

Transitions: Rebirth and Renewal

Amid casualty reports from a war prematurely declared "over" one year ago, but still taking a toll in human life, sapping the emotional energy of concerned citizens, and in the wake of recent allegations of abuse of Iraqi prisoners, urban public health practitioners face nightmares closer to home: reports of infant mortality on the rise, an epidemic wave of obesity, budgets built on shifting sands of funding here today, but possibly reallocated tomorrow, and with transitions affecting every aspect of their work.

What experience is more predictable in public health than the prospect of transitions and change? Yet, our members display unwavering commitment to social justice and remarkable ability to face change while remaining focused on attaining positive outcomes for women, children and families. This roller coaster ride tempers and shapes their resolve like a glass bottle found on an ocean beach. Smooth; unbroken spirit.

If nothing ever



changed,
there'd
be no
butterflies.

—Unknown


As Dr. Magda Peck so eloquently states in this edition's *CityView*: "Rituals of rebirth and renewal spring forth this time of year." In her jubilee year, Dr. Peck, CEO and founding Executive Director of CityMatCH is participating in her own ritual of rebirth as she transitions from active leadership of the organization to an advisory capacity. Remaining connected and committed to CityMatCH, Peck now serves as Senior Advisor, mentor and friend, offering sage advice, sharing her unparalleled vision. In her stead, Patrick Simpson has taken on the role of Acting Executive Director.

CityMatCH (like urban public health departments) faces its own transitions which, like rebirth challenge and impact the services we provide. CityMatCH faces these transformations with focused intentionality, moving deliberately toward the next phase. Look for a new and improved **DaTA** Institute with greater opportunities for members; find new opportunities for PPOR training as CityMatCH joins hands with Healthy Start and NFIMR to reduce fetal and infant mortality (*see page nine*).

With renewal and rebirth come opportunities for reflection. In this edition, an advisory panel of MCH Epidemiologists reflect on their formative training experiences, the importance of acquiring certain skills, public health issues that need to be tackled, the future of the field. Three health departments reflect on promising practices in urban women's health. CityMatCH Project Coordinator Mark Law, reassigned to duty in Iraq for the past full year relates his chronicle of transition and renewal for Iraqi families.

CityMatCH Board elections loom on the horizon with transitions in several regions (*see page eleven*) offering up opportunity for "new energy" on a platter. Find inspiration, challenge, and rejuvenation by participating in the Urban MCH Leadership Conference, with its bellwether themes of knowledge, action and influence.

A time of transition and renewal? Surely. A time for rebirth, with growth and new energy? Absolutely.

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Dayenu

Thoughts and Reflections from Magda Peck, ScD



Rituals are actions whose double helix of meaning and memory form the social DNA of our

very souls. Seamlessly we pass them on from generation to generation, bending and shaping until they're our own. Rituals of rebirth and renewal spring forth this time of year in variant forms of faith. For those of us who are among the oldest prisoners of hope, the rituals of Passover celebrate our Exodus from slavery a very long time ago. We gather in homes around the globe as we have done for centuries to tell the story the same way it always has been told, so that the story will always be told.

No Passover *seder* would be complete without song. Some of the tunes are melodies so ancient it seems our great-great grandparents are singing along. My favorite is the many-stanza *Dayenu*, which loosely means "It would have been enough!" It was my Dad's favorite too, and whenever I sing it, I almost can hear his deep voice chime in with mine. Singing praises for all the wondrous things which were done for us, *Dayenu* reminds us that any one of these miracles would of itself have been enough for us to give thanks. In other words, you don't need to get it

Carole Douglas -- Life, Well-Lived

CityMatCH lost a remarkable member of our extended family with the passing of Carole Douglas, RN, MPH, age 56, on March 18, 2004 in Lincoln, Nebraska. A memorial fund has been established in her name (see page ten).

Carole's life was a reflection of her passion and commitment to public health. At the time of her death, she was employed at the Lincoln/Lancaster County Health Department. Carole served January 1983 - March 2004 as division manager of the Community Health Services Division. She served as Interim health director from April December 1998, and April - July 2001. Carole was also involved with numerous community, state and national organizations, including Region VII Board Representative and former Chair of the Board of Directors of CityMatCH.

Last year, Carole shared news of her illness in the Winter/Spring 2003 edition of *CityLights*. Her measured words resonate (see box, below left), and crystallize our resolve to strive for the well-being of women, children and families in America's cities.

all to appreciate just what you get. You don't need perfection; doing some or most honorably and with good intention is, well, *enough*.

Only it isn't. It never is new enough, fast enough, big enough, important enough. And because it is never good enough, there is no celebration of what already is, no matter how stellar the work or how much the effort. Just how much a slave I am to "Not Enough" became painfully clear recently on the eve of another Spring when my friend and colleague, Carole Douglas, died.

When Carole was diagnosed with an unforgiving form of cancer a year ago, I pledged to be there for her throughout the workup and unending treatment at the University of Nebraska Medical Center. We developed weekly rituals - rendezvousing in radiology, hanging out in the Cancer Center, visiting with her folks in the

cafeteria. I didn't get down to their house in Lincoln much, and with my travel, sometimes could only check in from the road. I wanted my medical center to provide the best treatment for her, to miraculously kill the beast. She knew, her folks knew, we all knew that all hope must be tempered by the odds. It was a long, rough course with little quality, and suffering that is so unfair.

Carole told me plain and clear with her full smile

and radiant soul she was ready, that her faith assured the next life to be even better, that she'd had enough. She lived a life full of faith and family and service and laughter and meaning. In these hazy first weeks of sadness and loss, I've been unable to shake off this feeling of what more I should have, could have, ought to have done. It just wasn't enough.

But it was. As we sang *Dayenu* together at the Rabbi's *seder*, slightly off-key and full of gusto, it hit me. *Of course* it was. To doubt is to demean all those moments of musing together this past year - and all the years before - about her nephews and my boys and the future of CityMatCH. To hear only a distorted monologue of self-recrimination is to drown out the very real and hugely loving voices of her mother and father who have embraced me as family. Somewhere in the fourth refrain, I began to see the wondrous adolescent imperfection in Sam and David's faces and almost let go of my need for them always to be more. The possibilities of celebrating all that already is at home and at work were abundantly clear by the last verse when the whole world seemed to tilt just a few degrees toward the light.

Maybe as I edge over 50 this month and do the mandated work of Jubilee, I will truly free myself from the slavery of doubt and forgive myself - and those around me - for never doing what I think is enough. This is Carole's parting gift, for which I shall be eternally grateful, and for which I say: *Dayenu*.



"On March 21, 2003, I was diagnosed with a serious cancer of the liver. I am much more conscious of the opportunity of each day... Without recklessness, with strong information (data) and with firm resolve I challenge all of us to look to the opportunity of today.

For today, try doing something a new way or make a new relationship to make your city a little safer and healthier for your family, your neighbors, your coworkers and the mothers, children and families in your community. Spend today fully so that you anticipate the tomorrow waiting for you with the next sunrise," said Carole Douglas.

What We've Learned:

Advisory Group Panel Members

♦ Hani Atrash

Associate Director for Program Development
Centers for Disease Control and Prevention (CDC) National Center on Birth Defects & Developmental Disabilities

♦ Janice Daniels

Executive Director, Regional Perinatal Network
Gwinnet, Newton, Rockdale, Cobb & Douglas Counties
Georgia Department of Human Resources

♦ Yvonne Fry

Chief, Maternal-Child Health
National Center for Primary Care
Morehouse School of Medicine

♦ Richard Hopkins

Associate Director for Science
Division of Public Health Surveillance & Informatics
Epidemiology Program Office, CDC

♦ Alwin Peterson

Director, WIC Branch
Georgia Department of Human Resources

♦ William Sappenfield

Medical Epidemiologist & MCH EPI Team Leader
Division of Reproductive Health
CDC /National Center for Chronic Disease Prevention & Health Promotion

♦ James Buehler

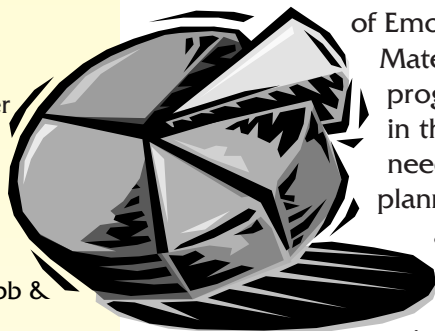
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Moderator:

♦ Karen N. Bell

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Reflections on Maternal and Child Health Epidemiology



In the fall of 2002, the Rollins School of Public Health of Emory University inaugurated a distance-based Maternal and Child Health (MCH) Epidemiology program that offers the opportunity for professionals in the public health community to obtain much-needed expertise in evidence-based program planning and evaluation. Students may obtain either a Masters in Public Health with emphasis in MCH Epidemiology or a Certificate in MCH Epidemiology (see page five for more information). This mission dovetails beautifully with the mission of CityMatCH, *"to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities."* To that end, efforts such as the CDC-sponsored CityMatCH DaTA Institutes (www.citymatch.org/DaTA/) and Emory's program, also sponsored by CDC, provide varying levels of training for public health workers and community colleagues to equip them to translate data into action that will make a measurable difference.

As part of the self-evaluation of its new MCH Epidemiology training program, Emory invited in August 2003 several members of its Advisory Group to participate in a panel discussion and reflect on their formative training experiences, the importance of acquiring certain skills, public health issues that need to be tackled, and the future of the field. CityMatCH is pleased to collaborate with Emory to share highlights from the discussion. A brief summary of their responses to a common set of questions follows, with quotations from selected panelists shown in italics.



How does one become an MCH Epidemiologist?

MCH epidemiologists enter the field through a variety of career pathways, including clinical medicine, disease surveillance, and specific programs like HIV/AIDS. Some spend their career working in one area and develop a tremendous depth of expertise about a particular subject. Others work in a mix of areas, in essence "cross-pollinating" the field by sharing tools and ideas among areas. Still others move in and out of epidemiology itself, for example, by working in

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other areas like clinical practice in community settings.

The CDC's Epidemic Intelligence Service still serves as the initial training experience for many epidemiologists who work in state and local health departments. Whatever the initial training, an early exposure to both field experience and grounding in epidemiologic methods is important. Learning from colleagues is essential; the best way for a young epidemiologist to learn is to go for the top and work with the best people. Certain key individuals can impart invaluable lessons even in brief encounters.

R. Hopkins: *When I was at the Ohio State University medical school and the Ohio Department of Health, in the late 1980s, and was first getting interested in MCH epidemiology, a mutual friend arranged for me to spend an hour with Brian McCarthy. In just that time, he oriented me to the enormous value of linked birth and death certificates, and of birthweight- and gestational-age-specific mortality rates, and to some of the pitfalls in using such data. One of the best hours I ever spent.*



What is the role of an MCH Epidemiologist?

Epidemiologists must undergo some behavioral modifications to be effective in their jobs. They need to start by accepting that they are both leaders and support staff in that they provide information to program and policy people to use in making their (informed) decisions. They are also expected to practice outreach to colleagues within their departments and in other departments. Modesty, humility, teamwork, and collaboration are essential attributes. These are social skills acquired through experience, not skills one can learn in school.

Epidemiologists are the glue that connects program, policy, and data workers; and they perform essential work in analysis of data that tells a story. They need to learn to work as members of teams, and to seek input from team members in formulating research questions.

J. Buehler: *Prior to assuming my position as Georgia's MCH epidemiologist, I had worked in HIV/AIDS surveil-*

lance at CDC. This involved collaborating . . . with state and local program managers, clinicians, and community advocates. . . because of the intense public and political attention given to HIV, epidemiologists working in HIV were pushed into the broader political arena in a way that was particularly intense.

Understanding the interplay among science, administrative and programmatic realities, the way health care is provided, politics, and the perspective of community representatives was essential to my ability to function effectively as a state MCH epidemiologist.



What skills and training do you value most in the work of MCH Epidemiologists?

Most MCH epidemiologists walk into their first assignments with basic medical and/or epidemiological skills. The most basic include analytic thinking, practical approaches to problem solving and public health, writing/presentation skills, and thinking big picture. In summary, being technically competent is essential, and those who have sophisticated epidemiologic skills are valued. Moreover, updating and advancing these skills is also as important as keeping up with the specialized knowledge in the specialty areas of public health. Thus, technical competence alone is insufficient, and it is essential to acquire the ability to translate the insights gained from epidemiology into

practical guidance.

J. Buehler: *One of the challenges in working with program managers is that they have the pesky habit of asking big questions that epidemiologists can't answer (e.g., what should we be doing to lower our preterm birth rate?). So, we need to help them ask us smaller questions that we can answer in the short term, in a way that gives them something immediately useful. This requires skills in listening and communicating in nontechnical terms.*



MCH epidemiologists must have the ability to define a question, design an analysis method to answer it, and present the result. This ability to design a parsimonious approach to answering a question and devise creative approaches to important questions can help program

Maternal and Child Health Epidemiology Certificate Program*

The Rollins School of Public Health at Emory University's MCH Epidemiology Certificate program is designed to train and certify professionals employed by state and local public health departments who have graduate training in the biomedical sciences and/or data analysis but who lack the specific knowledge and skills needed to plan and evaluate women's and children's health, reproductive health, and family planning programs. Students may complete the certificate in one year (three academic terms) by taking courses worth 18 credit hours via a combination of internet distance learning and two three-day weekends per term in residence at the Rollins School of Public Health. Students will participate in the orientation and instructional support offered by the [RSPH Career MPH Program](#), and their on-campus weekends will follow the same schedule as the career MPH students.

Interested mid-career employees who do not have the equivalent of a Masters in Public Health may want to apply to the Career MPH Program first, and select the MCH Epidemiology Option for their concentration. See: <http://www.sph.emory.edu/CMPH/options.html#MCH>.

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*Source: <http://www.sph.emory.edu/academic/MCHEPI/>

managers reformulate their goals and objectives. In addition, helping program managers to redefine the questions they ask is equally important, for it can lead to new uses of existing data (e.g., PRAMS and WIC) as well as measuring concrete program advances.

Greater attention must be paid to program evaluation, and MCH epidemiologists can contribute to the development of this capacity in state and local health departments. Clearly, program evaluation is a discipline in its own right, and epidemiologists should not presume that they have all the skills needed to do this well. In fact, practicing epidemiologists usually need further training in this area. However, epidemiology is a discipline that can support efforts to evaluate the effectiveness of programs. Epidemiology (and epidemiologists) should be integrated into program planning, management, and evaluation; organizational models that accomplish this should be identified and promoted.

Epidemiologists must understand the perspective of policymakers and the economic lens that shapes their sometimes skeptical responses to requests for more and better data as well as to demands for proposed interventions in response to documented public health problems. Career opportunities for the MCH epidemiologist exist in the public health system, if they can combine the science with the capacity to clearly see what is at stake in the eyes of the state and local policymakers and communities they serve.

A. Peterson: *The Epidemiologist must ask many questions. The most important questions are: “what are the issues?” and “why and to whom are they important?” The second most important questions are: “who are my constituents?” and “who are my adversaries?”*

Lastly, the epidemiologist must be aware of the economics of the proposed strategy for remediation. These are basic questions that are always asked by policymakers and legislators. The MCH epidemiologist has to understand the economics of the proposal as well. Although the economics do not necessarily have to be understood during the development of the hypothesis, economics must be considered for implementation.

Evidence-based interventions are increasingly emphasized in MCH program design and implementation. Epidemiologists must distinguish between what we know, what we don't know, and what we

wish we knew in designing studies.

Issues of the day influence MCH programs and the questions posed to epidemiologists. They must be able to frame these issues in ways that data can answer, and to select the best set of indicators to track problems or monitor progress. The work of MCH epidemiologists has to be grounded in issues to be appreciated by public health program and policy staff.

If you had a wish list of questions that you believe MCH Epidemiologists can productively tackle over the next 5 years, what would these be?

- ◆ **New uses for administrative data.** MCH epidemiologists need to learn to use administrative data, including hospital discharge data and especially claims data in the newly-standardized X-12 format, to supplement and illuminate findings from other kinds of data. They also need to document the limitations of such an approach.

H. Atrash: *The main question to me is: Are we doing the right things? I feel that the burden is on us to document that what we are doing as “right” has scientific basis and is supported by scientific evidence. Many of our current practices will be challenged because of cost cutting reasons but also because we have failed to prove they are needed. For example, a few years ago, postpartum length of hospital stay was challenged, we were unable to defend it, and the practice of keeping women in hospitals five or more days has been dramatically changed. I expect a similar fate to the 14 prenatal visits, circumcision, content of prenatal care, etc.*

- ◆ **Adoption of best clinical practices.**

If we know preconception care works and is needed, why is it not standard practice? Why do we have to wait until after pregnancy to start prenatal care when we know many interventions to improve pregnancy outcome will be more effective or only effective if implemented before pregnancy. MCH leaders and workers should not rest until they know why an infant or a mother died.

- ◆ **Early interventions.** Most of our current epidemiological work is based on vital statistics and “easily available” data.

The needs of the MCH population, however, are much more significant in the area of child health. We need more evaluation activities. For example, does early intervention make a difference? What components work? How can we empower families without compromising their and their children's welfare?

- ◆ **Non-traditional issues.** Our MCH bread-and-butter has been “vital statistics” analysis to look at prenatal care, low birth weight and preterm delivery. How about the leading cause of infant mortality and its causes and prevention -- birth defects?

What specific steps would you take to assure a brighter career future for MCH epidemiologists in state and local health departments and NGOs?

- ◆ **Better funding for MCH services in general** will allow program managers to invest in surveillance, epidemiologic analysis for program planning, program evaluation and other functions which are sometimes seen as competing for program dollars with direct services and program management. MCH program managers still need training in how to use epidemiologists well, and to recognize the need to focus on the whole population in a community. Epidemiologists can contribute importantly to program analysis, program evaluation, and program reporting, but their skills are not generally well-used if restricted to supporting these activities. Epidemiologists can help keep the focus, not just those who happen to obtain services from a public health agency.

- ◆ **Provide opportunities for MCH epidemiologists in training** to work with local programs.

For example, birth defects and developmental disabilities is an important area for MCH services (e.g., the HRSA-supported Children with Special Health Care Needs programs), and this has also been an area of intensive research for epidemiologists. But the link between epidemiology and practice has not been made for this dimension of MCH as it has in other areas like low birthweight, infant mortality, or teen pregnancy. With the long history and continued improvement of birth defects registries in this country

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Reflections on Maternal and Child Health Epidemiology

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and with the advent of similar registries for monitoring developmental disabilities, MCH epidemiologists should give greater attention to exploring how these and other data can be used to guide CSHCN programs.

- ◆ **Enhance communications skills.**

Of all the needed skills, communication arts, health economics and negotiations are particularly important. As a whole, the MCH epidemiologist is well versed in methods and statistical computation.

However, he/she needs to learn how to use these methods and statistical computations and communicate results and the methods in a manner that can and will be understood by public policymakers and decision-makers.

W. Sappenfield: One of the important lessons that I learned practicing early on is that it takes just as much time as an epidemiologist to effectively use the

results of an analysis or a report as it does to generate it. So many times I have seen high quality MCH analyses and reports sit on a shelf after being completed because we assumed as epidemiologists that our job was done. Epidemiologists need to work closely with policymakers, planners and program managers to assure effective translation of information into policy and program decisions. In fact, this is best done before the analysis or report is completed.

- ◆ **Apply broad epidemiological perspective to program improvements.**

Programs need to be examined within a broad context that includes access to services, education of the public about their value, and motivating people to use them. For example, interdisciplinary applied research on immunizations led to the use of many strategies to increase awareness of parents, making access to

services easier, and increasing availability from private physicians. MCH epidemiologists participated in this research and contributed to increased immunization rates.

* Summarized by: **Karen Bell**, Associate Director, Women's and Children's Center, Rollins School of Public Health, Emory University, Atlanta, Georgia. Edited by Maureen T. Fitzgerald, and Magda G. Peck, CityMatCH, December 2003.



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CDC Announces New Goals and Organizational Design

Centers for Disease Control and Prevention (CDC) Director Dr. Julie Gerberding recently announced new goals and integrated operations that will allow the federal public health agency to have greater impact on the health of people around the world. The announcement evolved from an ongoing strategic development process called the **Futures Initiative** which began a year ago at CDC and has included hundreds of employees, other agencies, organizations, and the public.

Dr. Gerberding announced that CDC will align its priorities and investments under two overarching health protection goals: **1)**

Preparedness: All people in all communities will be protected from infectious, environmental, and terrorists threats. **2) Health Promotion and Prevention of Disease, Injury and Disability:** All people will achieve their optimal lifespan with the best possible quality of health in every stage of life. In addition, the agency is developing more targeted goals to assure an improved impact on health at every stage of life including infants and toddlers, children, adolescents, adults, and older adults.

The integrated organization coordinates the agency's existing operational units into 4 coordinating centers to help the agency leverage its resources to be more nimble in responding to public health threats and emerging issues as well as chronic health conditions.

"For more than half a century this extraordinary agency with the greatest workforce in the world has accomplished so much for the health of people here and around the world," said CDC Director Dr. Julie Gerberding. *"However, today's world characterized by tremendous globalization, connectivity, and speed poses entirely new challenges. This... initiative will better position us to meet these challenges head on. Our aim is to help ensure that all people are protected in safe and healthy communities so they can achieve their full life expectancy."*

Dr. Gerberding and executive leaders throughout CDC will be moving forward to implement these changes by October 1, 2005, the start of the next fiscal year.

For additional information, please visit the CDC website at www.cdc.gov.

New Coordinating Centers and Their Directors

Coordinating Center for Infectious Diseases – includes the National Center for Infectious Diseases, the National Immunization Program, and the National Center for STD, TB, and HIV Prevention. Dr. Mitchell Cohen.

Coordinating Center for Health Promotion – includes the National Center for Chronic Disease Prevention and Health Promotion and the National Center for Birth Defects and Developmental Disabilities. Dr. Donna Stroup.

Coordinating Center for Environmental Health, Injury Prevention, and Occupational Health – includes the National Center for Environmental Health, the Agency for Toxic Substances and Disease Registry, the National Center for Injury Prevention and Control, and the National Institute for Occupational Safety and Health. Dr. Henry Falk.

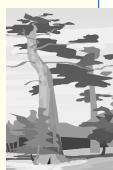
Coordinating Center for Health Information and Services – includes the National Center for Health Statistics, a new National Center for Health Marketing, and a new Center for Public Health Informatics. Dr. James Marks.

Office of Global Health – Dr. Stephen Blount.

Office of Terrorism Preparedness and Emergency Response – Dr. Charles Schable.

The CityMatCH commitment to urban women's health is clear. We are challenged to describe the unique characteristics of urban women health status, and charged to find ways to improve it. The CityMatCH Urban Women's Health Subcommittee is engaged in a number of activities to achieve this goal. For example, a second CityMatCH issue brief showcasing current resources in urban women's health is well underway. Proposed sessions for the upcoming CityMatCH Urban MCH Leadership Conference spotlight local health department practice in urban women's health, and a leadership forum will challenge current thought and action in urban women's health. A compendium of CityMatCH members' replicable promising practices on this topic is slated for late 2004 release. As a brief foretaste of this compendium, three CityMatCH member health department efforts to enhance urban women's health in their communities are highlighted below. Helene Kent, author of these highlights, is a public health consultant with twenty plus years of experience in maternal and child health. She has worked with women's health issues at the local community, state, and national level. Her report follows:

1. Contra Costa Health Services



Contra Costa Health Services (CCHS) in Martinez, CA, does remarkable work. In 1992, white women were much more likely to have breast cancer than black women, but black women were much more likely to die. By 2001, those statistics had changed for the better. The community achieved parity in breast cancer early detection rates between white and black women.

Contra Costa County spans nearly 800 square miles and is the second largest county in the San Francisco Bay area. Home to nearly one million people, its citizens ethnic demographics mirror those of the United States taken as a whole. The county has transitioned from a rural, agricultural nature to urban/suburban. CCHS operates a managed care plan, a regional medical center, twelve health centers, and many public health programs.

In 1992, CCHS identified breast cancer and the related disparity in health outcomes as a major priority for the department. Staff knew a likely reason for this poor outcome was a lack of early detection of breast cancer among black women. Staff also knew it would require protracted community-wide efforts using a multitude of strategies to make a difference.

Staff were committed to eliminating the disparity. Instead of going to the general public and telling them what needed to be done, staff showed up at meetings with data and asked the

community how to fix the problems. The community responded.

Under CCHS's leadership, the Costa Breast Cancer Partnership was initiated. A diverse coalition of nearly 400 breast cancer survivors, medical providers, health advocates, and community agencies, the Partnership used numerous innovative approaches to make a difference. Reaching out to underserved communities of African-American, Latinas, lesbian, and Asian/Pacific Islander women was a priority.

The Partnership resolved many obstacles: reducing tensions between local organizations; enabling women to address issues related to sexuality and modesty that kept them from getting breast health screenings; and helping community groups focus on improving women's health rather than single interests.

CCHC learned many important lessons. Health disparities are not inalterable facts of nature. They have identifiable causes, which with persistent community-wide efforts can be reduced or eliminated. Public health and government have roles to play in improving community health. By partnering with the community, people of all ethnicities will embrace and act on information that improves their health and that of their community.

Recently, new and more challenging obstacles have emerged. Project funding has been eliminated. This tenacious agency has not given up! They are regrouping and creating new ways to sustain their successes. They are addressing new challenges involved in keeping urban women healthy. Kim Cox, Manager of the Women's Health Partnership, says, "We are expanding our efforts to reduce other health disparities facing women with cancer. For the past 10 years we have addressed breast cancer and now we hope to reduce some of the disparities

From Data to Action: Promising Practices in Urban Women's Health

that exist in the early diagnosis and treatment of cervical, ovarian and uterine cancers as well. We know that we are ambitious, but in partnership with the community we hope to see a difference in at least five years."

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2. Wake County, North Carolina



Wake County North Carolina has not always considered women's health a priority, but the PPOR Coalition is working to change that! The Healthy Mothers, Healthy Babies Coalition, the Wake County Human Services (the departments of health, social services, and mental health), March of Dimes, local colleges, and sixteen other community partners decided that if you want healthy babies, you need healthy women.

Wake County, comprises Raleigh and several rural towns, has a population of nearly 700,000, making it the second most populous county in North Carolina. Approximately twenty percent of the community is African American and five percent are Hispanic/Latino. Wake County is rich with resources, yet continues to experience significant white and minority disparities and health care access issues.

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Promising Practices in Urban Women's Health

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Wake County PPOR partners and others began a community-wide women's health improvement process in January 2002. A onetime Women's Health Forum and an ongoing Women's Health Committee were convened. Health Forum participants were asked to identify the major women's health issues in their communities and strategies for health improvement. Five key concerns arose:

1. Increasing knowledge of health advocacy among grassroots community;
2. Increasing quality/quantity of childcare;
3. Addressing racism/discrimination within the delivery of care system;
4. Creating opportunities for women to support women; and
5. Increasing access to women's health services

As a result of this process, trained community volunteers are assigned to ten low-resource communities in the county, providing information, resources, and needed referrals to women any time assistance is needed, not only when they are pregnant.

The Coalition is also developing a women's health screening tool for health and social service settings. The tool screens for health behaviors including nutrition, exercise, smoking, substance use, and health risks including domestic violence and sexual risk behaviors. The tool will be used by a variety of service providers who can refer women to appropriate services.

Laura Oberkircher, the project coordinator, believes the success of the women's health planning process is because community members and agency personnel have been involved in all stages of the plan's development. Putting time, creativity, and effort into community engagement is worth the effort due to the positive results, including a community focus on women's health, an increase in community-based knowledge of women's health issues, and an increase in resources committed to women's health.


The March of Dimes, the North Carolina Department of Health and Human Services, the Healthy Mothers, Healthy Babies Coalition, the Wake County Health Department all contribute funding, and substantial in-kind donations are provided by multiple organizations. A halftime paid coordinator assists with this project and volunteers receive stipends. Project evaluation is underway.

For more information, please contact:

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Phone: (919) 838-1488
loberkircher@hmbnc.org

The Amarillo Department of Public Health in Texas took a road not typically taken as part of their CityMatCH Data Use Institute (DUI) project. The objective of improving birth outcomes through improving the overall health of women

3. Amarillo, Texas Dept of Public Health



was not unusual. The innovation was the focus on psychosocial stressors and characteristics of the environment that influence women's health.

Amarillo is located in the heart of the Texas panhandle. The Amarillo Department of Public Health provides the nearly 188,000 citizens of Potter and Randall counties with public health services. The community served by the health department is predominately White with 22 percent of the population Hispanic and six percent African-American.

Two issues drove the DUI team's health improvement approach: PPOR analysis indicated that maternal health/prematurity factors were the major contributors to local infant mortality rates. Instead of focusing exclusively on high-risk pregnancies, the team decided to target a larger population of low and moderate risk women of childbearing age. The team believed a broad-based social marketing campaign would have greater impact over time. Second, local public health programs including public clinics and WIC were using limited resources to deliver personal health services instead of community based-services. Partnering with community agencies was essential to reshape the social environment and reduce public health department provision of personal health services.

In 2002, the Amarillo Health Department contracted for a Behavioral Risk Factor Surveillance Survey (BRFSS) of the two county service area. The Texas Tech

Health Sciences Center analyzed the data to identify risk factors for poor self-rated health among women of childbearing age. The analysis indicated that smoking, obesity, unsafe neighborhoods, and social isolation increased the risk for poor self-rated health among women of childbearing age. Social isolation was considered the most important factor. Age, race, ethnicity, and education levels were not independently related to poor health.

The findings suggest that MCH programs targeted on the basis of age, race, or ethnicity, might be less effective than those targeting social isolation and unsafe neighborhoods. Community partners will use the BRFSS results to develop activities focused on empowering urban women to maintain and improve their health. The survey results will also enable the PPOR team to better target policy changes.

The Amarillo DUI was a collaborative effort between the Amarillo Department of Public Health and Texas Tech University Health Science Center. According to Anne Denison at the Amarillo Health Department, "One of the most exciting aspects of the project was the exchange of ideas and philosophy that evolved through the course of our DUI year." Jim Rohrer, Professor at the Texas Tech Medical Center, believes that a progressive approach to public health can be used that does not involve great expense. "It is important to focus on policy changes that address the physical and social environment. It does not require as much money as you think, however, it does require political will, which can be a difficult problem." He advises other agencies who want to develop a similar project to "think 'outside the box' of personal health services. Change the environment, so that more women will choose to be healthy. Don't be trapped into 'blaming the victim' for unhealthy behaviors that are reinforced by unhealthy environments.

For more information, please contact:

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anne.denison@ci.amarillo.tx.us

Carole Douglas Memorial Fund



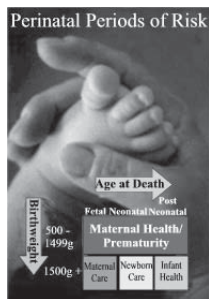
Former
CityMatCH Chair,
Carole Douglas,
Lincoln, Nebraska,
lost her battle against
cancer on March 18,
2004. In honor of

the life she led and her
commitment to those she served, a
memorial fund has been established
to support individuals who could
not attend the Annual CityMatCH
Urban MCH Conference without
financial assistance.

If you would like to make a
contribution to the **Carole Douglas
Memorial Fund**, please make your
check payable to: UNMC
Department of Pediatrics, Federal ID
#47-0491233

Please mail your check to:
CityMatCH
Department of Pediatrics/Carole
Douglas Memorial Fund
University Nebraska Medical Center
982170 Nebraska Medical Center
Omaha, NE 68198-2170

*** In addition to contributions,
memorial pins will be available for
purchase during the Conference.
Proceeds will support the Memorial
Fund. ***



Advancing the Practice: Perinatal Periods of Risk Approach (PPOR)

In 2000, CityMatCH launched the National Perinatal
Periods of Risk Practice Collaborative to generate effective,
evidence-based PPOR practice in U.S. cities to improve the
health of women and infants.

The objectives achieved through the Collaborative
included: 1) development of this approach as a community
tool to improve the health of women and infants; 2)

description and encouragement of best practices in PPOR use; 3) development of
easy-to-use materials and services to support communities interested in using
PPOR; and 4) assurance of the strategic linkage of this approach with related
efforts such as FIMR and Healthy Start.

CityMatCH, in coordination with National partners including the March of
Dimes, CDC, MCHB/HRSA, ASIP, NHSA, and many others continue to advance
the dissemination, utilization and integration of the PPOR approach through
three distinct levels of activities providing increasing intensity.

As of May, 2004, CityMatCH has provided Level 1 and Level 2 PPOR training
to teams which include 47 urban communities from 32 states, including 21
Healthy Start sites. 12 of the original cities have continued to advance the PPOR
practice and expanded their commitment as participants in the **Level 3** PPOR
Practice *Advancement* Collaborative (PPOR-PAC.)

Upcoming Opportunities:

PPOR & FIMR... Working Together to Prevent Infant mortality
NFIMR Conference: August 13, 2004, Washington, DC

www.acog.org/goto/nfimir

PPOR "How to Do" Workshop...
CityMatCH Urban MCH Leadership Conference:

September 11-14, 2004

PPOR Workshop 14-15 (2:00-5:30 & 8:00-12:00)

For more information, visit the CityMatCH website at www.citymatch.org or
contact Amy L. Johnson, Project Coordinator, (402) 561-7500 or via e-mail at
aljohnson@umnc.edu.

CityMatCH Announces

REQUEST FOR APPLICATIONS -

The 2004-2005 CityMatCH Urban MCH DaTA Institute

Join CityMatCH and participate in the enhanced and revised **DaTA**
Institute. Come together as a team to learn leadership and data
use skills around scientific thinking, data methods, planning,
evaluation, political strategy and more. Skills will be
applied to a project of importance in your community
throughout the year.

DaTA Institute

Data To Action for Effective MCH Leadership

Don't miss this opportunity! Apply for your team today.

- Applications for the 2004-2005 **DaTA** Institute are available on-line beginning **May 24, 2004**.
- **Applications are due June 18, 2004.**
- We will kick off the new **DaTA** Institute on September 11, 2004 at the **CityMatCH Annual Urban MCH Leadership Conference: Expedition 2004: Exploring the Boundaries of Urban MCH**, in Portland, Oregon.

For more information, visit the CityMatCH website at www.citymatch.org or contact Kathleen Kock, Project Coordinator,
(402) 561-7500 or via E-mail at kkockt@unmc.edu.



Iraq Transitions: A Chance to Rewrite History

Mark Law, CityMatCH Project Coordinator and Sergeant, South Dakota Army Reserves, Unit 1742 called to duty in Iraq.

How do I describe ten months in Iraq and Kuwait? Summer temperatures stretching the limits of the thermometers, 140 degrees Fahrenheit in the shade. Cool winter temperature, pouring rain, and mud. Wind, sand, and dust. Children, as young as infants, in their mother's arms, next to a dusty road waiting for the convoys to throw out food and water. No shoes on the hot asphalt and sand of the summer months. No coats during the cool, rainy winter months. Most wave and give us the "thumbs-up," with wonderment and smiles on their faces.

I've experienced the adventure of a lifetime. We arrived in the Middle East in June, 2003. I live and work inside the Sunni triangle: Iraq. Almost everything I've experienced has been framed from the window of a truck.

The Iraqi people see and do things in a way hard for my western mind to comprehend. Many have seen two wars and widespread shortages over the last dozen or so years. Women, children, and general healthcare has been neglected. I've driven over 20,000 miles and I've only seen one local medical clinic. Terrorists use the new ambulances as weapons, loading them with explosives targeting other Iraqi's or coalition forces. Army medics talk about the lines of people waiting for medical care they provide

to the Iraqi public, amazed at the line's length and the Iraqi people's determination to receive care reflected by waiting in line for hours.

Iraqi citizens relate stories of abuse at the hands of Saddaam, his sons, and "advisors." One Iraqi truck driver told a story of how Saddam's sons would get drunk and shoot into crowds, killing many, including the truck driver's uncle. Another story, told by a crane operator, explained how a general in the army killed his brother when this brother refused to continue to fight during the 1990 Desert Storm conflict. This gentleman ran away to the Kurdish controlled territories of the north and had not returned home until after the 2003 invasion.

Many units around Iraq have adopted schools to renovate and improve. The school which our unit adopted had not been updated since 1956, and students had been learning in a facility lacking water, electricity and heat. The U.S. Army dedicated money recovered directly from Saddam Hussein, millions of dollars, creating a fund to pay for these renovations. Local Iraqi contractors were hired to do the work, thereby providing jobs and bolstering the local



economy. Our job was to pay weekly visits to the school and assure the work was being done. On a personal level, our families took it upon themselves to procure and send needed items for the school, such as sports equipment and school supplies. Before we knew it, several organizations had adopted our project and in the end, we were able to deliver more than 160 boxes of supplies to our adopted school.

Change takes time. Power has been restored to much of the country, but the aging and outdated facilities cannot produce enough power for everyone. Water purification, trash and police services continue to be upgraded. Iraq is leading the charge to clean up war debris and rebuild buildings and the social structure.

We hope to hand the keys to the future to the Iraqi children. We give them a chance to rewrite history.

Emerging Issues in MCH Audio Conferences Upcoming Call Topics

This series of national audioconferences on areas not necessarily in the traditional "realm" of MCH is the result of collaboration between CityMatCH and the National Association of County and City Health Officials (NACCHO).

On-line registration is available on the CityMatCH website at www.citymatch.org or the NACCHO website at www.naccho.org. Registration opens one week prior to each call.

Archived presentations including audio recordings, Powerpoint presentations and resources are housed on the CityMatCH website. For more information or to participate on the calls, contact: Maureen Fitzgerald, phone (402)561-7500 or e-mail at mfitzger@unmc.edu.

- | | |
|---------------------|--|
| August 19 | Impact of Mother's Healthy Weight on Birth Outcomes |
| September 16 | Immunizations |
| October 21 | Preventing Transmission of Perinatal HIV/AIDS |
| November 18 | Newborn Screening |
| December 16 | Teen Pregnancy |
| January 20 | MCH and Social Justice |
| February 17 | Diabetes Disparate Impact on Minority Populations |
| March 17 | Tobacco/Substance Abuse |

Clip-N-Save



Leading the Way! CityMatCH Board Elections Set for June

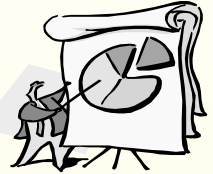
Elections for the CityMatCH 2004-2005 Board of Directors are taking place this spring! This year's round of elections brings great opportunity for current and emerging leaders in urban MCH with an unprecedented number of regions up for election. Expect some new faces among our organization's top leadership!

Regions II, IV, VII and VIII, along with two At-Large positions, will be competed by popular vote this June. Additionally, one vacancy on the CityMatCH Board Nominating Committee will be on this year's ballot. Candidate nominations are due to CityMatCH no later than May 7, 2004. Voting will take place throughout June. Results will be announced in mid to late-summer 2004.

Special thanks to all of our current Board members for their services and visionary leadership! For additional information, contact CityMatCH at (402) 561-7500.

Calling All Members... CityMatCH Membership Assessment

By now, all CityMatCH member health departments should have received an e-mail from Acting Executive Director, Patrick Simpson, asking you to complete the CityMatCH 2004 Membership Assessment.



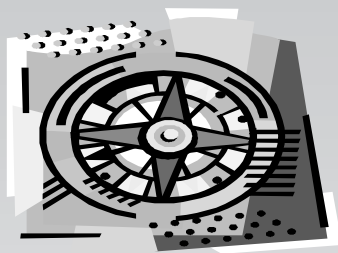
This information is critical for the success and future of our organization. Your responses enable us to provide targeted leadership training, technical assistance and collaborative learning opportunities that lead to more effective urban MCH practice in U.S. cities and urban counties.

We need your help! Please take the time to go to the CityMatCH website (www.citymatch.org) and complete the assessment. Once your assessment has been completed, you will automatically receive \$50.00 off conference registration (see page twelve for general conference information). But even if you can't make it to conference this year, please log on and help us represent and build urban MCH capacity nation wide.

For additional information, contact Chad Abresch, Project Coordinator, CityMatCH, (402) 561-7500, or E-mail: cabresch@unmc.edu



CityMatCH



Announcing: The CityMatCH Annual Membership Meeting

Expedition 2004: Exploring the Boundaries of Urban MCH taking place in Portland, OR, will be the site of our next Membership Meeting on Saturday, September 11, 2004, from 4:00 to 5:00 p.m. local time. The agenda is already filling up with several important organizational priorities and should prove to be fruitful time for our organization.

This year's Membership Meeting will take place immediately following the all-day CityMatCH Leadership Encounter. This leadership training opportunity has been designed to advance the knowledge and practice of our membership around critical leadership skills for effective urban MCH practice. We strongly encourage you to take advantage of the Leadership Encounter and contribute to the future of the organization through your representation at the Membership Meeting to follow. See you in Portland this fall!

"The challenges of change are always hard. It is important that we begin to unpack those challenges that confront this nation and realize that we each have a role that requires us to change and become more responsible for shaping our own future."

— Hillary Rodham Clinton



CityMatCH Annual Urban Maternal and Child Health Leadership Conference

EXPEDITION 2004:

Exploring the Boundaries



of Urban MCH

Portland, OR
September 11-14

We invite your participation in the CityMatCH Annual Urban Maternal and Child Health Conference, **Expedition 2004: Exploring the Boundaries of Urban MCH**. What a wonderful opportunity to be inspired, challenged and rejuvenated! We will come together to grow, learn, exchange ideas and build relationships.

Empowering communities through knowledge, action and influence is what **Expedition 2004** is all about. Learn new and creative ways to address the constantly shifting challenges in MCH. In 2004, we will offer an additional day of pre-training for public health leaders. An exceptional array of exciting and challenging experts will offer in-depth preparation on critical leadership issues. Stimulating action breakouts, dynamic skills-building sessions and workshops will provide cutting-edge information for implementing change in your community.

Take the next step toward undoing racism and eliminating social disparities. Find out how to ask questions that result in a process that strengthens your organization's ability to realize its full potential. Come and learn about community-based participatory research, childhood nutrition, building relationships with foundations and funders and how faith can positively impact health. Join us as we explore the boundaries of urban MCH.

All you heroes of public health; this conference is for you! Don't let budget cuts, travel restrictions or the many obstacles you may be facing stop you. Contact the CityMatCH office or visit the website at www.citymatch.org to discover creative ways for reducing costs. Join our expedition and be refreshed and renewed.

See you in September at the **Hilton Portland and Executive Tower**, downtown and close to the water in beautiful, breathtaking Portland!

CityLights is supported in part by Grant # U93 MC 00120-11 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services



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