am Plenary: Racism and Public Health, Revisited
- 11:30 am Learning “Navigation” Lunch and Learn Challenge #1
- 2:00 pm Action Workshops for Change, Session I & II
- 6:00 pm DUI Dinner (*By Invitation*)
- 6:00 pm Undoing Racism Dinner (*By Invitation*)

**Monday, August 25 - Results**
- 7:30 am Working Breakfast: Coffee, Conversation, Connections
- 8:30 am Plenary: Getting Real Results: From Data to Action
- 9:25 am 2002-2003 Data Use Institute Graduation
- 10:00 am Concurrent Skills-Building Sessions
- 12:00 pm Pittsburgh Picnics: Reverse Site Visits
- 1:45 pm Navigation Challenge #2
- 3:00 pm Results: Promising Practices from the Field
- 5:30 pm Reception: Posters, Promising Practice Abstract Awards

**Tuesday, August 26 - Resilience**
- 8:00 am Navigation Team Breakfast and Challenge #3
- 9:00 pm Concurrent Skills-Building Sessions
- 11:15 am Closing Plenary: Resilient Leadership
- 12:00 pm Montage of Leaders: Sage Advice for Harder Times

**Post-Conference Activities**
- PPOR “How to Do” Workshop (**Preregistration Required**)
  - **Tuesday, August 26** 2:00 pm - 5:00 pm Part I
  - **Wednesday, August 27** 8:30 am – 12:00 pm Part II

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