

LEADERSHIP
 PERSPECTIVES:

WHAT'S HOT IN PUBLIC HEALTH - 2009



Patrick Simpson, MPH,
 Executive Director

MAYBE AN EASIER QUESTION MIGHT BE, "WHAT ISN'T HOT?"

When we ponder the depth and diversity of critical issues affecting the public's health, the experience can be very daunting. There is so much to do; so many complex issues require our immediate attention. Our budgets have been tight and feel even tighter as the calendar year winds down. Local health departments are deeply involved with preparation and response to the H1N1 pandemic, and although Health Care Reform is on the tip of everyone's tongue, it is but one of the many hot topics of concern to local public health.

A recent query of selected members of the CityMatCH Board of Directors provided a diverse list of hot topics in public health. We heard about everything from teen pregnancy to tight budgets, from healthcare access and disparities to fears about H1N1 vaccine shortages, from social determinants of health to the built environment, from building leadership to looking at health across generations through a life-course approach.

Obviously, we cannot touch on each member's hot topic in one newsletter. Instead, we feature several of our members most pressing chronic issues. Those topics selected are listed below, along with a brief description of the story or stories that focus on this topic.

1. Infant Mortality: Alameda County (CA) Public Health Department (ACPHD) *Place Matters* Team (see #4, Inequities in health, on the next page) is working to address disparities in infant mortality, a hot button issue across this nation. After a review of their 2004-2006 county-wide rates for low birth weight and infant mortality by race and ethnicity, significant disparities were revealed.

ACPHD identified a cluster of social inequities as root causes of infant mortality, low birth weight, and other health disparities and determined that it was time to take action. See page six to read how they used their research on root causes to create strategies that address this hot topic.

2. Life-Course Models: The maternal and child health field is drawn toward Life-course frameworks for many reasons. One is their ability to provide fresh insights, energy, and approaches to entrenched problems such as the persistence of differences in black and white infant mortality and disparities in cancer, cardiovascular and other chronic disease outcomes.

Life-Course approaches also have shown prom-
 (Continued on Page Two)



**COMING SOON!
 THE CITYLIGHTS ANNUAL
 CONFERENCE EDITION**

CityMatCH staff Just got back from the Annual Urban MCH Leadership Conference in beautiful New Orleans, LA. Now we are working hard to produce the CityLights Conference Edition.

Stay tuned to hear about "Reinventing MCH Practice: Rising to the Challenge, Committing to the Future," in the next edition. The Conference also featured an "Urban MCH Summit: Committing to the Future." Recommendations from the Summit will form the basis of an action plan for local governmental public health. Learn more at <http://www.citymatch.org/Conference!>

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WHAT'S HOT IN PUBLIC HEALTH - 2009

ise in improving the organization of service delivery to support obvious Life-Course mediated experiences.

On page three, guest contributor, Dr. Neal Halfon walks readers through the concept of integrating health development into Life-Course Models.

3. Women's Health is an Indicator of community health in Duval County, FL, says Carol Synkewecz, MPH in her opinion editorial on page seven. Social determinants of health can influence a woman's life and the potential health of future generations.

A confluence of environmental, behavioral and genetic factors can get in the way of achieving better health, safety and well-being. Synkewecz describes a simple premise: health problems can only be remedied if they are recognized, and to be recognized and remediated, women must have access to good health care.

4. Inequities in Health. The Joint Center for Political and Economic Studies' Health Policy Institute has developed an initiative called, *Place Matters*. They work to address the social determinants of health gaps by cultivating new leadership and advancing the Fair Health Movement at the community level.

The initiative is addressing social inequity (e.g., institutional racism, inequitable power arrangements and educational opportunities), economic inequity (e.g., economic insecurity and poor job opportunities), infrastructure inequity (e.g., inequities in built environment, housing, land use, transportation, parks and recreation), and inequitable access to resources (e.g., services and healthy foods).

On page four, readers will hear more about how *Place Matters* works in community-based teams across the country to address inequities in health.

5. Eliminating Health Disparities. The Boston Public Health Commission, which is a *Place Matters* team site, utilized a Model of Social Determinants of Health Inequities to assist with guiding and framing evidence-based work to eliminate disparities in health.



Data collection, analysis and dissemination of relevant information; community capacity-building and coalition development are key pillars of their work. Inequities are a primary issue, and therefore elimination strategies are integrated into core public health functions. See pages four and five to see how Boston is working to eliminate health disparities.

6. Teen Pregnancy Prevention. The National Campaign to Prevent Teen and Unplanned Pregnancy noted that Latinos are the fastest growing racial and ethnic group in the nation and have the highest teen birth and pregnancy rates of all racial and ethnic groups in the country. They estimate that more than half of all Latinas become pregnant as teens.

State and Local Programs and Initiatives are utilizing science-based approaches to teen pregnancy prevention to address this crisis. On pages nine and ten, readers will review two state and local programs working address the high rates of teen pregnancy among Latinas.

7. Public Health Leadership. The Recent CityMatCH Urban MCH Leadership Conference focused on this theme, "Rising to the Challenge, Committing to the Future." Readers will have a comprehensive opportunity to read about this in the next

edition of *CityLights*.

As an organization, we build leaders through education, training and capacity-building opportunities. Turn to page eleven for a look at the 2009-2010 CityMatCH Board of Directors and Nominating Committee.

We encourage all our members to take advantage of CityMatCH leadership opportunities; first, Board-Led Action Groups: Healthy Equity and Social Justice, Policy and Communication, Education and Training, and Organization Effectiveness, or become a member of our conference planning team.

Furthermore, we encourage members to run for a seat on the Board of Directors. We recognize that each CityMatCH member is a leader in their jurisdiction and we have much to learn from you. Drop us a line and share your stories.

In this edition of CityLights, we have taken a glance at these selected hot issues in public health.

We hope the articles within will increase your knowledge, raise your awareness and lead to new ideas and programs in your jurisdiction. Please, let us know your success stories as well as your challenges, and how we can help.

INTEGRATING HEALTH DEVELOPMENT INTO LIFE-COURSE MODELS

This is the first in a series of columns written by Neal Halfon, MD, MPH, Professor of Pediatrics, Public Health and Public Policy, UCLA Center for Healthier Children, Families, & Communities, Los Angeles, CA. Our thanks to Dr. Halfon for his time and input on this key public health issue.

Interest in Life-Course models is growing among health care researchers, public health and other health-related service providers, especially within the MCH community. This interest has been stimulated by an expanding body of research in two areas: Life-Course chronic disease epidemiology and the developmental origins of adult disease. Life-Course chronic disease epidemiology connects the dots between early life exposures to risk factors and chronic diseases that appear several decades later.

The work of David Barker, who showed that fetal growth and birth weight were associated with heart disease, hypertension and diabetes later in life, is perhaps the best example of this research. Readers can hear directly from Barker by attending the December 2009 Maternal and Child Health Epidemiology Conference in Tampa (FL), where he is a featured presenter. (See: <http://www.cdc.gov/reproductivehealth/MCHepi/2009/About-Conference.htm>) Numerous studies are starting to connect the dots between early life risks and later life chronic diseases.

Other research has taken a different vantage point, examining the developmental origins of adult diseases. Here researchers begin their focus on the gene environment interactions that take place early in life, in order to understand the changes in bio-behavioral pathways that are programmed by early life experiences.



In addition to the intellectual “push” these new areas of research have catalyzed, the MCH field has been pulled toward Life-Course frameworks for a number of other reasons. For example: their power to provide new insights, approaches and strategies to intractable problems such as the persistence of differences in black and white infant mortality and disparities in cancer, cardiovascular and other chronic disease outcomes. Life-Course approaches also have great utility in enhancing the organization of the delivery of services that support obvious Life-Course mediated risks, transitions and turning points.

Last, but not least, is the importance of Life-Course frameworks in evolving new

mechanisms to integrate the maternal components with the child health components of MCH, as well as helping to integrate individual and population health approaches.

Life Course Is Not Enough

Connecting the dots across the life span is useful but does not provide the kind of actionable strategies that require a better understanding of the mechanisms involved in producing health at different ages and stages of development. For that reason, it is argued that Life-Course frameworks need to be paired with concepts of how health develops in order to realize their full potential.

From the science of human development (including developmental psychology, developmental biology and other areas of human development) there are five major conceptual tools that provide the foundation for how investigations in developmental science proceed. These include:

- **Ecological factors/models** These models are based on the work of Urie Bronfenbrenner and suggest that, from an ecological standpoint, individual development can only be understood in relation to the nested context and environment in which the individual develops. The power of ecological models is in considering multiple levels of interaction across multiple domains. From a service delivery standpoint, these approaches force us to consider the different sectors that impact individual health development outcomes.
- **Transactional factors/models** These models are largely based on the work of Arnold Sameroff. His work frames development in terms of systems theory, and highlights dynamic ways in which environments transform the individual and how individuals transform their environments. This been important for understanding developmental processes and also for understanding and modeling gene-environment interactions.
- **Sensitive and critical periods** This is the notion that timing and development are important due to the hierarchical nature of many developmental processes. It highlights how the timing of exposures can influence certain developmental outcomes. This includes considering socially defined temporal punctuations associated with transitions and turning

points in an individual’s life (e.g. transition from kindergarten, graduation from college and entry to work force).

- **Channeling** Risk and protective factors are often linked together as socially-constructed factors that impact development and may channel that development toward a particular trajectory or path.
- **Trajectories** Describing life-course health development in terms of health development trajectories helps illustrate how early experiences can affect later health status.

These developmental concepts and tools help move the Life-Course approach from a simple framework to one that begins to explain how health develops across the life span and the specific mechanisms involved with the production of different health outcomes. Clyde Hertzman, I and others have suggested that there are three basic health development mechanisms that explain many of the ways in which health is produced. These include:

- **Cumulative mechanisms** account for the added effect of multiple risk and protective factors over time. This is the mechanism that is being used to account for the impact of cumulative risk or “weathering” and how it impacts birth outcomes.
- **Programming** accounts for specific instances of risk and protective factors at very critical and sensitive periods of the up and down regulation of specific genetic and physiological processes.
- **Pathways** are chains of socially constructed and often linked exposures that create a constrained conduit or channel through which development occurs.

By adding the health development processes and mechanisms to the Life-Course model, we are better able to approach important concepts like preconception care and consider the nested role of context in aligning risk and protective factors.

Rather than looking at the life course in an undifferentiated and linear way, we then account for developmental processes that happen during critical periods during which intervention is likely to be most effective.

Life-Course Health Development models can also help construct the kind of service-based scaffolding that are necessary to channel developmental pathways into more optimal trajectories over time.

In March 2009, CityMatCH and NACCHO co-sponsored a webcast on Place Matters and two of their community-based teams in Boston, MA and Alameda County, CA. This article describes this nationally-driven effort to address the social determinants of health, including the built environment, in order to reduce inequities in health.

PLACE MATTERS: ELIMINATING HEALTH DISPARITIES BY ADVANCING THE 'FAIR HEALTH' MOVEMENT

Edited by Brian Smedley, PhD, Director of Health Policy Institute, Joint Center for Political and Economic Studies

Place Matters is a nationwide initiative of the Joint Center for Political and Economic Studies' Health Policy Institute. Their mission is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. They work to address the social determinants of health gaps by cultivating new leadership and advancing the Fair Health Movement at the community level. Sixteen **Place Matters** Teams are working to design and implement strategies to improve health equity within communities in 22 counties and three cities. Place Matters team members come from a variety of sectors – including local government, public health organizations, business entities, educational systems, faith-based groups, and community-based organizations.



Place Matters creates shared learning experiences and provides assistance with the development and implementation of community-based strategies to address social factors that determine health. The specific efforts of two community teams located in Boston, MA and Alameda County, CA are featured in this story.

Place Matters' strategies for building a Fair Health movement are to increase the capacity of local and national leaders to elevate health equity in the public discourse, conduct research to continue to build the evidence-base to compel action, harness new tools, such as internet-based mapping, social networking, and advocacy platforms, proactively engage key stakeholders and constituencies, and to promote new ideas for action to eliminate health disparities. They seek to improve an array of health outcomes, including chronic diseases (like asthma, cardiovascular disease, hypertension), cancer (breast, cervical) mental health, maternal and child health, and injury.

Some of the social determinants of health the initiative is addressing include social inequity (e.g., institutional racism, inequitable power arrangements and educational opportunities), economic inequity (e.g., economic insecurity and poor job opportunities), infrastructure inequity (e.g., inequities in built environment, housing, land use, transportation, parks and recreation), and inequitable access to resources (e.g., services and healthy foods).

Each **Place Matters** team has a set of core functions/strategies. They identify the social determinants of health, collect and integrate data to inform practical interventions; develop and disseminate tools to catalyze community leadership in implementing these interventions, and use strategic leadership to inform and influence policymakers, public officials, and legislators about strategies to eliminate health disparities.

Place Matters is taking key steps now to harness new media and web-based tools to assist with their policy and advocacy efforts. They look to Web 2.0, YouTube and various social networking tools as mechanisms for the translation and dissemination of findings. Interactive web-based mapping platforms will be used to illustrate spatial dimensions of health inequality and point to place-based solutions. For more information on **Place Matters**, visit their website at: < http://www.jointcenter.org/new_site/placematters.htm >

PART 1: TAKING ACTION TO ELIMINATE HEALTH INEQUITIES IN BOSTON

Edited by Barbara Ferrer, Ph.D., MPH, M.Ed, Executive Director, Boston Public Health Commission

The city of Boston has slightly more than 600,000 residents and is increasingly diverse: 50% white, 23% black, 17% Latino, 9% Asian/PI, 28% of residents are foreign born. 20% of residents are living with income below the poverty level. 31% of children live in households with income below poverty level. Racial disparities in health are stark in Boston and life expectancy in particular is a source of significant inequity.¹

The City has 26 community health centers, 12 Teaching Hospitals, three med-

ical schools, four schools of public health, five nursing schools, and eight allied health programs. 95% of residents have health insurance through the 2007 health reform law.

Boston's Guiding Principles

The Boston Public Health Commission (BPHC) utilized a Model of Social Determinants of Health Inequities to assist with guiding and framing their work. (see Figure 1)

To continually remind themselves

that this work can be achieved, the BPHC frequently cites the 'mantra' of the Peoples Institute for Survival and Beyond, "If racism was constructed, it can be undone. It can be undone if people understand when it was constructed, why it was constructed, how it functions and how it is maintained."²

Efforts conducted by the BPHC to eliminate disparities in health are evidence-based. Data collection, analysis and dissemination of relevant information;

(Continued on Page Five)

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community capacity-building and coalition development are key pillars of their work. Inequities are considered a central issues, therefore elimination strategies are integrated into core public health functions.

To address these inequities, the BPHC works “upstream” with non-traditional partners to address the root causes of inequities. Significant funding is directed to support efforts to eliminate inequities.

Mayor’s Task Force Blueprint Report: A Plan to Eliminate Racial and Ethnic Disparities in Health

Released in June 23, 2005, the Blueprint’s plan for eliminating health disparities incorporated a review of the research, history and underlying causes. Leaders from health and human services, businesses, academia and community coalitions provided input.

Recommendations focused on health care as well as larger societal and environmental factors. A combination of broad and specific recommendations was directly linked to action steps.

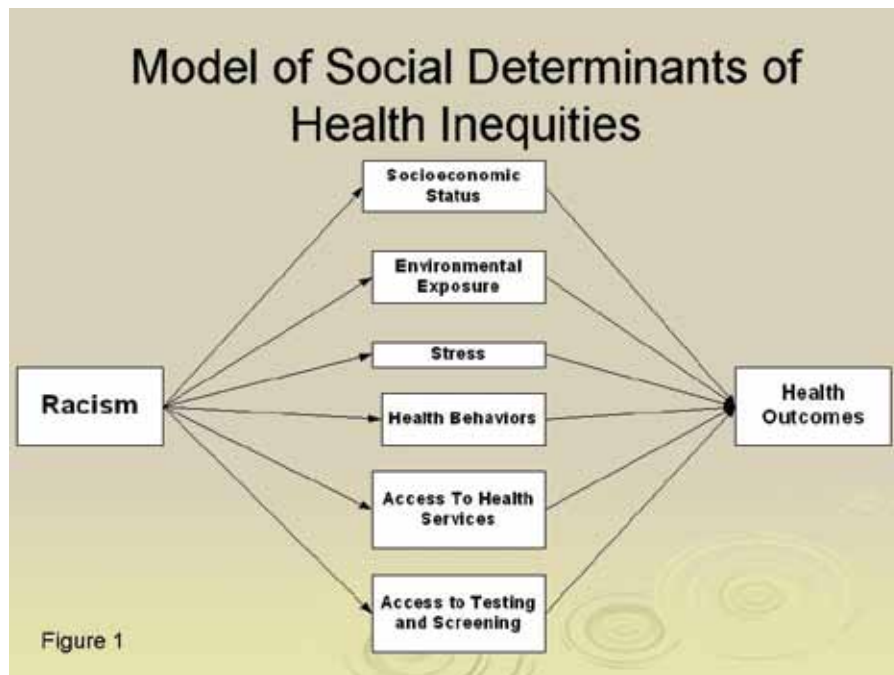
A framework for promoting health equity with three overall strategies to eliminate inequities was defined. These strategies clustered around developing institutional competency to engage in sustained efforts; supporting and building community leadership capacity, and identifying beneficial partnership opportunities.

Subsequently, the Mayor’s Hospital Working Group released a report defining hospital-specific recommendations across five domains: collecting information on race and ethnicity, measuring health disparities, diversifying the healthcare workforce, improving cultural competence in the hospital and including the community in institutional decision-making processes.

Implementation

To strengthen their own institutional capacity, the BPHC now provides education and training opportunities around core competencies and leadership development, integrates elimination of inequities into every program, and strives to identify and change policies that perpetuate inequities.

Boston has invested two million dollars in 54 community and health institutions to



address community health inequities.

Key project areas include data collection, health systems, raising public awareness, workforce diversity, patient education, violence prevention and trauma response and food access/obesity prevention.

To address food access and obesity prevention, for example, the BPHC selected a very broad goal – to promote healthier neighborhoods by increasing access to healthy food options and by involving youth input.

An extensive array of activities were undertaken, including: youth leadership development, championing healthy school breakfasts and lunches, promoting local food production and marketing, constructing community gardens, providing nutrition and physical activity education, and developing food cooperatives in Boston Public Housing.

A key result of Boston’s larger effort has been the adoption of major changes to environmental regulatory policies that affect the built environment. A regulation requiring permits and inspections for container lots, junkyards and recycling facilities was passed.

This regulation created a legal process to review site suitability, proximity, adequacy and the potential for adverse impacts, and to monitor facilities for excess noise, litter, rodent, insect or avian infestations, odors and nuisances.

80% of the facilities have since closed because they could not satisfy the requirements, resulting in cleaner and safer neighborhoods.

For those health departments just beginning to address health inequities, the Boston Public Health Commission offers the following suggestions.

- Promote a skilled, diverse workforce and leadership team.
- Thoughtfully identify the root causes of health inequities.
- Build and sustain diverse partnerships, to assure success.
- Collect appropriate data to understand challenges, measure progress and establish accountability.
- Continually refocus activities going beyond traditional health boundaries to address all policies with the potential to enhance health.
- Seek funding for efforts that promote community health.

To learn more, visit the Boston Public Health Commission website at <<http://www.bphc.org/disparities>>

Footnotes

1. CityMatCH, Emerging Issues in Maternal and Child Health (E-MCH) Place Matters: Eliminating Health Disparities by Addressing the Social Determinants of Health, Mar 19, 2009. <http://www.citymatch.org/EMCH_calls.php?id=97>
2. The People’s Institute for Survival and Beyond, <<http://www.pisab.org>>

PART 2: ADDRESSING ROOT CAUSES OF HEALTH INEQUITIES THROUGH A LOCAL POLICY AGENDA

Edited by Alexandra Desautels, MSW, Community Assessment, Planning, Evaluation;
Alameda County (CA) Public Health Department

Between 1991 and 2006, Alameda County Health Department (ACPHD), noted a steady rise in low birth weight births while at the same time, their infant mortality trends saw a slow decline.

ACPHD reviewed county rates for low birthweight and infant mortality by race and ethnicity for the years 2004-2006. The three-year average rate of low birth weight births for African Americans was 10.8 per 1,000 live births. The rate for whites was 3.4; the overall rate was 7.2. ACPHD identified a cluster of social inequities (see Figure 2) as root causes of infant mortality, low birth weight, and other health inequities and determined that it was time to take action.

ACPHD began their effort by assessing the potential impacts of institutional changes, community capacity building, and data and research-based policy changes on health equity. This led to the inception of their **Place Matters** initiative to “promote health equity through a community-centered local policy agenda focused on education, economic development, housing, incarceration, land use, and transportation.”

To date, ACPHD has completed needs assessments in each policy area, responded to community and staff requests for policy analysis, built relationships with community stakeholders and other governmental agencies, and planned and implemented a process for institutionalizing policy work at the health department.

“Reactive” Policy Efforts

At the outset, most of the policy work was “reactive.” For example: addressing transit fare increases, land use policies and the lack of affordable housing. Requests would come in from community groups or government agencies to the ACPHD. The would, in turn, apply basic screening cri-

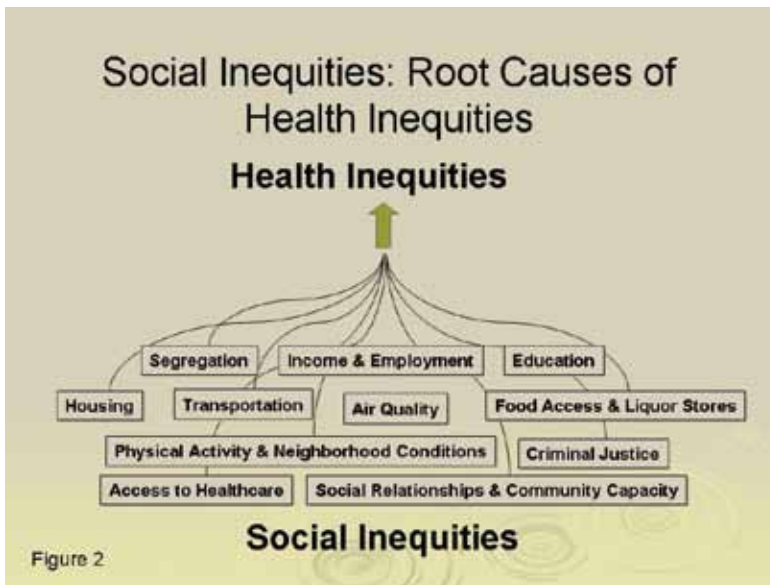


Figure 2

teria, including asking the following questions:

1. Is there disproportionate impact on communities experiencing health inequities?
2. Does the policy address the root causes of the inequity?
3. Will working on the policy help build healthy relationships?

A complete analysis is done to examine potential health impacts of decisions. ACPHD and stakeholders are engaged for oral and written testimonies.

Reactive policy work has real limitations. ‘Silos’ may serve to disconnect needs from programs; a unifying vision and goals to identify root causes may be absent. Policy work is often disconnected from community priorities.

Advancing a Proactive Policy Agenda

ACPHD is now taking a more proactive policy approach. To achieve this, they first identified process goals and an outcome goal, which is to address the root causes of health inequities through policy change.

Process goals support this outcome and include institutionalizing policy work efforts at the ACPHD; ensuring all ACPHD policy work is community-

driven, research-driven, proactive and responsive; creating and enhancing stakeholder buy-in; building relationships, and ensuring that service-level interventions are connected with policy change efforts.

ACPHD has created a matrix to frame their efforts to build a local policy agenda. Policy workgroups have been assembled to create and advocate for the agenda; for increased staff capacity for policy analysis and advocacy, and for increased capacity to partner with stakeholders.

Their approach has two phases. Phase I focuses on understanding the issues and Phase II moves toward policy analysis and setting a policy agenda. Utilizing decision-making tools and policy assessment tools keeps policy efforts advancing in a structured and analytical fashion. Their structured process assures stakeholder engagement. Once a policy agenda has been set, implementation is accomplished through the workgroups.

The ACPHD **Place Matters** Leadership Team provides guidance on all policy work. The Leadership Team includes representatives from the policy workgroups, key ACPHD decision makers, and partners. The Leadership Team measures impact by changes in baseline indicators and assesses impact of using a health frame to influence policy decisions.

When implementing policy change, ACPHD recognized it is critical to be cognizant of local politics, to assess policies for health impact, to clearly and strategically communicate the impact, and offer criteria for evaluating alternative solutions.

To learn more, contact Alexandra Desautels: Alexandra_desautels@acgov.org, or visit the website: www.acphd.org/health-equity/placematters.htm.

FOCUS ON WOMEN TO ACHIEVE A HEALTHIER FUTURE

Op Ed by Carol Ann Synkewecz, MPH, Maternal and Child Health Director,

Women's Health Liaison, Duval County (FL) Health Department

In public health circles, infant mortality is frequently cited as being a fairly descriptive indicator of a community's health. We suggest that women's health may well be an indicator of generational health. Women represent about half of the population nationally and locally, with a growing diversity racially and ethnically distributed across all age groups. I write this article to help my health department and others to start thinking differently about how we address health in our jurisdictions.

From Life-Course experts such as Neal Halfon (see page three), we now know that health is impacted by a confluence of environmental, behavioral and genetic factors throughout life.

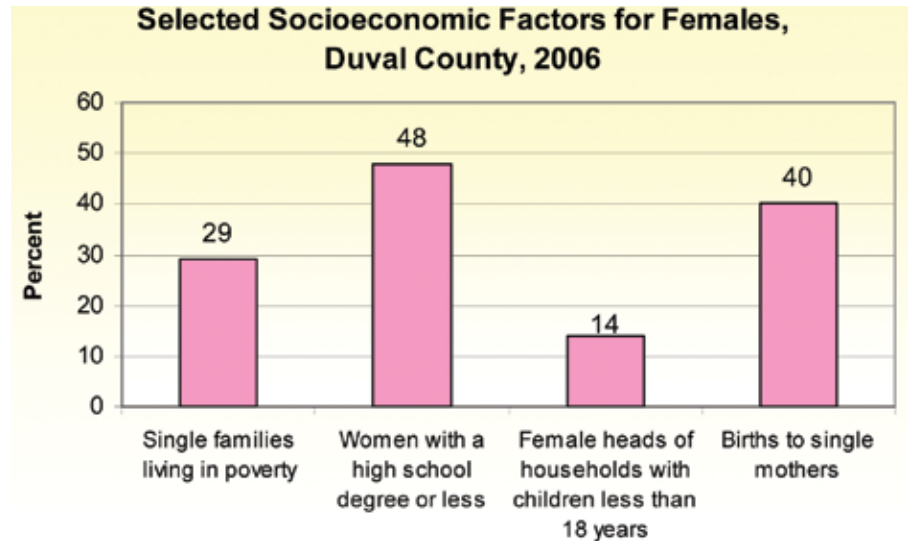
These social determinants of health can influence a woman's life and potential health for future generations. Simplistic as this may sound, health problems can only be remedied if they are recognized. For health problems to be recognized and remediated, women must have access to good health care.

The Health Department where I serve as the MCH Director is located in Duval County, FL. A brief sampling of selected 2006 statistics is as follows:

- There were 454,567 females in Duval County.¹
- Whites accounted for 64% (291, 009) of the female population whereas African Americans made up 31.8% (144,758) of the female population.¹
- Nearly 23% (47,954) of family households consisted of female heads of households.²
- The number of women between the ages of 15 to 50 who had a birth was 13,595.³
- Over 40% of women who had given birth were single.³

Moreover, in Duval County, increasing numbers of women are striving to attend and complete college. Many lack the opportunity to fulfill hopes beyond secondary school. Just 52% of women over 25 years-of-age in Duval County have more than a high school education.⁴

Beyond race and ethnicity, income and education are critical factors that contribute to women's health and access



to health care. Women are more likely than men to live in poverty. We know that a number of negative health conditions are closely linked to family income. The built environment in which many of these women live may also contribute to poorer mental and physical health.

Opportunities for improved women's health exist from preconception through the senior years. From infancy to maturity, the quality of women's lives is impacted by factors and behaviors which we are beginning to understand will have real impact on future generations.

Those factors impact choices and decisions women in Duval County make around nutrition, exercise, social activity, health access, mental health, and safety. Quite possibly, many health conditions and diseases associated with poor nutrition, physical inactivity, lack of contraceptive use, smoking, alcohol, and depression, might be avoided or minimized if overall living and social conditions more fully supported women through such strategies as assuring equitable income, opportunity and education, and more. I wonder what the health of women in Duval County might be like if we were to address these larger, systemic issues?

In the *Report to the Jacksonville Citizens, JCCI Study of Infant Mortality 2008*, some of the following conclusions are described: *"The cumulative, chronic stress faced by black women causes psychological and physiological harm not only to themselves and their unborn*

babies, but these effects are carried into the adult life of that baby and into the next generations. In addition to racism, sexism (the discrimination against and devaluing of people based on their sex rather than their individual merits) is another factor in the infant mortality rate."

The report describes system issues that must be repaired: *"Jacksonville lacks a holistic life-course approach to women's and girl's health, from early health and nutrition concerns, through puberty, to the time before, during, and after pregnancy. The health care and social service systems are fragmented, uncoordinated, and too often inaccessible or unaffordable."*

To improve the health of women in Duval County, I believe we must think big. We must look at larger policy issues; address the social determinants of health. We must change/create opportunities across the lifespan, starting with preventive health care, educational opportunities, safe and healthy housing, nutrition, exercise and positive social activities, to name just a few. These efforts, along with aggressive and coordinated strategies to eliminate racial and ethnic disparities in health are critical components of breaking the cycle of accumulated disadvantages over one's lifetime.

Footnotes

1. Florida Legislature's Office of Economic and Demographic Research (EDR), 2006.
2. U.S. Census Bureau, American Community Survey, 2006.
3. Florida Department of Health, Office of Vital Statistics, 2006.
4. U.S. Census Bureau, 2000.

BRIDGING TWO WORLDS: WORKING WITH THE LATINO COMMUNITY TO PREVENT TEEN PREGNANCY & IMPROVE REPRODUCTIVE HEALTH

Edited by Katherine Suellentrop, MPH, Senior Manager, Research Programs, and Ruthie Flores, MTS, Senior Manager, The Latino Initiative, The National Campaign to Prevent Teen and Unplanned Pregnancy

In early 2009, CityMatCH and NACCHO co-sponsored a webcast featuring “The Latino Initiative,” a groundbreaking project of *The National Campaign to Prevent Teen and Unplanned Pregnancy*. This webcast raised awareness of the unique needs of the Latino community in addressing reproductive health and reducing teen pregnancy, and showcased two teen pregnancy prevention (TPP) initiatives in Colorado.

Because this information is of such critical importance to all urban health departments who serve the Latino community, we have reconnected with each of these organizations to provide updated information on recent survey data and programmatic efforts.

The National Campaign frames the issues and provides the ‘big picture,’ honed with updated data. The Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention and The Denver Teen Pregnancy Prevention Partnership describe how they are working to harness the potential of Latino youth, to address disparities in teen pregnancy rates, and explain the challenges of implementing science-based programs.

Why Is a Latino Initiative Needed?

The National Campaign to Prevent Teen and Unplanned Pregnancy noted that Latinos are the fastest growing racial and ethnic group in the nation and have the highest teen birth and pregnancy rates of all racial and ethnic groups in the country. The National Campaign estimates that fully 53% of Latinas become pregnant as teens.

“While Latino teen pregnancy has gained national attention in recent years, little work has been done to understand subgroup differences and similarities within the Latino community,” said Ruthie Flores, Senior Manager of The National Campaign to Prevent Teen and Unplanned Pregnancy’s Latino Initiative.

A survey of 759 Latino teens and 915 Latino parents, “Toward a Common Future: Latino Teens and Adults Speak Out About Teen Pregnancy,” was commissioned by The National Campaign to Prevent Teen and Unplanned Pregnancy and the National

Council of La Raza (NCLR) and unveiled in May 2009.

Flores states, *“We hope this survey shines much-needed light on the beliefs and attitudes of Latino teens and parents about sex, contraception, and future goals to help inform teen pregnancy prevention efforts and messages nationwide.”*

The following selected findings from The National Campaign’s survey highlight why such a focus is crucial at this time:

- 72% of sexually experienced teens say they wish they had waited longer.
- 34% of Latino teens believe that being a teen parent would prevent them from reaching their goals; 47% say being a teen parent would delay them from reaching their goals.
- 49% of Latino teens say parents most influence their decisions about sex compared to 14% who cited friends, 6% other family members, 3% religious leaders, 2% teachers, and 2% the media.
- Although three-quarters of Latino teens say their parents have talked to them about sex and relationships, only half (49%) say their parents have talked to them about contraception.
- 74% of Latino teens believe parents send one message about sex to their sons and another to their daughters.
- Latino teens in this survey report the most common reason teens do not use contraception is due to concerns that their parents might find out.
- Latino teens want more information: 70% said they want more information about both abstinence and contraception. 88% wish the media showed more or talked about the consequences of sex, including teen pregnancy.¹

The Bigger Picture: Culture, Poverty, Education, Hope

The Latino culture is one of great diversity in language, acculturation, theology, immigration status, norms, origin and socioeconomic behaviors. Latinos may



come from Mexico, Puerto Rico, Cuba, Central America, South America and other areas. They cannot and should not be stereotyped.²

Unfortunately, according to the National Campaign, almost half of Latino adults living in the United States do not have a high school diploma. Latino teens are more likely to drop out of high school than their peers. In 2003, 22 percent of Latinos were living at the poverty level compared to eight percent of non-Hispanic Whites.

Latino youth who responded to the survey provided important insights for practitioners, counselors, educators, and policymakers working to improve TPP programs, interventions and services for the Latino community. For example, more than 8 in 10 Latino teens (84%) report that either graduating from college or having a promising career is the most important goal for their future. Over three-quarters (77%) of Latino teens reported that planning their future is important and within their control.³

Why Are Latino Teen Pregnancy Rates So High?

To understand reasons why Latino teen pregnancy rate are high, The National Campaign suggests a number of factors: age differences between partners: (Latina teens are more likely to have older partners (4+ years older); sexual and contraceptive behavior: Latinos are less likely to use any form of contraception, less likely

to use condoms at last sex compared to their peers; acculturation: differences in behaviors with respect to generational status, language and country of origin and parent/teen communication.

The National Campaign's Latino Initiative focuses on the following areas: building capacity and partnerships with guidance from the Latino Initiative Advisory Group; strengthening the research base for action; offering technical assistance and providing resources for parents, teens and communities; and finally, reaching out to key organizations and sectors, including policymakers, faith leaders and the media.

Based on the survey findings as well as identified education and poverty concerns, the importance of engaging Latino teens to create better understanding and openness around relationship and sexuality issues cannot be overstated. Creating this understanding will be critical to local, state and national efforts to shift the current trends.

What can we do? The National Campaign suggests that local health departments first believe in Latino youth, encourage them to set goals and chart a "dream" map, educate/involve parents, especially recent immigrant parents who might have different values and understand clearly the diversity of the Latino community. Employ proven, science-based approaches to teen pregnancy prevention that can be achieved with fidelity.

Six science-based programs have demonstrated success with Latino teens. They include:

- Draw the Line. Respect the Line
- ¡Cuidate!
- Safer Choices
- Carrera Program – Children's Aid Society
- Reach for health Community
- Poder Latino (*quasi-experimental design*)

Additional programs that show promise are:

- Wise Guys/Jovenes Sabios
- El Joven Noble
- Plain Talk/Hablando Claro
- Pathways/Senderos⁴

For more information from The National Campaign, visit the web at TheNationalCampaign.org; or StayTeen.org, or http://myspace.com/latino_initiative.

PUTTING THEORY INTO PRACTICE IN COLORADO

Lori Casillas, Executive Director, The Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention (COAPPP)

Significant effort and resources are being dedicated at the state level by COAPPP, and at the local level by The Denver Teen Pregnancy Prevention Partnership, to enhance the opportunities and harness the potential of Latino youth. COAPPP, a state-wide non-profit organization, actively engages Colorado communities to promote healthy sexual and reproductive development of all teens and advances the well-being of parenting teens, by focusing on training/technical assistance, policy and advocacy, and public education.

In Colorado, in 2006, 55% of all teen births (15-19) were to Latina teens.⁵ The teen birth rate was 104.3 per 1,000 for 15-19-year-old Latinas, whereas the teen birth rate for non-Hispanic white 15-19-year-old females was 20.1. Latinas represent 20% of Colorado population, according to the US Census.

Recent achievements in Colorado have created an environment ripe for progress, including passage of HB 1292 – providing Comprehensive Sexuality Standards for Public Schools, the Governor's rejection of Title V (abstinence-only state dollars) and increased interest/participation of schools and school-based health centers in sexuality education. More communities are using and exploring science-based programs.

For example, Denver was selected as a pilot site for ¡Cuidate! — a cultural adaptation of Be Proud! Be Responsible! — and several school districts serving high proportions of Latinos are implementing science-based sex education programs.

COAPPP is partnering with La Escuela Tlatelolco, a Mexican/Indigenous charter school to enhance sex education and provide clinical support to the youth.

La Escuela Tlatelolco, located in North Denver, received funding through an HIV prevention grant, and has achieved very high overall parent approval and participation by the school-based health center, teachers, the assistant director and the families. The teacher team is trained in ¡Cuidate!, and the parent training/education component is Raices y Alas, which has adapted components of the Talk Early, Talk Often Program.

Challenges in Colorado

As in many states, a small, but vocal opposition to comprehensive sex education exists; indeed no state dollars are earmarked for teen pregnancy prevention. Considerable stereotyping and misperceptions about Latinos exist and must be addressed. More importantly, sexuality education is still not frequently enough integrated into broader conversations related

to education, economic opportunities, youth development, and Latino leaders, communities and youth historically have not been a meaningful part of the conversation.



Finding Solutions

Framing "the issue" effectively is imperative. For example, you are "supporting teens, as opposed to "condoning/encouraging" early pregnancy. Be prepared for the numerous issues that may prevent engagement in family planning and talking about sexuality.

Latino teen's needs are the same as any young person: they need to have a voice, to have access to health care, to dream and have opportunities to achieve dreams. They need quality and engaged education, healthy and vibrant communities and families, and respectful, truthful and comprehensive information about sexual health and all aspects of their health.

To learn more, visit the COAPPP website at www.coappp.org, phone 303-225-8870 or E-mail [Lori Casillas at lcasillas@COAPPP.org](mailto:lcasillas@COAPPP.org).

(Continued on Page Ten)

BRIDGING TWO WORLDS: LOCAL LEVEL PROGRAM IMPLEMENTATION

(THE DENVER TEEN PREGNANCY PREVENTION PARTNERSHIP)

Edited by Jocelyn Martinez, former DTPPP Director

The Denver Teen Pregnancy Prevention Partnership (DTPPP) was formed by the Denver Office of Strategic Partnerships and funded through the Denver Department of Human Services and The Colorado Health Foundation. The Partnership was created to coordinate and deliver proven, effective and comprehensive teen pregnancy prevention approaches in select Denver Public Schools to decrease teen pregnancy rates.

Planning, Implementation, & Evaluation

The DTPPP identified key stakeholders in Latino teen pregnancy prevention, provided tools for program design and capacity-building, and identified what works and the key lessons learned when working collaboratively. In August 2007, Temporary Assistance for Needy Families – Denver Department of Human Services contributed \$750,000 toward a two-year pilot program implementation. They sought to support science-based approaches to teen pregnancy prevention and promising practices that incorporate characteristics of science-based programs.

From the State Health Department, the DTPPP obtained birth rate data of Colorado teens broken down by ZIP Code. The DTPPP then sorted out ZIP Codes correlated with high birth rates and identified middle and high schools located within those ZIP Codes. The schools identified primarily served Latino students; most qualify for and receive free/reduced lunches. Graduation rates were lower than the state average.

Initial steps in the program design process comprised community mapping to assess need and opportunity, identification of gaps in essential services, and creation of a “dream team” – collaborative partners who prevent service duplication and help leverage and maximize resources. A multi-tiered program intervention design (saturation model) was employed utilizing after-school leadership programs, in-class programming, school-based health centers (clinical component) and parent engagement/education workshops. Collaborative key stakeholders were cultivated to create broad-based support for addressing teen

pregnancy and take advantage of political will within the community. The number of students and parents served in Year One of the Pilot phase was: classroom: 874; school-based health centers: 138; after-school: core group of 30; and parent engagement: 97.

An external evaluator was selected and a logic model created. The model outlined the risk and protective factors each program provider would address and how that might be linked to the health goal. Qualitative and quantitative data was collected at mid-year and year-end intervals using pre/post test instruments. A uniform evaluation was created for a collaborative intervention using both science-based and promising programs.

Challenges

This effort has faced significant challenges. Left unresolved, class time and school space limitations would have hampered faithful program implementation. Conflicts between service providers’ schedules and school schedules had to be dealt with. Cultural issues, including responding to the need for bilingual educators and awareness of cultural nuances also had to be respectfully addressed.

Individual schools’ internal communications about programming and referral were sometimes problematic. The time and investment required to saturate schools with messages about reproductive health was underestimated. Finally, there was a lack of clarity about district-wide policies for planned/unplanned sexual health curriculum and about the program approval processes at individual schools.

Strong school and community buy-in provided additional momentum and leverage; and helped bring in non-traditional funding streams. However, the top-down buy-in only (e.g., principals) may unfortunately have sometimes left regular school staff less informed and engaged about the programs.

What Worked Thus Far

- Drafting a thorough logic model
- Creating infrastructure
- Identifying a collaborative coordinator between schools and partners



- Defining clear provider roles and expectations
- Allowing sufficient planning time for relationship-building and establishing a pilot
- Utilizing a saturation model – in-class, after-school, school clinics, parent education, trained community providers
- Utilizing science- and culturally-based, and/or promising programs, e.g. ¡Cuidate!; Latinas of Vision; Will Power, Won’t Power; Tailoring Family Planning; Safer Choices
- Requiring parental approval for programs attended by children
- Maximizing outspoken community leaders
- Establishing strong agency relationships

Key Partners

Partners include the Colorado Organization for Latina Opportunity and Reproductive Rights, Colorado Statewide Parent Coalition, Denver Area Youth Services, Denver Public Schools, Denver Office of Strategic Partnerships, Denver School-Based Health Centers, Girls Incorporated of Metro Denver, Planned Parenthood of the Rocky Mountains, and the Colorado Health Foundation.

To learn more, contact Dace West, Co-Director of the Denver Office of Strategic Partnerships at dace.west@denvergov.org

Footnotes

1. http://www.thenationalcampaign.org/media/PDF/Latino_polling_PR.pdf
2. http://www.thenationalcampaign.org/espanol/default_eng.aspx
3. Ibid, #3.
4. Summerville, G. (2006). Copy That: Guidelines for Replicating Programs to Prevent Teen Pregnancy. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
5. Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2006. National vital statistics reports; vol 56 no 7. Hyattsville, MD: National Center for Health Statistics. 2007.

2009-2010 CITYMATCH LEADERSHIP UPDATE

CityMatCH Members participating on the **Board of Directors in 2009-2010** will actively engage in shaping future MCH policy at the national level. As CityMatCH enters year two of its strategic plan, the leadership of the organization will be working with the membership to address our ten strategic goals. A few examples of the work to be done in the year ahead include:

- Present and vote on an expanded definition of “CityMatCH Member Representative” to include more individuals from CityMatCH Member Health Departments as active participants in the organization.
- Create a topical membership assessment to be sent in the Spring 2010 delving deeper into the priorities of Member Health Departments so CityMatCH can better assist with education, training, and advocacy around these complex issues.
- As CityMatCH approaches our 20th Anniversary, our Board will reexamine the CityMatCH brand, image and communication strategies to assure we are best meeting the needs of urban MCH professionals.

If you would like to become more involved in the leadership of CityMatCH, several opportunities are available each year. First, join one of our Board-led Action Groups: Healthy Equity and Social Justice, Policy and Communication, Education and Training, and Organization Effectiveness. Each Action Group holds monthly calls, discusses current issues of importance to urban MCH, and takes on special projects that benefit the CityMatCH membership. You can also run for a seat on the Board of Directors. Nominations for open board seats are taken at any time, and Board elections are held in the Spring. Finally, if you have an idea to share regarding moving urban MCH forward or what CityMatCH can do to better assist its membership, please share your thoughts with any of our current Board members or staff. Below is the list of the 2009-2010 CityMatCH Board of Directors and Nominating Committee:

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* See Page Twelve for Peck Update

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CityMatCH thanks two Regional Representatives who retired from the Board in August 2009, **Ann Sayler-Caldwell, MPH, RD/LD** (South Central) and **Kathy Carson, BSN** (West).

Questions? Contact Mark Law, at (402) 561-7500 or mlaw@unmc.edu or visit the website at www.citymatch.org.



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DR. MAGDA PECK NAMED ASSOCIATE PUBLIC HEALTH DEAN AT UNMC

CityMatCH extends congratulations and best wishes to Dr. Magda G. Peck, ScD, the “founding mother” of CityMatCH, its first Executive Director and CEO until 2007. In late September, Dr. Peck was named Associate Dean for Community Engagement and Public Health Practice in the University of Nebraska Medical Center’s College of Public Health. Dr. Peck assumed her role on October 1, 2009.

The new college of Public Health Dean, Ayman El-Mohandes, MBBCh, MD, MPH, said, “*Dr. Peck is well-respected in the national public health community for her innovative thinking and program development.*”

The College of Public Health is committed to improving the health of communities in Nebraska and beyond and to provide sustained education and leadership development for practicing public health professionals. “*A primary focus of this college is to contribute to the health and well-being of communities and populations,*” Dr. Peck said. “*Around the state and around the world, we will make a greater difference in the public’s health through effective partnerships in research, education and service.*”



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<http://www.citymatch.org>

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