Urban MCH: New Challenges, Changing Boundaries

Editors Note: This edition of CityLights focuses on issues in maternal and child health (MCH) that transcend the traditional boundaries of reproductive health. CityMatCH responds with key information and strategies for these disproportionately urban problems, emphasizing effective data use in the translation of research to practice and data to action.

E-mail Roundtable

▲ Wendy Chavkin, MD, MPH, Professor in the School of Public Health, Columbia University; New York, New York, is an expert in women's and reproductive health.

▲ Maxine Hayes, MD, MPH, Assistant Secretary, Community and Family Health, Washington State Department of Health, and is the immediate past president of AMCHP.

▲ Lorraine Klerman, DrPH, Professor and policy expert, is with the Department of MCH, School of Public Health, University of Alabama, Birmingham.

▲ Lillian Shirley, RN, MPH, MPA, recently became the Health Department Director of the Multnomah County Health Department, Portland, Oregon.

▲ Carolyn Slack, RN, MS, long-time CityMatCH leader, is Director of Planning and Community Partnerships, in the Columbus, Ohio Health Department.

Experts Call for Broad Definition of MCH

CityMatCH recently queried several prominent Maternal and Child Health experts (listed at left) via E-mail for their perspectives about the Urban MCH landscape. A synthesis of these virtual conversations appears below with excerpts on page three.

CityMatCH asked these national leaders what "MCH" meant to them, particularly when thinking of "MCH" in local health departments serving major U.S. cities. A very fluid definition for maternal and child health appears to be functioning in public health. As Columbus Health Department's Carolyn Slack put it, "I think of children, their families and their communities. Anything that affects the children and families, I need to think about. Whatever is going on with the child and family may affect their physical, mental, social or spiritual well-being, that is, their health." Her larger view was echoed by national policy expert Lorraine Klerman, who defines MCH as, "Any issue that impacts the well-being of women of reproductive age, infants, children, and adolescents. I would even extend that to young families."

A broadening range of issues seems to fall under the rubric of "MCH" in urban communities. Within the construct of historically categorical funding, MCH leaders are finding new ways to paint with a broad brush to better the health of children and families.

Q. Which preventable health problems are part of "MCH" in urban communities?

A. "Preventable health problems that are part of urban MCH include:

▲ alcohol and substance abuse  ▲ domestic violence
▲ child abuse and neglect  ▲ tobacco use
▲ HIV/Perinatal transmission of HIV  ▲ STDs
▲ unintended pregnancy  ▲ childhood asthma
▲ hunger  ▲ infant mortality
▲ racial disparities in health status  ▲ access to health care
▲ oral health disease  ▲ child deaths
▲ teen pregnancy  ▲ injury prevention
▲ vaccine preventable diseases
▲ lack of identification, treatment, coordination for children with special health care needs and their families

...and there are probably many more." -- Maxine Hayes
MCH Meaning
Magda Peck, ScD
CEO, Executive Director of CityMatCH

Reunions with my sons after nights gone for work follow predictable rituals. For David the Younger, it is a flying leap across the room into my arms. He has learned from past near misses to first give the sign before he leaps: two claps and a ”ready?” With my nod, he charges like a vault. Sam the Elder is more hesitant. Holding back until I become real, he’ll rub his cheek against mine, to assure himself that I am fully returned. Often he will linger for a while in my shadow, unwilling to let me out of his sight or touch.

These rituals played out the last four nights of Hanukkah. I had never missed the lighting of a single candle over the years, and I felt like a skunk to miss the lighting of a single candle on the fourth night of Hanukkah. I had never before spoken up. These rituals had meant so much to me, and I felt like a skunk to miss them.

I walked in just after ten on the eighth and final night to telltale signs of Hanukkah past. Melted wax covered the side table, and the smell of burnt offering still hung in the air. Both boys were in bed, sort of, having fought sleep waiting up. In lieu of a leap and a rub, we settled for something else: the promise of an extra night of Hanukkah. Whoever said Hanukkah could only be eight nights? Wouldn’t it have been an even greater miracle if the oil had lasted yet another eve? I said: “Give us a ninth night!”

At sundown we set up our menorahs, 27 flames all lit at once, each with nine candles. We turned off all the lights and watched the last lights of the season flicker and dance. One by one, the candles gave up the ghost with a wisp of smoke. David’s hug was brief, “bye Mom,” and he was out of there. But sweet Sam lingered at my side, lost in the darkness. Sam has taught me to wait for him to speak his heart. In the darkness, he finally spoke, his voice barely a whisper. “Thanks, Mom.” I listened longer. “I love you, Mom.” I returned his embrace.

The next morning I woke with angst: was I allowed to change a ritual passed down through generations? Who has the authority to shape practice? No bolts of lightning, no voice on high. And then it was clear: I do. It is my duty to create sacred time for a stronger family. I have the power to stretch the boundaries of ritual to let an extra night of lights bring back its meaning. Ritual without meaning becomes simply habit.

Now more than ten years old, CityMatCH has developed its own rituals and ways of doing our business, within the traditional boundaries of “MCH.” As the founding leader of this still young organization, I challenge us to take a hard look at our shared accountability for the health of the women, children and families who live in America’s cities. Before we fall into habit, we must stretch traditional MCH boundaries to include childhood asthma, perinatal HIV/AIDS, and other conditions often compartmentalized elsewhere in our health departments, beyond our usual knowledge or concern.

It is time to embrace a broader meaning of “maternal and child health,” for a change.

CDC Salutes MCH Leaders for Building Data Capacity

At its annual Maternal, Infant and Child Health Epidemiology Workshop in Atlanta on December 8th, the Centers for Disease Control and Prevention (CDC) presented local, state and national awards for building MCH data capacity levels.

Dr. Larry Sands, Director of Community Health Services, and Dr. Sarah Santana, Director of Epidemiology and Data Services, were recognized for leading Maricopa County Department of Public Health’s efforts to significantly strengthen departmental data capacity in addressing health issues facing women, children and families.

This has been a critical component in redirecting the department’s energies and resources toward providing essential public health services: monitoring health, investigating problems, educating and mobilizing the community and evaluating public health.

Dr. Magda Peck, CityMatCH founder and CEO, was recognized for her vision to provide a forum to increase communication and collaboration among urban health departments for the purpose of improving the planning, delivery and evaluation of services for women, children and families locally and nationally.

Dr. Rugmini Shah, Chief, MCH Branch for the California Department of Health Services, was recognized as a pioneer in developing epidemiologic capacity at the state and local levels through close partnerships with local health departments, academia and the private sector.

Dr. Hani Atrash, Chief, Prenatal and Infant Health Branch at CDC, was given a meritorious award for developing capacity at all three levels, and Dr. Roger Rochat, from CDC, was given a lifetime achievement award for his many contributions.

CityMatCH and its partners were among these first award recipients, and CityMatCH has been invited to participate in a committee which will define the future of these awards.

11th Annual CityMatCH Urban MCH Leadership Conference
September 12-16, 2000
Westminster, Colorado
in the Denver Metropolitan Area
Five Shifts in Urban MCH: National Experts Respond

1. Local health departments serving America’s larger cities may no longer be the sole or leading provider of public health services to women, infants, children and adolescents as other entities enter the prevention arena and/or are significant safety net providers.

   “Local health jurisdictions (LHJs) have always shared maternal and child health-related public health services with other community partners. At LHJ core health function roles have increased and local revenues have decreased, we may see a trend toward even more MCH services provided by community partners.” -- Maxine Hayes, MD, MPH, Washington State Department of Health

   “We have observed increased interest and involvement in traditional public health services and prevention efforts by other entities. There is no way governmental public health can, or even should, be the sole or leading provider of all prevention/safety net services. It always takes more time and effort to get something done collaboratively; the payoff usually is a better result. Public health has a specific role in convening and facilitating these partnerships.” -- Carolyn Slack, RN, MS, Columbus, OH, Health Department

2. Local health departments increasingly are shifting from categorical MCH programs and services to more integrated, cross-cutting approaches that target the population of women, children and families in their urban jurisdictions.

   “The family unit as a way to structure interventions is seen as a more viable unit to make substantive behavior changes and reach populations at risk for abuse, neglect and educational deficits.” -- Lillian Shirley, RN, MPH, Multnomah County, OR Health Department

   “I think local health departments are working to make programs and services more integrated in spite of categorical funding streams and program specific requirements. We cannot shift away from our categorical funding streams; we can only work to adapt them to benefit the families we serve. A lot of our work is spent juggling the budgets, justifications and narratives so that they not only meet categorical requirements but also make sense for families.” -- Carolyn Slack

3. Health issues not traditionally in the realm of maternal and child health - such as asthma, HIV/AIDS, and persistent STD's - have a significant impact on the population of women, children, and adolescents.

   “I would also include environmental issues such as lead.” -- Lillian Shirley

   “If being in the “realm of MCH” refers to the fact that the categorical funding streams for these issues and programs often did not flow to the MCH unit, yes. I would hope that these issues have been and are on the radar scope of public health professionals concerned with our city’s population of women, children and adolescents.” -- Carolyn Slack

4. Urban health departments’ efforts in MCH and related areas - such as environmental health, immunizations, communicable diseases, and HIV/AIDS - are often fragmented and poorly integrated.

   “This is due to how public health is traditionally categorized, by profession and by funding” -- Lillian Shirley

   “I don’t think the problem is fragmentation or integration, but rather that they do not think these are in their scope of work (they are!) or if they do, they have turf problems with the agencies currently involved in these issues.” -- Lorraine Klerman, DrPH, School of Public Health, University of Alabama, Birmingham.

   “Staffs and program managers are stretched incredibly thin. While improved internal communications and partnerships may better serve families and staff, the up front investment of the time and energy to create these benefits seems overwhelming.” -- Carolyn Slack

5. Urban public health leaders accountable for the health and well-being of the women, children and adolescents in their jurisdictions need to know more about emerging MCH-related issues - including urban asthma, congenital syphilis, and perinatal HIV.

   “And loss of health insurance and safety net providers, local restrictions to access to reproductive health services and education.” -- Wendy Chavkin, MD, MPH, Columbia University, New York, NY

   “For emerging issues in general, agreed. The issues referenced in this statement have been around for quite awhile. A particular challenge is access to data that will help us identify the issues earlier and also be able to track incidence, prevalence and trend changes. Our data needs may lead us to new partners both within and outside the public health system.” -- Carolyn Slack

(continued from page one)

This broadening range of issues is creating changes in the urban MCH landscape, however, some aspects remain the same: the local health department continues to be an important leader of community-wide efforts to better the health of children and families.

Local urban health departments fulfill categorically defined functions, as well as provide needed help to community groups, and offer science-based, data-driven partnerships to help communities achieve health-related goals.

Creating cross-cutting solutions to make best use of categorical funding is a recurring strategy in urban public health. Emerging issues do not fit neatly into categorical boxes, so the challenge becomes weaving together these funding sources to make successful programs that can make a difference.

Increasing public health attention is being focused on issues not on the historical pathways of maternal and child health. Local health departments recognize that these issues impact urban children and families each day.

There is a strong sense that public health leaders are doing the best they can with the mechanisms that presently exist.

The five nationally recognized public health leaders who participated in these virtual conversations have a pulse on local, contemporary urban maternal and child health. Their thoughtful responses provide additional grist for the mill as policy decisions are made in the heart of our cities each day.
The number of children in cities born with HIV continues to be far above what is potentially achievable.

Cities Face Disproportionate Burden in Perinatal HIV/AIDS

The number of perinatally-acquired AIDS cases in the United States has decreased nearly 70% since the 1994 introduction of Zidovudine (ZDV) for use among HIV-positive pregnant women and their newborns. This is an incredible milestone, but still too many women deliver babies with HIV. Women in metropolitan areas are disproportionately affected by perinatal HIV transmission: 85% of pediatric AIDS cases are in the 100 largest metropolitan areas and 73% are in 29 of the larger metropolitan areas. Current cases of perinatal HIV transmission are concentrated in specific geographic areas and among specific population groups, with the greatest concentrations in urban communities.

Health departments can play a vital role in helping eliminate perinatal HIV transmission. The strategies listed in the box at right are among key steps that several health departments have already taken. There have been great strides in reducing perinatal transmission of HIV; however, there is still more work to be done. Preventing perinatal HIV transmission in our country needs to be a priority. With the help of city and county health departments, along with other health officials at all levels, we can continue to decrease the percentages of babies born with HIV.

Strategies for Local Health Departments

City and county health departments whose jurisdictions include the larger cities where perinatal and pediatric AIDS are concentrated can and must play a greater role in the prevention of perinatal HIV transmission. Consider the following strategies health departments can take in helping to prevent perinatal HIV transmission:

- Strengthen partnerships among people who work in substance abuse, maternal and child health and HIV.
- Strengthen partnerships between urban health departments and community-based organizations.
- Promote communication and collaborative learning within and across urban and state health departments.
- Ensure access to and adequate services for prenatal care.
- Provide quality training for providers on prevention of perinatal HIV.
- Prevent perinatal HIV/AIDS by providing sufficient education and awareness. For example, equip each provider within the state with a guide to routine HIV testing and counseling during prenatal care.
- Maintain current HIV/AIDS surveillance information and comprehensive reports on perinatal HIV transmission.

CityMatCH Announces Three-Year Partnership with CDC to Address Perinatal HIV/AIDS

CityMatCH is one of five national organizations recently funded by CDC to address perinatal HIV transmission. The three-year CDC-CityMatCH partnership focuses on promoting the translation of research and data into effective practice in urban communities with the highest rates of perinatal HIV.

Project Goals. This project has two goals: (1) to identify more effective approaches to the assessment and prevention of perinatal HIV transmission through facilitated learning across the urban communities most greatly affected; and (2) to inform and engage urban public health agencies and their leaders in the prevention of perinatal transmission of HIV/AIDS. This initiative also will build and strengthen community-based capacity to generate and use data strategically for more effective local programs and policies. To reach these goals, two key strategies will be used: Multicity “Learning Clusters.” Based on the success of earlier collaborative work in reproductive health between CDC and CityMatCH, learning clusters enable the translation of research into practice through strategic interchange between scientists and other content experts and practitioners in communities. The perinatal HIV learning clusters will include a mix of urban community teams, HIV and Maternal and Child Health (MCH) experts, and CityMatCH staff for team-based learning and problem solving in the area of perinatal HIV transmission. Up to five cities may be included in each of two multicity learning clusters. The selection process targets 26 cities that are both CityMatCH members and have the highest prevalence of perinatal HIV infection, according to CDC.

Targeted Information Dissemination. This second strategy targets local health departments and their leaders with timely information about perinatal HIV prevention, including updates on basic and clinical scientific research; findings regarding HIV surveillance, assessment, and prevention from the public health and epidemiologic literature; and practical lessons learned as determined in our multicity learning clusters. Information will be disseminated via proven CityMatCH communication mechanisms: our quarterly newsletter CityLights, the CityMatCH Annual Urban Leadership Conferences, Members FAX alerts, electronic NewsBriefs, and our website: www.citymatch.org

Contact Information. For more information, contact Deanna Bartee, Perinatal HIV Project Coordinator, at (402) 595-1700 or dbartee@unmc.edu
DUI Teams Hone in on Perinatal HIV/AIDS

With special funding from CDC, CityMatCH offered a unique opportunity to focus on preventing perinatal transmission of HIV as part of the third CityMatCH-CDC Urban Maternal and Child Health (MCH) Data Use Institute (DUI).

CityMatCH has accepted two HIV cities, Houston and New York City, to join the 1999-2000 Institute. The following project descriptions provide the framework for each city’s plans and demonstrates exceptional capacity to develop, implement, evaluate and learn effective ways to reduce perinatal transmission.

**Houston, Texas:** Three offices within the Houston Department of Health and Human Services (HDHHS) will form the “Core Team” collaborating on this project: the Bureau of HIV/STD Prevention, the Bureau of Epidemiology, and the Bureau of Family Health Services. The Texas Gulf Coast Chapter of March of Dimes, also based in Houston, will act as an auxiliary team member and consultant in advocacy and policy development issues. Each office has an expressed interest in the surveillance of HIV infection among children and women of child-bearing age.

It is the intention of the core team to pursue the following goals to bridge the information gap during the first year of the program to:

1. Electronically integrate existing data maintained by the three programs in such a manner that the scope and purpose of this project are supported.
2. Analyze the existing data epidemiologically and to identify pockets of need.

**New York, New York:** The New York City Department of Health (Bureaus of HIV Prevention and Maternity Services and Family Planning), is collaborating with the New York State Office of Alcoholism and Substance Abuse Services, the March of Dimes, the New York State Department of Health (AIDS Institute, Bureaus of Women’s Health and Local Health). The health department plans to enhance its existing perinatal transmission prevention program and to overcome barriers to services needed to reduce perinatal transmission by: (1) designing a comprehensive model for reaching pregnant women who are not in prenatal care and are at high risk for HIV infection; (2) developing an expanded HIV curriculum for Perinatal, HIV and Substance Abuse outreach workers; and (3) educating physicians through hospital obstetrical departments.

These areas in New York City have been already identified for this targeted intervention for this year, and an additional two to three high-risk communities have also been identified for targeted intervention in the following year. The goal of the New York City Department of Health’s Data Use Institute project is to continue to refine the data collection for the identified communities by geo-mapping HIV/AIDS surveillance data and vital statistics records. Through qualitative methods of interviews and focus groups, the team will identify barriers and fears that keep high-risk pregnant women from obtaining prenatal care. The data will be used to define where to focus program activities and how to formulate provider education training modules and information for dissemination and presentation. The team will also integrate the new outreach curriculum into the New York City Department of Health, HIV Training Institute.

**CityResources**

Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States. Published by the Institute of Medicine and the National Research Council, this report provides recommendations for reducing the rate of perinatal HIV transmission. This report is available by calling 1-800-624-6242, or by visiting on-line at <www.nap.edu>.

Position Paper on HIV Counseling and Testing for Pregnant Women. This is a position paper released by the Association of Maternal and Child Health Programs (AMCHP). AMCHP’s position on HIV counseling and testing for pregnant women has been revised in light of new treatments, practice guideline changes, and recent recommendations from the Institute of Medicine. AMCHP recommends that states and health care providers work towards the goal of universal HIV testing for pregnant women after obtaining informed consent. This is available by calling (202) 775-0436.

The HIV/AIDS Surveillance Report. This report contains tabular and graphic information about U.S. AIDS and HIV case reports, including data by states, metropolitan statistical areas, and mode of exposure to HIV. It is published semiannually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC). The report is available on-line at <http://www.cdc.gov/nchstp/hiv_aids/stats/hasrlink.htm>.

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Asthma is on the rise in our nation, and the disease is disproportionately more severe among African Americans living in urban inner cities. CDC statistics bear out the grave news. Blacks have consistently higher rates for asthma-related emergency room visits and hospitalizations than whites. The mortality rate for blacks of all ages between 1993-1995 was 38.5 per 1,000,000 compared with 15.1 per 1,000,000 for whites, and black children up to four years of age are six times more likely to die from asthma than white children of the same age.

Because inner cities are inhabited by a disproportionate number of poor nonwhites, the demographics cloud the research as to whether race/ethnicity or socioeconomic status is the higher risk factor for asthma. Whatever the cause, the result is the same – pockets of extremely high rates of asthma in the poorest areas of urban neighborhoods. Reduced access to proper health care, substandard housing, low infant birthweight, and air pollution also play a role. Exposure to environmental triggers such as cockroaches, tobacco smoke, and mold can make asthma much worse. To minimize both the underlying conditions and the symptoms of an impending asthma attack, a person with asthma must consistently use medication exactly as prescribed. However, because of challenging living conditions and conflicting priorities, many urban families are unable to dedicate the time and resources necessary to manage asthma.

Asthma now has the nation’s attention. In 1997, President Clinton established an interagency Task Force charged with recommending strategies for protecting children’s environmental health and safety. This Task Force identified asthma as one of four priority areas for immediate attention in 1998. Last year, the First Lady unveiled a $68 million initiative to fight childhood asthma through a comprehensive national strategy, which includes school-based programs, investments in research, funding to states and health care providers who implement asthma management programs for children on Medicaid, and a public information campaign.

Overcoming asthma’s detrimental impact upon our cities’ children is possible only through a coordinated and collaborative public health response. Consider the factors involved in successfully managing this disease:

❤ Providing quality medical care to diagnose and treat
❤ Ensuring adequate housing that reduces exposure to molds, cockroaches, rodents and dust
❤ Encouraging families to make behavioral changes: to quit smoking, get rid of pets, and implement stringent cleaning regimes
❤ Motivating a child to take medications, learn about symptoms and triggers, and change behaviors to reduce the chance of an attack
❤ Convincing school administrators to maintain the school environment and facilitate children’s access to medicines
❤ Persuading insurance companies and managed care groups to provide adequate coverage for asthma-related equipment and education.

So where do we begin? It takes a committed effort to move an asthma management program from concept to reality. A key first step is the establishment of a coalition with representatives from within the community who possess the drive, resources, interest and influence to see the program through. Together, this group of partners can assess the current situation, develop strategies and objectives, and implement interventions. They can set measurable outcomes to evaluate program progress and to determine if the interventions were a success.

Someone needs to take the first step towards this solution, and local health departments are well positioned to identify stakeholders and facilitate initial meetings. If a local church, school, or civic organization wants to take the first step, it should be encouraged and supported.

Fighting asthma in our nation’s cities is an urgent priority. We can stop needless suffering and give children and their families the tools to control this disease. An effective public health response means getting beyond public health agencies to the communities, schools, care providers, pharmaceutical and insurance companies, and others who play a role in creating positive change. Change can be good. And change that frees children from the burden of asthma is very good, indeed.

For additional information on urban asthma, contact: Julie Madden, MA, National Center for Environmental Health, Air Pollution and Respiratory Health Branch, Centers for Disease Control and Prevention (CDC), 1600 Clifton Road NE, Mail Stop E17, Atlanta, Georgia 30333. Phone: 404-639-2551 or E-mail: zsd6@cdc.gov

Submitted by Julie Madden, MA, Health Educator, CDC.
In the United States, the rate of congenital syphilis (CS) - syphilis transmitted from a pregnant woman to her fetus - has fallen below the Healthy People Year 2000 (HP2000) Objective of 40 cases per 100,000 live births. While the U.S. rate declined by 78% between 1992 and 1998, congenital syphilis remains a maternal and child health challenge where its rates remain highest, in urban areas and among minority populations. The rate of CS exceeded the HP2000 objective in 23 of the largest U.S. cities (those with populations greater than 200,000). The CS rate in 1998 was 5 to 15 times greater than the HP2000 objective in six of these cities: Newark, Baltimore, Houston, Memphis, Birmingham, and Miami. Racial disparities in CS persist; in 1998, the highest CS rates were among Blacks (87.0 per 100,000 live births), Hispanics (27.9), and American Indians (14.0), compared to Asians (4.9), and Whites (2.9). Populations with high CS rates also experience increased rates of infant mortality and stillbirths. According to CDC, 12% of infected newborns will die due to CS. In addition, a pregnant woman infected with syphilis will have a 40% chance of stillbirth or infant death shortly after birth.

Windows of opportunity to eliminate congenital syphilis in the United States emerge given the seven- to ten-year cycle syphilis undergoes. Efforts to eliminate the disease must start before the cycle begins anew with an upswing of syphilis. Congenital syphilis can be prevented by preventing maternal syphilis infection during pregnancy.

Previous efforts to control syphilis have been hampered by social barriers, including racism, poverty, homophobia, sexism, and the stigma associated with sexually transmitted diseases (STDs). According to CDC, syphilis can best be described as a social disease which can only be contained through multicomponent, concentrated, collaborative efforts among public health professionals and community leaders.

Key prevention strategies include:

- **Providing disease intervention activities for individuals with infectious syphilis**, including interviews with infected individuals to obtain information regarding past sex partners, and contacted partners to provide information about testing and treatment;
- **Ensuring that comprehensive prenatal care is provided to pregnant women**;
- **Working to overcome barriers to care such as language problems and financial barriers to screening and treatment**;
- **Conducting adequate surveillance activities among target populations**, including complete data about and observing trends in the rates of occurrence of syphilis and CS; and
- **Educating the community about CS and syphilis** through public service announcements and other outreach activities.

Urban Health Departments are currently presented with a unique MCH challenge and opportunity. Through concentrated public health-community partnerships, a major victory could be won by eliminating congenital syphilis in America.

In addition to utilizing local and state health department STD contacts, for more information, contact Jo Valentine of the Program Development and Support Branch of the Division of STD Prevention at the National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Mail Stop E27, Atlanta, GA 30333. Phone: 404-639-8315. Or, National Coalition of STD Directors (NCSD), 202-842-4660.

**Guidelines for the Prevention and Control of Congenital Syphilis.**

This report, published by the Morbidity and Mortality Weekly Report, at the CDC, presents a comprehensive plan to control Congenital Syphilis. The report is available on-line at <http://wonder.cdc.gov/wonder/prevguid/m002630/entire.htm>. Copies of the report may also be obtained by writing: CDC, MMWR MS (C-08), Atlanta, GA 30333.

The National Plan to Eliminate Syphilis from the United States. This report was published in October 1999 by the Division of STD Prevention at the National Center for HIV, STD, and TB Prevention at the CDC. The report presents a national public health goal of eliminating syphilis in the US by 2005, discusses strategies to accomplish this goal as well as requirements for a syphilis elimination plan. Online at <http://www.cdc.gov/stopsyphilis/ExecSummPlan.htm>.

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**Did You Know?**

While the nation overall met the Healthy People 2000 congenital syphilis objective of 40 cases per 100,000 live births, 23 cities with populations over 200,000 had rates exceeding the objective.

The rate in five cities: (Newark, 592.3; Baltimore, 516.5; Houston, 266.7; Memphis, 234.8; Birmingham, 219.0 - cases per 100,000 live births) was five to fifteen times greater than the HP2000 objective.

Who Knew Data Could Be Such Fun?

“Data work can be fun” and “It takes all of us to be successful,” expressed participants during the final moments of the “Hands On” Workshop of the 1999-2000 Urban MCH Data Use Institute. On Feb. 5, 2000, 45 DUI members from 10 cities attended “this weekend--a working weekend--that was well spent” in Atlanta. This three-day workshop was an evolving case study in fictitious Peach City that reinforces learning on the three corners of the Data Use Triangle: 1) Data and Analysis, 2) Planning and Programs, and 3) Policy and Politics. Case studies are one of the best ways to reinforce adult learning. Evaluation comments included, “The case studies were all powerful at putting lecture content into practice,” and “The lectures are just a starting point for what you really learn through the case studies.”

Four excellent supportive and informative lectures were provided by Dr. Arden Handler of the University of Illinois in Chicago on program evaluation, Ms. Melissa Shephard of CDC on effective communication, Dr. Magda Peck of CityMatCH on performance measures and Dr. Bill Sappenfield of CityMatCH/CDC on needs assessment. In response to the performance measure presentation, Lincoln, NE DUI team member Gina Dunning stated, “This is the first time that I have seen this information presented in a way that actually makes sense.”

High quality volunteer faculty facilitated each of the four case-study work groups. These faculty members, who were the key element to the workshop’s success, include Dr. Marianne Zotti of Mississippi State Department of Health/CDC, Dr. Mary Rogers of CDC, Dr. Gilberto Chavez of California Department of Health/CDC, Ms. Kay Johnson, private consultant, Dr. Debora Barnes-Josiah of University of Nebraska Medical Center and Dr. Scott Santibanez of CityMatCH/ CDC. Drs. Peck and Sappenfield were also group facilitators.

The Hands On Workshop culminated with “mock” presentations before “real” political leaders in DeKalb County, Georgia: County Commissioners, Mayors, County Board of Health Members, and County Public Health Leaders. Special thanks are due to Dr. Paul Wiesner, DeKalb County Health Director, for recruiting such strong mock city council members. “This year’s presentations were excellent, a marked improvement over last year’s,” commented one mock city council member.

“One of the best activities I have ever done. Working through the process was illuminating and really cemented the other sessions from the workshop,” reported a DUI member.

One of the strongest comments came from a DUI funder. “I have only attended two of your events, but both have been excellent!” stated Jesse Richardson from CDC. “CityMatCH definitely has a handle on adult learning and engaging participants... CDC should register for classes with you!”

Leadership into Action Through Effective MCH Data Use

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Applications are due on May 1st.