Toward Women’s Health: A Compendium of Promising Practices to Improve Urban Women’s Health
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CityMatCH is a national organization of urban maternal and child health programs and leaders, dedicated to improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. Initiated in 1988, CityMatCH through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for the addressing health concerns of urban families and children.

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Toward Women's Health: A Compendium of Promising Practices to Improve Urban Women’s Health, highlights selected CityMatCH member efforts to improve the health of urban women in their communities. CityMatCH is the freestanding national membership organization of city and county health departments’ maternal and child health (MCH) programs and leaders representing urban communities in the United States which seeks to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities.

In the winter of 2004, a query was sent to all CityMatCH members asking for promising practices that were making a difference in the health and lives of women in their jurisdictions. Health departments responding answered a series of questions exemplifying their promising practices. Initial responses led to the selection of a smaller group of respondents for site visits, and the totality of responses led directly to the development of this short compendium.

One might ask what a compendium such as this has to offer its readers. Certainly, readers seek advice on developing creative collaborations to overcome barriers to program effectiveness and on moving from “project” to scale. They require effective strategies to obtain and sustain resources. They may simply need the spark of seeing an idea another health department has developed and recognizing its utility in their own. This compendium offers four well thought-out clusters of selected ideas, tools and local contacts for initiatives in urban women’s health. Many of the initiatives discussed have not yet undergone formal evaluation processes, yet we believe you will find value in the initial background work, strategies and concepts they offer for developing and/or augmenting your own local urban women’s health projects.

Fielding the original query, leading site visits and producing Toward Women’s Health: A Compendium of Promising Practices to Improve Urban Women’s Health, fell primarily to CityMatCH Consultant, Helene Kent and to Maureen Fitzgerald, Coordinator for Policy and Communications at CityMatCH. Special thanks are offered to Kelly McIntosh for her beautiful graphic design, layout and production of the compendium, and also to Michelle Coe and Janet Rogers for the office management of logistics, production and dissemination of this tool.

We hope this compendium will spark ideas, action and change which lead to improved health and well being of women in urban communities. Please let us know if this tool has been helpful to you.

Regards,

Patrick Simpson, MPH
Acting Executive Director, CityMatCH
Introduction
CityMatCH is pleased to present Toward Women's Health: A Compendium of Promising Practices to Improve Urban Women's Health. The compendium highlights how CityMatCH members are working to improve the health of women in their communities.

Background
A 2002, NACCHO and CityMatCH member survey identified women's health as a high priority issue for a majority of local public health agency leaders. Local public health leaders indicated that key women's health issues included prenatal care, family planning services, breast cancer prevention, prevention of tobacco use, and general health education. However, respondents indicated there was an abundance of unmet need related to women's health. As a result, important issues such as health services access and chronic disease/general health education were not being adequately addressed. Overall, survey respondents reported a need for women's health best practice information. This response led to the formation of an Urban Women's Health Initiative at CityMatCH to review and address those issues. This compendium is in answer to that request.

Selection Process
A CityMatCH query was sent to members in winter of 2004 asking for descriptions of promising practices they were using that was making a difference in the health of women in their community. Each agency was asked a series of questions to describe their practice:

- What is the promising practice?
- How did this practice come about?
- What are the primary goals and expected results?
- What are the key strategies/activities of this promising practice?
- What specific, measurable results have evaluations shown have been achieved?
- What are the costs associated with this project?
- What else would you like your colleagues to know about this initiative?
- What barriers were encountered and how were they overcome?
- What advice do you have for your colleagues who wish to engage in a similar effort?
- Whom can we contact for additional information about this initiative?

Submissions were reviewed by the CityMatCH Urban Women's Health Subcommittee using the following criteria:

- Extent to which query questions were addressed
- Relevance of practice to colleagues
- Degree of innovation associated with this practice
- Apparent ease of replication
- Addresses access, resource, or leadership issues associated with women's health
- Extent to which the practice embraces a broad view of women's health within MCH practice
- Extent to which the practice encourages the development of comprehensive women's health services

Each selected agency was contacted and interviewed so that the following promising practices accurately reflect their work.
Four sites: the Magnolia and Azalea Projects of the Northeast Florida Healthy Start Coalition in Jacksonville Florida; Healthy Mothers Healthy Babies Coalition of Wake County; Raleigh, North Carolina, and the County of Los Angeles, Department of Health Services, Office of Women's Health received site visits to better document the work being done.

Content
Some of the activities described are natural extensions of current services; other are more involved, requiring new resources and ways of doing business. All are a response to data and address the needs of urban women.

The four issues of Toward Women's Health provide a snapshot of the work being done by seventeen community-based agencies nationwide. Highlighted are complex community-based campaigns to reduce cervical cancer (Los Angeles) or to improve birth outcomes (Phoenix), as well as, more readily implemented activities, such as internal agency efforts to reshape health department services (Little Rock) to better meet the needs of women, or to provide health information requested by community women (Dayton).
design and initiate evidenced-based responses to improve women’s health (Wake County, NC). A number of projects reach out to special populations of women such those involved with the correction system (St. Louis, MO), pregnant adolescents (Memphis, TN), substance involved women (Jacksonville, FL), and Native American women at risk for poor birth outcome (Seattle, WA).

Some grapple with helping women become as healthy as possible before pregnancy (St. Petersburg, FL and Jacksonville, FL), while others assist women experiencing perinatal depression (Detroit, MI and Boston, MA). Important women’s health issues such as breast cancer are addressed (Contra Costa, CA). One practice describes a community-wide effort to creatively fund health care (Fort Collins).

Six Ways to Improve The Health Of Urban Women

CityMatCH has identified six ways to improve the health of urban women. The promising practices illustrate these principles.

Embrace a broader view of women’s health within maternal and child health.

Many of the agencies highlighted are not traditional MCH programs. Agencies have reached out and embraced a view of urban women’s health that includes the traditional maternal role, but also takes a comprehensive view of women’s health throughout the life span. The agencies recognize that improving the health of women is an important goal in itself. They also recognize that healthy infants, children, and families are more likely if there are healthy women and mothers.

Provide leadership for urban women’s health.

These agencies continue in their resolve and maintain their resiliency to be a change agent in their community. They are local advocates for the needs of local women. They have learned what comprises local women’s health needs through data and analysis, and by listening to community members and have taken action to meet those needs.

Engage in collaborative activities to improve women’s health.

Many of the promising practices rely on coalition-building and community action to make a difference. Agencies work with local and state partners to better address women’s health issues. They also reach out to new, current, and non-traditional partners focused on women’s health issues.

Document, disseminate, and implement promising practices to improve urban women’s health.

Many thanks to the seventeen agencies who have share their experiences with us. They have done the work of developing and in many cases the evaluation of these practices, so that other programs may benefit from their experiences.

Engage in training and skills-building opportunities.

The programs represented in these practices developed the skills they needed to better meet the needs of women in their communities. Examples of skills that were developed are data analysis, evaluation, leadership, communications, and advocacy.

Advocate for comprehensive women’s health services.

These agencies took seriously the need to advocate for the health needs of women in their community. The practices show may examples of agencies working with a variety of other partners to make a difference. Program staff involved the right community members and used a variety of techniques to share their messages.

Each of these varied efforts is based upon a commitment to improve the health of women, families, and communities; and they illustrate the ingenuity, hard work, and resourcefulness of the urban health departments that created them. As you read these summaries, look for ideas that spark your imagination about what else you can do to improve the health of urban women in your jurisdiction. Contact information is provided and the identified person is looking forward to sharing her/his experience with you.
A recent joint NACCHO-CityMatCH member survey identified women’s health as a high priority for a majority of local public health agency leaders. They indicated that key women’s health issues included prenatal care, family planning services, breast cancer prevention, prevention of tobacco use, and general health education. However, respondents indicated that many needs related to women’s health, such as health services access and chronic disease/general health education are not being adequately addressed. Overall, survey respondents reported a need for women’s health best practice information.

In response, CityMatCH is pleased to present, “Toward Women’s Health: A Compendium of Urban Promising Practices to Improve Women’s Health.”

This four-issue compendium highlights how CityMatCH members are working to improve the health of women in their communities. Some of the activities described are natural extensions of current services; while others are more involved, requiring new resources and ways of doing business. All are a response to data and address the needs of urban women.

In this issue, you will read about outreach to promote healthy birth outcomes. We visited the Magnolia Project in Jacksonville, Florida and It’s a Baby’s Life in Phoenix, Arizona to learn about their responses to infant mortality data analyzed with the Perinatal Periods of Risk Approach. We touched base with the Access Prevention for Women at Risk project in St. Louis, Missouri to hear about their outreach to women in the correctional system. We spent time with the Maternity Case Management Excellence team in Minneapolis, Minnesota to listen to the results of their program addressing the psychosocial issues of minority women in the Twin Cities, and now we bring all their stories to you. We hope their resourcefulness, commitment and collaboration will provide you with inspiration to implement a promising practice for urban women in your community.

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What is the promising practice?
The Magnolia Project provides comprehensive health promotion services for women in their childbearing years that are or could become pregnant. What sets Magnolia apart is this focus on a primary audience of at-risk women who are not yet, but may become pregnant.

How did this practice come about?
In 1998, an analysis of local data showed an alarming increase in Jacksonville’s (FL) infant mortality rate, and a widening of the gap among racial groups. In response, a special Infant Mortality Work Group was convened. This group reviewed data from the area’s Fetal and Infant Mortality Review (FIMR) project and the Perinatal Periods of Risk (PPOR) analysis to identify factors influencing the trend. The data indicated that women’s preconception health needed to be improved and it was also critical to improve the accessibility and use of prenatal care by African-American women.

What are the primary goals and expected results?
The Magnolia Project focuses on making a difference by:
• Providing outreach and education to women who need well-woman care, prenatal care, and other services;
• Increasing the availability of case management and care coordination to at-risk women ineligible for existing services because they are not pregnant;
• Providing health education directed at specific risk factors, such as: substance use including smoking cessation; STDs and infections; douching; baby spacing and family planning; and an unhealthy lifestyle including nutrition, exercise and safe sex; and
• Increasing the accessibility and availability of well-women health care and prenatal care.

What are the key strategies/activities of this promising practice?
The Magnolia Project is a federal Healthy Start grant-funded program that also receives state dollars. The initiative addresses the high rates of infant mortality in Duval County’s African-American community by improving the health and well-being of women during their childbearing years.

We need to think about how we can integrate an overall women’s health assessment, health education and risk reduction activities in (existing) programs

The Magnolia Project Community Council functions as the community-based advisory group and is composed of neighborhood leaders and project participants who take an active role in project governance, outreach, and community education activities. An example of their work is the “Cooking Among Sisters – Magnolia Project Community Council Cookbook,” which provides healthy eating advice and lifestyle tips and is filled with recipes that uses commodity foods. The cookbook has been extremely well received and is often requested by community members.

The Magnolia Project’s key strategies include:
• Outreach, well-woman and prenatal care, care coordination, health education, and community development activities;
• Outreach and client recruitment to increase community awareness of the Magnolia Project, to promote services to potential participants, and to assist participating women in obtaining health care and other needed services;
• Comprehensive well-woman, preconception, and prenatal health services; and
• Multidisciplinary care coordination to facilitate risk reduction services for community organizations, business, insurers, nurses, housing agencies, child care, educational systems, and others committed to improving the health and well-being of mothers and babies in Northeast Florida.
preconceptional women at high-risk for poor pregnancy outcomes. The Magnolia Project is located in a neat and tidy storefront in a key neighborhood that accounts for nearly half of the nonwhite infant mortality in northeast Florida. In this attractive and inviting setting, clients are received warmly and treated with respect and caring. Project outreach, case-finding, case management, clinical care, and evaluation services are provided by contract with local public health, academic, and non-profit community based agencies.

Women, ages 15 to 44, living in specific Jacksonville neighborhoods, who are either pregnant or able to become pregnant, are eligible for services. Women must also have at least three of the following risk criteria to enroll: substance use including smoking; STDs and infections; douching; baby spacing and family planning; and an unhealthy lifestyle including nutrition, exercise and safe sex.

Women start care in Magnolia by visiting with the health educator who discusses these five community specific high-risk areas. Participants are screened for financial eligibility and linked to needed services at the clinic or in the community. Women can then make appointments for family planning and STD services. Magnolia staff provide case management services including: risk assessment, leveling of need, development of care plans, goal setting, referrals to needed services, follow-up and reinforcement. Staff also provide active follow-up on missed appointments. A number of thoughtful and age appropriate incentives, such as gift certificates, are used to encourage women to remain involved with the project for up to two year.

Magnolia places a strong emphasis on expanding the scope and focus of existing case finding activities and to providing support to community-based providers. Case finding and community education is done through activities such as neighborhood health fairs; outreach to neighborhood businesses and other sites; and coordination with community-based initiatives. Extensive outreach is done through media campaign using newspaper inserts, billboards, bus ads, bookmarks, fans, and other products. Other methods incorporate working in partnership with churches and providing nightclub outreach.

The Magnolia Project empowers women to take care of their own health. The project provides family planning and STD treatment and links women with primary care and other services in the community.

Although women receive STD treatment through Magnolia, they often experience repeated infections since their partners have not been treated. In response, Magnolia for Men was started in 2002, through a partnership between the Magnolia Project and the Duval County Health Department to provide partner testing, tracing and STD treatment. In addition, screenings for blood pressure and diabetes are offered, as is information and referral to community-based primary care services. Services are provided in a mobile clinic located in the Magnolia Project’s parking lot one evening per week.

What specific, measurable results have evaluations shown have been achieved?

Since 1999, more than 1,000 women have received well-woman and prenatal care from the Magnolia Project. About twenty percent of the women were pregnant and the remainder were in the pre/interconceptional period. The University of North Florida manages the evaluation component. Measures show a decrease in identified medical and social risks and an increase in assets. Work is continued on page 10
What is the promising practice?
Maternity Case Management Excellence (MCME) strengthens maternity and infant care coordination through enhanced collaboration, coordination, and the sharing of best practice information for behavioral and social assessments and interventions.

How did this practice come about?
Racially diverse, low-income pregnant women in Minneapolis and St. Paul have long received services through the local health departments, including public health nursing services. In addition, the Minneapolis Department of Health and Family Support’s (MDHFS) Twin Cities Healthy Start began providing outreach and case management services to pregnant African American and American Indian women in the two cities in 1999. A move to managed Medicaid in the 1990s led to a drastic shift toward a more medical model and away from addressing psychosocial issues. Over time, resources were diverted from the public and community health infrastructure. MDHFS, in collaboration with community-based clinics, insurance providers and other health professionals, began this project in April 2003 to return resources to the public and community health infrastructure by documenting and highlighting the impact these services have on racially diverse, low income pregnant women.

What are the primary goals and expected results?
• To assess and address pregnant women’s social and behavioral risk factors, and improve birth outcomes;
• To improve communication across the various medical and social service providers who care for racially diverse, low income women; and
• To create two to three community-based “Maternity Case Management Centers of Excellence” for the target population where strategies can be tested and evaluated, and best practices are showcased.

What are the key strategies/activities of this promising practice?
The practice includes:
• Two meetings per year of a large, multidisciplinary information-sharing group; and
• Pilot community clinic sites where MCME practices are highlighted, enhanced, supported with additional resources, and showcased to the larger MCME group, health care stakeholders, and the greater community.

The Health Department manages a complex network of care for pregnant women. Currently, five separate plans provide Medicaid managed care services in the area. Local community clinics provide prenatal care through a contractual arrangement with the county and each clinic works with more than one Medicaid managed care plan.

During the biannual MCME group meetings, case managers from various organizations and other perinatal professionals come together to network, share information, receive updates and access information about resources, and create community guidelines.

Three community clinics agreed to implement practices developed by the larger MCME group. At each of the three clinic sites, health department staff convened groups...
of eight to ten people comprised of clinic staff, managed care plan representatives, hospital social workers, public health nurses, and local and state health department staff. Each site met for a series of four meetings.

Meeting one was devoted to reviewing site-specific case management processes and systems. The group also looked at current best case management practices.

Meeting two was devoted to gap analysis. Selecting strategies and identifying resources to address the identified gaps was accomplished.

At meeting three, needs were prioritized and objectives set for the next six weeks when implementation and monitoring of objectives occurred.

Six weeks later, meeting four was held and outcomes were reviewed.

Results from assessments and pilot projects are shared with the larger MCME group at the biannual meetings.

What specific, measurable results have evaluations shown have been achieved?

1. The number of women receiving postpartum behavioral and social assessments, home visits, and medical visits increased at one clinic. It was also determined that many women were experiencing depression, but few were ready to seek assistance, in spite of the various resources readily available.

2. At another clinic, the pilot project led to a one-year grant (October 1, 2004 to September 30, 2005) from a local health plan’s Medica Foundation to bring together an interdisciplinary care team to:
   • Assess their current case management system;
   • Expand and improve screening for social risk factors;
   • Develop a comprehensive maternal case management protocol and system to serve all at risk mothers; and
   • Evaluate the results.

What was the health department’s role in this promising practice?

MDHFS coordinates the large MCME group, which includes facilitating the pilot community clinic sites efforts to assess services, implement projects, and evaluate results. In addition, MDHFS provides leadership for grant writing to gain additional funds and resources to support the project.

What barriers were encountered and how were they overcome?

Scheduling the multidisciplinary care teams can be difficult. Clinical provider representation is necessary, but they have little time to spend outside of patient care. In response care team meetings and updates were scheduled during regular provider meetings. Also, while an initial project kick-off meeting had all providers in attendance, follow-up meetings included only one or two clinician representatives.

The various organization and professionals had different understandings of what case management meant. At the first meeting, the large MCME group brainstormed about the issues and barriers minority, low-income pregnant women face, and what services and supports they need to help them get past these barriers. The group didn’t use the words “case management,” and instead spoke to the specific issues present and services required. The effort also

continued on page 11
**Access Prevention for Women at Risk (APWAR)**
City of St. Louis Department of Health
St. Louis, Missouri

**What is the promising practice?**
Access Prevention for Women at Risk (APWAR) provides pregnancy planning information to women of childbearing age and prenatal care referrals to pregnant women involved with the corrections system.

**How did this practice come about?**
The correction system noted an increase in the incarceration rate for women, as well as a higher number of women on probation with an increased rate of recidivism. Substance abuse and STDs were also a rising problem among women within the system. The City of St. Louis Department of Health saw an opportunity to address these issues through its established ties with the judicial system.

**What are the primary goals and expected results?**
APWAR seeks to provide:
- Health education and access to primary medical care services for high-risk women of childbearing age who are or have been involved with the corrections system.
- Services to women in need of enhanced pre-pregnancy and prenatal risk assessment, health education, and referral to case management to assure maintenance of on-going primary health care, specifically targeting women who use tobacco, alcohol or other drugs, or who are uninformed about the benefits of folic acid therapy.

**What are the key strategies/activities of this promising practice?**
To provide:
- Prenatal health education to 25 women referred from the Women’s Drug Court;
- Basic pre-pregnancy education and referral to a general audience of 200 women attending the Women’s Drug Court;
- Basic prenatal health education to 15 pregnant women referred by the 22nd Municipal Judicial Circuit or Washington University School of Psychiatry;
- Prenatal health education to 25 pregnant women referred from City Jail “Holdover” and Medium Security Institution; and

We have learned over time that it is imperative to embrace a holistic approach in our interventions

- Basic pre-pregnancy education and referral information to a general audience of 200 women in the City Jail “Holdover” and Medium Security Institution.

Based on its existing outreach and collaboration with the court system and the presence of a public safety and health task force, the Health Department approached the March of Dimes to support an intervention project for this high-risk population of women.

The women served by this program are predominantly African-American (90%) and approximately 23 years of age. A registered nurse and a health educator travel to the jails weekly to present on preparing for pregnancy and preventing STDs. Addition information is also provided about health and other topics, including drug treatment, transitional housing, and services for battered women. Public health nurses provide follow-up as
needed, however, losing women to follow-up is common.

This program is entered via a referral from the courts, which have authority to mandate women to attend. Although the project started in the municipal courts, it is now being expanded to the state division and drug court.

What specific, measurable results have evaluations shown have been achieved?

The City of St. Louis Department of Health is still exploring project evaluation possibilities with St. Louis University-School of Public Health for data collection, analyses, and program design evaluation.

What are the costs associated with this project?
The March of Dimes awarded a seed grant of $25,000 to the Health Department. Costs associated with this project include: staff time; health promotion material including brochures, advertisement on bus shelters and medibags; incentives such as cups, pens, pencils, posters, informational folders; and related administrative cost.

What else would you like your colleagues to know about this initiative?
The Department of Health has worked hard to collaborate with community partners from municipal, state, academia, business, and non-profit entities. Partner agencies include: Women’s Drug Court, Family Drug Court, Washington University School of Psychiatry, City Jail “Holdover” and Medium Security Institution, Blacks Assisting Blacks Against AIDS, and the St. Louis University School of Public Health, Community Wellness Project.

What advice do you have for your colleagues who wish to engage in a similar effort?
Keep foremost in your strategic plan that you will be working with individuals who are dealing with more pressing social issues that prevent them from focusing on their health. A vast majority of these ladies are facing critical life situations such as lack of housing, food, and/or clothing, drug addiction, domestic violence, STD/HIV exposure and more. We have learned over time that it is imperative to embrace a holistic approach in our interventions with these women. A resource manual and referral system have been useful tools that helped us help women address some of their other issues. This assistance has allowed them to be more receptive to information about living healthier and giving birth to healthier babies.

Whom can we contact for additional information about this initiative?
William Dotson
City of St. Louis Department of Health
Chief of the Bureau of Family & Community Health
634 N. Grand Blvd, Ste 833
St. Louis, MO 63103
(314) 612-5133
Fax: (314) 612-5005
dotsonw@stlouiscity.com
What is the promising practice?
This project required engaging in active, intense, and sustained community-building to increase awareness of and address the factors that result in infant mortality.

How did this practice come about?
The Perinatal Periods of Risk (PPOR) approach to infant mortality is a method that analyzes standard vital records (births, infant deaths, and fetal deaths), using a prevention framework. Based on birth weight and age of death, the PPOR approach divides fetal and infant deaths into four categories, each with different causes of death, risk factors, and corresponding interventions. PPOR also provides an estimate of the amount of fetal and infant mortality that is preventable. The PPOR analysis for Maryvale, Arizona indicated that a third of fetal and infant deaths were potentially preventable and also suggested that the biggest impact would be made by focusing on maternal health and maternal care.

What are the primary goals and expected results?
It’s A Baby’s Life seeks to improve the knowledge, strength and capability of the community in regard to MCH practices. The desired result is to achieve a community-sustained program.

What are the key strategies/activities of this promising practice?
It’s A Baby’s Life involves community residents in actively addressing infant mortality by raising awareness and providing education about the factors that lead to health mothers and babies.

The project seeks to engage the community through a volunteer-driven program consisting of citizen mobilization, educational workshops, and civic infiltration. Key activities include community meetings, coalition meetings, town hall meetings, and health fairs including activities at local hospitals, schools, and businesses.

Small stipends through grant funds from local charitable foundations are given to volunteers for specific services provided, but work is primarily provided on a volunteer basis.

The first Community Mobilizer Manager was a longtime community resident/activist with deep roots in the community. Her connections and skills proved extremely beneficial in developing neighborhood support of the project.

After recruiting Mobilizers, the next and larger challenge required gaining support from the political leaders of the community. Several visits were made to accomplish this task, and eventually City of Phoenix Councilmen, State Representatives and Senators were supportive.

After assuring political will, the next step was gaining support from the business community. Business leaders were happy to support the
campaign and the community. The challenge was helping them understand how they might benefit from having healthier moms and babies in their communities. Individual conversations with the business community and neighborhood leaders proved to be the critical factor to increase understanding and support. This support was mirrored by the local hospital, and school districts.

A Town Hall meeting was held in November 2002, with the Phoenix Vice-Mayor and City Councilman serving as Masters of Ceremony. In attendance were elected State legislators, school board members, the CEO of the local hospital, the superintendent of our elementary school district, and key community members. Each made a public commitment to support and work together for It’s A Baby’s Life.

What specific, measurable results have evaluations shown have been achieved?
Local health care and community facilities have expanded their prenatal care services and sites by 50% or more. Specifically, the local hospital has enlarged its prenatal care services not once, but twice, thereby doubling its size. This year, more births were delivered than ever before in the history of the hospital. The local social services agency has had to double its staff to accommodate clients.

Critical relationships have been established with CEO’s, politicians, and community members now know each other on a first-name basis.

What are the costs associated with this project?
The Virginia G. Piper Foundation, St. Luke’s Health Initiatives, along with Maricopa County Department of Public Health provided funding. Current funding sources are ending and additional resources are being sought to expand and sustain the project.

What else would you like your colleagues to know about this initiative?
Living in and being involved in the community is a key to gaining the trust and support of local people and businesses. Now community members who work for warehouses, department stores, local grocery stores, schools, and medical facilities are familiar with the It’s a Baby’s Life program. It truly has become embedded in the fiber of the community!

What advice do you have for your colleagues who wish to engage in a similar effort?
Work “with” the people in the community, and trust the process. There were many times when community members suggested a method we might not have considered using. Ultimately they were right and we were glad that we listened.

Whom can we contact for additional information about this initiative?
Wanda Thompson
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Family Health Partnerships
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being done to secure a longitudinal evaluation.

**What are the costs associated with this project?**
The Magnolia Project receives annual funding of $925,000 from the Federal Healthy Start Program. Additional funding ($280,000 per year) is generated through State categorical funding, Medicaid, and other third-party reimbursement.

**What else would you like your colleagues to know about this initiative?**
The Magnolia Project prides itself on its accessibility and community support. It attempts to deliver care in a personal way—from the size and location of the clinic to staffing. Health education is integrated into every participant service and interaction. Most important, the project is grounded in community-involvement and capacity-building. It defines its role as not only serving individual patients, but also improving the health and well-being of the community as a whole.

One way the Magnolia Project has reached out is through its partnership with *Holding Out the Lifeline*, a set of church-based initiatives designed to help the community. The AME Ministerial Alliance, Inc., a fifty-member church organization, serves as the lead agency for these efforts, including initiatives like *Project Moses* to a local increase in sleep-related deaths associated with bed-sharing and inappropriate sleep environments, *Project Moses* distributes volunteer crafted, safe bassinets and bedding to families with new infants.

**What advice do you have for your colleagues who wish to engage in a similar effort?**
There are many opportunities within current public health services to address the interconceptional health and social needs of at-risk women including family planning clinics, STD clinics and pediatric services. We need to consider how we can integrate an overall women’s health assessment, health education and risk reduction activities in these programs, absent funding to replicate a free-standing, focused initiative like the Magnolia Project.

**What is the role of the local Health Department in this initiative?**
The Duval County Health Department is a key partner in the Magnolia Project. The Coalition contracts with the health department to provide case management and clinic staff for the project. Involvement with the health department enables the federal Healthy Start program to leverage other funding (Title X, state and local categorical funding), as well as third-party reimbursement for medical services. It also has facilitated the development of complementary partnerships with other public health programs, including Ryan White Title III, communicable and infectious diseases, and environmental health. The Magnolia Project, in return offers the health department an opportunity to test new approaches to delivering care to at-risk residents of the county.

**Whom can we contact for additional information about this initiative?**
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consistently addressed the needs for both medical and social risk factor case management.

What are the costs associated with this project?
Project costs include staff time to conduct the biannual meetings, and the series of four meetings at the pilot sites. The pilot sites may or may not have additional costs to modify their services as identified in the gap analysis. Ideally, the sites involved in the project showcase their work to various stakeholders and this results in additional resources to address those gaps. Ultimately, evaluations at the pilot sites will provide information for the most effective and efficient use of resources throughout the perinatal health care system.

What else would you like your colleagues to know about this initiative?
The term “excellence” resonates with people. While excellence is often used to describe high-end medical treatment, it translates well into the provision of services to identify and address social risk factors to improve health outcomes.

What advice do you have for your colleagues who wish to engage in a similar effort?
The project was initiated using existing staff and allocating only a few hours per month. Once the project was underway and successful, additional dedicated staff time was needed. After about 18 months of the project, MDHFS was able to dedicate the time of a CDC Prevention specialist exclusively to the project, which has been very positive.

Whom can we contact for additional information about this initiative?
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Six Ways to Improve Urban Women’s Health

CityMatCH has identified six ways to improve the health of urban women. The promising practices illustrate these principles.

1. **Embrace a broader view of women’s health within maternal and child health.**

Embrace a view of urban women’s health that includes the traditional maternal role and takes a comprehensive view of women’s health throughout the life span. Advocate for this expanded view of women’s health within your agency.

2. **Provide leadership for urban women’s health.**

Continue to have the resolve and resiliency to be a change agent in improving urban women’s health. Advocate locally for urban women’s health. Educate and train yourself and others about the health needs of women in your community. Provide data and information to illustrate the needs of urban women.

3. **Engage in collaborative activities to improve women’s health.**

Work with local and state partners to better address women’s health issues. Reach out to new, current, and non-traditional partners focused on women’s health issues such as reproductive health providers or health care access advocates.

4. **Document, disseminate, and implement promising practices to improve urban women’s health.**

Develop and duplicate promising practices. Respond to requests for promising practices, so that other agencies may benefit from your experiences.

5. **Engage in training and skill-building opportunities.**

Participate in agency and staff assessments to determine where skill gaps exist. Develop staff and personal skills in areas such as: data analysis, leadership, communications, advocacy, and other needed areas. Use these skills to address women’s health issues.

6. **Advocate for comprehensive women’s health services.**

Provide needed care in the best manner for your community. Ensure that services are women-centered and women friendly.
A recent joint NACCHO-CityMatCH member survey identified women’s health as a high priority for a majority of local public health agency leaders. They indicated that key women’s health issues included prenatal care, family planning services, breast cancer prevention, prevention of tobacco use, and general health education. However, respondents indicated that many needs related to women’s health, such as health services access and chronic disease/general health education are not being adequately addressed. Overall, survey respondents reported a need for women’s health best practice information.

In response, CityMatCH is pleased to present “Toward Women’s Health: A Compendium of Promising Practices to Improve Urban Women’s Health.”

This four-issue compendium highlights how CityMatCH members are working to improve the health of women in their communities. Some of the activities described are natural extensions of current services; while others are more involved, requiring new resources and ways of doing business. All are a response to data and address the needs of urban women.

Promising Practices in this Issue

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In this issue, you will read about multiple approaches to improving women’s health. We visit the Cervical Cancer Prevention and Education Initiative in Los Angeles, California and learn about their intensive multi-cultural campaign to reduce cervical cancer. The Perinatal Depression Project in Detroit, Michigan describes a depression screening and intervention program directed at pregnant women. The Endowment Program article describes work accomplished by determined citizens in Fort Collins, Colorado that led to long-term health care funding. The final practice describes Bright Beginnings, a special program for pregnant teens, in Nashville, Tennessee. We hope the resourcefulness, commitment and collaboration shown by these stories will provide you with inspiration to implement a promising practice for urban women in your community.
What is the promising practice?  
We assure intensive, culturally-competent outreach to encourage high-risk, low-income, underserved women of color to participate in cervical cancer screening and treatment.

How did this practice come about?  
In 1997, Los Angeles County held a Women’s Health Policy Summit attended by nearly 400 stakeholders who developed 101 recommendations to improve women’s health in their community. One of the recommendations was to create an Office of Women’s Health (OWH) which was established in 1998 as part of the Department of Health Services. Soon after its inception, the Women’s Health Policy Council, the OWH advisory body consisting of 22 community and county leaders, selected cervical cancer as the first initiative. Cervical cancer was chosen because of the exceptionally high rate among women of color, and because it is nearly 100% preventable. Los Angeles County, one of the most ethnically diverse places in the United States with an uninsured population of 2.5 million, had cervical cancer rates for women of color significantly higher than the national average. Latinas, who comprise the largest single ethnic population in Los Angeles County, were the group most at risk, followed closely by Korean women.

To address these health disparities, The California Endowment funded the Cervical Cancer Prevention and Education Initiative. After a successful pilot in county hospitals and clinics, the OWH conducted a comprehensive, multi-faceted outreach and education campaign among high-risk, low-income, underserved women of color beginning in January, 2002.

What are the primary goals and expected results?  
- Increase awareness that cervical cancer is preventable with a routine Pap test;  
- Increase the number of women screened with emphasis on women who have not been recently tested; and  
- Decrease the stage at diagnosis.  
- Increase access to screening, follow-up, and treatment by addressing barriers to care.

What are the key strategies/activities of this promising practice?  
A grassroots and multi-media campaign were designed for this project. Both strategies included a strong evaluation component. A three-pronged approach was used:  
- A multicultural media campaign in ethnic and general media outlets;  
- A “1-800” hotline in seven languages through which eligible women could schedule no-cost cervical cancer screening appointments with local providers; and  
- Community-based outreach activities.

To reach the maximum number of low-income women at high risk for cervical cancer in Los Angeles County, the OWH hired four ethnically-focused marketing agencies with expertise in effectively targeting media campaigns to reach specific communities. The target populations were: Latina, African-American, Asian (Korean, Chinese, Vietnamese, Filipina, and Cambodian), and Armenian women. The marketing agencies used public service announcements and public relations efforts with ethnically-directed television, radio, and print ads. Unpaid media was frequently leveraged due to the high costs of media buys.

A multi-language “1-800” hotline was established to provide information and screening appointments for eligible women. Women who called the hotline could speak with an operator in Spanish, Vietnamese, Mandarin, Cantonese, Armenian, Korean, or English and, for a brief time, Khmer. The OWH recruited 300 community partners including 166 clinical providers who agreed to provide the OWH with clinic appointment slots. Operators screened callers for eligibility for available programs and coordinated clinic scheduling for cervical and breast exams. The hotline provided each eligible woman with an appointment that took into
account her location, language, and transportation needs. Each woman received a confirmation notice of her appointment in her preferred language as well as a map to the site. Participating clinics were kept informed about scheduled appointments.

Community partners agreed to participate in quarterly meetings and activities appropriate to them, including disseminating multilingual literature about cervical cancer and the OWH hotline, participating in health fairs, referring clients to the hotline, and accepting patients referred from the hotline. The multilingual hotline operators also participated extensively in outreach activities among their respective multicultural communities. OWH outreach activities resulted in the distribution of more than 750,000 educational and promotional items (brochures, fans, magnets, etc.).

**Women's Health Mobile Clinic Outreach Program**

Another element of the campaign is the Women's Health Mobile Clinic Outreach Program, which began in May 2002, and targets hard-to-reach women, linking them into a medical home.

The mobile clinic visits parks, schools, churches, community centers, Latin American consulates, and other community locations. Services provided by the mobile clinic include: screenings for diabetes, hypertension, cholesterol, body mass index and cervical cancer, as well as gynecological and breast exams. An appointment is made at a local county or community clinic for women who receive an abnormal test result in an attempt to establish a medical home. This program leveraged the staff of the Cervical Cancer Initiative as well as receiving additional private and county resources.

**What specific, measurable results have evaluations shown have been achieved?**

It is estimated that, based on 1997 cost data, at least $1.6 million was saved in future costs associated with high-grade cervical lesions or invasive cancers from the women screened in this campaign between January 2002 and August 2003. OWH activities during this time resulted in 25,600 answered calls to the hotline for information or appointments. Of the women who called, 11,376 women made appointments for screening. Ninety-eight percent were under 200% of the federal poverty level. Overall, the show rate for women who received appointments was 65% which is remarkable for a high-risk population.

The women reached by the Cervical Cancer Prevention and Education Initiative (CCPEI) were primarily low-income women of color, overdue for cervical cancer screening, most of whom preferred a language other than English.

The Women's Health Mobile Clinic Outreach Program reached an additional 1,383 women at 78 locations between May 2002 and December 2003.

**What are the costs associated with this project?**

The CCPEI was a large multi-year endeavor. The California Endowment’s contribution of $2.2 million was utilized for one year of preparation (2001) followed by two years of program implementation (January 2002-December 2003) which included an outside evaluator. The primary costs were personnel and marketing (both media purchases and agency costs).

**What was the health department’s role in this promising practice?**

In 2000, two of the health department’s hospitals, six comprehensive health centers and four health centers received hotline patients during the three month pilot and participated in the “Free Pap Test Fridays” program. For the CCPEI campaign, matching funds were received from the health department to hire seven CCPEI

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**Perinatal Depression Program**
Detroit Department of Health and Wellness Promotion
Detroit, Michigan

What is the promising practice?
This promising practice provides depression screening and intervention for pregnant and postpartum women who receive services through the Detroit Department of Health and Wellness Promotion (grantee agency for the Detroit Healthy Start Project) and collaborating community mental health programs.

How did this practice come about?
A 2001 competitive Healthy Start grant application included perinatal depression as one focus area for funding. Considerable flexibility was allowed in developing this service component. The Healthy Start evaluator had considerable expertise in the area of depression. In collaboration with several infant mental health specialists, she developed the framework for screening and a two tiered intervention.

What are the primary goals and expected results?
- To screen pregnant and postpartum women for depression using the Edinburgh Depression Screening tool.
- To provide those scoring mildly (12 – 15) to moderately (16 and above) depressed on the screening tool with either short or long term intervention.
- It is expected that women experiencing perinatal depression will be identified and provided appropriate interventions that will improve both their mental health and life skills in order to promote a healthy pregnancy and a happy child.

What are the key strategies/activities of this promising practice?
Pregnant and postpartum women receiving care at one health department clinic and those receiving home-based case management services are screened for depression using the Edinburgh Perinatal Depression Scale (EPDS). The EPDS is administered three times, i.e., at initial screening, post intervention, and at evaluation. Screening is routinely conducted once during the prenatal period (about 24 to 28 weeks) and once during the postpartum period (about six to eight weeks after delivery). Screening is also done whenever a woman states she is depressed or the health care provider identifies signs of depression. Women who are enrolled in services outside the routine screening time frames are screened as soon after enrollment as possible. The type of intervention treatment determines when the post intervention and evaluation EPDS screenings are administered.

A two-tiered, home-based intervention is provided to women with mild to moderate depression. The first tier (Tier one) is an eight-week cognitive behavioral therapy (CBT) model for women with mild depression. Specially trained Detroit Healthy Start Project social workers provide this service. The second tier (Tier two) intervention is a six-month infant mental health model, including CBT elements for women with moderate depression. Master's prepared infant mental health specialists or other Master's prepared professionals from community mental health programs provide this service through a contractual agreement with Healthy Start. Detroit Healthy Start Project intervention services are not provided to women with severe depression. In addition to the need for more in-depth evaluation, medication is often indicated in the treatment of severe depression. Women with severe depression are referred to primary care and/or mental health centers with physicians or providers with prescriptive authority.

Clients who receive Healthy Start Perinatal Depression services are tracked to determine if they complete the intervention status and to assess their outcomes using return reports and post intervention screening with the EPDS. A post treatment EPDS is administered at the final intervention visit. In addition, those who complete the intervention have a three-month post intervention visit conducted by an evaluation team member to assess the long-term outcome of the intervention. The EPDS is administered as a part of the evaluation.

What specific, measurable results have been shown through evaluation results?
In 2003, 356 women were screened for depression. Of this number, 29 scored mildly depressed, 45 scored moderately depressed and 13 scored severely depressed. An additional 17 women who scored in the
normal range requested depression intervention services.

The post-intervention depression scores of the women who completed Healthy Start depression program services (either Tier one or Tier two) were generally lower than their scores at screening. In addition, this improvement persisted over time.

Screening and post intervention EPDS scores are available for 12 women. For eight of these women, EPDS scores for the evaluation visit are also available. The average screening EPDS score for the 12 women was 16.1 at intake while the average post intervention score was 6.2 (t = 6.847, p = <.0001). The average scores for the eight women for whom we have completed evaluation data were 16.6 at intake, 6.4 at the end of intervention, and 5.9 at the three-month follow-up evaluation visit. The depression scores of the women for whom there is intake and evaluation data have significantly improved (time at intake, time at end of service, and time at three months at intervention services/evaluation visit: t = 4.255, p = <.005). Although the scores were not significantly decreased between end of treatment and the evaluation visit, the lower scores were maintained over time.

What are the costs associated with this project?
The costs associated with this program are salaries of staff who provide the intervention services, and consultation fees for ongoing support and training to the front-line staff. Because the EPDS is a brief, ten-item questionnaire, screening can easily be incorporated into the routine assessment activities of nurses and other case managers in the prenatal and postpartum clinics and home visits. The staff who provide intervention for women with mild depression (Tier one) are two bachelor's or master's prepared social workers who are part of the case management team. The eight-week intervention is part of their case management assignment. Two master's prepared infant mental health specialists/social workers in the community mental health agencies provide the six-month intervention for the women with moderate depression (Tier two). The salaries of these four staff members are $100,000. Two mental health consultants provide ongoing reflective supervision/support or training to the front line staff on a monthly basis.

This intervention team has provided services to 107 women in 2002-2003. It has been well-documented that children of women with maternal depression are more withdrawn, have difficulty in establishing positive relationships with their peers in early childhood, and have difficulties in school at a later age. While this program may seem costly, it is less costly than the medical expenses for the women and specialized care that may be needed for the infants and young children if their mothers remained untreated.

What else would you like your colleagues to know about this initiative?
Health professionals need to screen women for perinatal depression and offer interventions to improve the mental health of women in urban communities. Depression can remain undetected despite interaction with the medical community because many health professionals are not trained to screen and treat women with this condition. As a result of this component of DHSP, pregnant and postpartum women who receive care within this Detroit Department of Health and Wellness Promotion program are screened for depression.

What advice do you have for your colleagues who wish to engage in a similar effort?
The most important issue is having an intervention program in place before you begin to screen women for depression. It is not ethical to screen women and not have services in place to assist them to deal with their depression. In our community, there were no services available that focused specifically on women with perinatal depression. More important, the few services that were available did not attend to the mother infant relationship and the influence of depression on the child’s growth and development.

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**Endowment Program**
Larimer County Health Department
Fort Collins, Colorado

*What is the promising practice?*
Community partners working together created an endowment program that provides perpetual funds for medical care and risk reduction services for underserved populations, such as low-income pregnant women.

*How did this practice come about?*
Pregnant women because of their inability to pay and inadequate Medicaid reimbursement were unable to find prenatal care providers in Fort Collins, Colorado. The Family Practice Residency was unable to take additional maternity patients because they would not meet their family practice residency ratio regarding kinds of patients served. In addition, the Health Department had inadequate revenues to support the risk reduction services for clients in need.

*What are the primary goals and expected results?*
Improve access to prenatal care for low-income pregnant women.

*What are the key strategies/activities of this promising practice?*
A partnership between Larimer County Department of Health and Environment, the Poudre Valley Hospital Foundation, and public involvement helped access operating funds from the Kellogg Foundation to use for medical prenatal care and to augment prenatal risk reduction services. This allowed revenues from community contributions, fees, and Medicaid to go toward an endowment program. Perpetual funds from revenues generated by the endowment are used for medical care for underserved people in the city of Fort Collins.

An endowment program located at the Poudre Valley Hospital Foundation was created to provide prenatal care through the Poudre Valley Prenatal Program. The Poudre Valley Prenatal Program is a community based prenatal, labor and delivery program for low income, uninsured, and medically underserved women and teens. Family practice resident physicians from Poudre Valley Hospital’s Family Medicine Residency Program provide medical care for program participants. The Larimer County Department of Health and Environment staff works to enroll women in Medicaid, ensure access to prenatal care and WIC, and provide a variety of risk-reduction case management services to improve birth outcome for at risk women. The Health Department’s Maternity staff is composed of public health nurses, social workers, program workers with bilingual skills and registered dietitians. Funding from the endowment helps to support these services.

*What specific, measurable results have evaluations shown have been achieved?*
The endowment fund for prenatal access in Fort Collins, Colorado is approximately $5 million. This amount is necessary to ensure adequate revenues are generated each year. Endowment funding is used to provide prenatal care for low-income women through the Poudre Valley Prenatal Program. The arrangement makes it possible for women who have Medicaid, or who are underinsured or uninsured to receive medical prenatal care. In addition, Health Department Maternity Assistance/Prenatal Plus staff are able to assist more women access services and to provide case management services to a larger number of low-income pregnant women than would be possible with current resources.
What are the costs associated with this project?
The Health Department's Maternity Program budget is comprised of funds from the Caring for Colorado Foundation, Poudre Valley Hospital Foundation, and the Newborn Hope Foundation. Other sources are Colorado State University Safety Grant, The National March of Dimes Birth Defects Foundation, Medicaid revenues, Church Women United, local stores, MCH Block Grant funds, and County general fund allocations. To develop the endowment, representatives from Family Medicine, Poudre Valley Hospital Foundation, Larimer County Department of Health and Environment, and other interested community representatives applied for and received operating funds through the Kellogg Foundation so program revenues could be added to other community contributions and thereby develop the endowment fund.

What was the health department's role in this promising practice?
The Health Department developed community forums, and brought together community leaders and providers to seek long-term solutions to inadequate prenatal care in Fort Collins. Larimer County Health Department staff provided some of the data regarding need and utilization of prenatal care. The Department also worked with the Poudre Valley Hospital Foundation to write the grant to help develop a local endowment.

What barriers were encountered and how were they overcome?
Pregnant women could not find care. No long-term funding existed to pay for prenatal care. Everyone was looking to someone else to solve the prenatal care access problem. The medical practitioners who had been serving this population were depicted as villains when they could not take more clients. These problems were overcome when the story was told publicly, the media picked it up, and stakeholders worked together.

What advice do you have for your colleagues who wish to engage in a similar effort?
All partners need to clearly understand and take responsibility for their role in resolving community problems. Key decision-makers must be involved, not just line workers. Forums need to focus on the clients and their stories, providers and their difficulties, and public figures. Data needs to be collected to identify the consequences of not providing services.

What else would you like your colleagues to know about this initiative?
Medicaid reimbursement only covers approximately one third of the real costs associated with the Health Department's maternity program. The endowment has expanded Larimer County's ability to provide medical services to low-income pregnant women and improve the health of women and infants.

Whom can we contact for additional information about this initiative?
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What is the promising practice?
Bright Beginnings is a home-visiting and case-management program for pregnant teens under 20 years of age. Services begin at the time of the positive pregnancy test and continue throughout the entire pregnancy.

How did this practice come about?
A disproportionate percentage of young pregnant women (10-19) tend to enter prenatal care late in their pregnancy, receive helpful services late, and therefore deliver with an increased rate of low birth weight (LBW) and very low birth weight (VLBW) infants. These infants are at an increased risk for life long health issues that are often debilitating, and costly. In Nashville, only 74.8 percent of women 10-19 entered prenatal care during the first trimester (MPHD 2001). Eleven percent of babies born to women 15-19 were LBW and 12.9 percent were premature (Tennessee State Department of Health 2000).

What are the primary goals and expected results?
1. Improve entry into first trimester prenatal care rates to the HP2010 goal of greater than 90 percent;
2. Improve birth outcomes for teen mothers; and
3. Identifying preconception stage girls and engaging in intervention and education.

What are the key strategies/activities of this promising practice?
1. Separate teens out of family planning clinic.
2. Identify young women with positive pregnancy tests at the time the test is performed.
3. Assess risk, and enroll at-risk pregnant teens into home visiting case management services.
4. Ensure WIC, TennCare (Medicaid Program) services, assist with scheduling first prenatal care visit.
5. Involve nurse home visitors to provide pregnancy and parenting information and skills building.

Bright Beginnings, a program for adolescents with positive pregnancy tests, began in March of 2003. The purpose of the program is to provide comprehensive case management and follow-up services to all women under 20 starting at the time they have a positive pregnancy test at one of the three MPHD family planning clinics. A nurse or social worker provides services.

Services provided at the time of the pregnancy test include pregnancy history, risk assessment, options counseling, presumptive TennCare application, assistance with WIC application and scheduling of the first prenatal appointment, issuance of prenatal vitamins (or prescription), referral for dental screening, and other pertinent community services. All young women who consent to follow-up are then referred to a professional home visitor for prenatal case management services including: monthly home visits throughout pregnancy, comprehensive pregnancy education, follow-up on prenatal appointments with OB/GYN, and coordination with school and homebound services.

The Bright Beginnings home visits continue throughout the pregnancy and at least one visit after delivery. The mother and baby are then transitioned into the HUGS or Healthy Start program (home visiting programs for infants and young children) for continued follow-up, if needed.

What are the costs associated with this project?
Some of the costs include staff salaries and benefits, mileage, pregnancy tests, other lab work, educational materials and curriculum, cell phones (for home-visitor), interpreter services, office supplies, and training.

What specific, measurable results have evaluations shown have been achieved?
• Entry into prenatal care in the first trimester is 93 percent among adolescents in this program;
• More than fifty percent of the teens are breastfeeding at one week post-partum; and
• Ninety-five percent of all infants delivered to date have been full term.

What barriers were encountered and how were they overcome?
A large number of non-documented Hispanic clients are unable to obtain health insurance. They must pay for their prenatal care at the time of services making it very difficult to obtain care early in the pregnancy. Language barriers create an increased demand for
medically competent interpreter services. The Health Department has been approved to hire a part-time interpreter for use by all home visiting programs and a full-time bilingual home visitor. All home visitors have up-to-date information on prenatal care services in the community for clients with no health insurance and the cost of each service.

What advice do you have for your colleagues who wish to engage in a similar effort?
Staff should have previous home visiting experience and preferably prenatal and/or OB experience as well. In addition, a bilingual home visitor is needed on staff to avoid issues related to lack of interpreter services. Staff should have cultural competency and safety training prior to visiting with clients and ongoing (yearly) updates.

What else would you like your colleagues to know about this initiative?
The Health Department is able to bill for visits through traditional home visiting programs. The program was started with no additional staff. New staff were hired in response to the positive program outcomes.

Whom can we contact for additional information about this initiative?
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Six Ways to Improve Urban Women’s Health

CityMatCH has identified six ways to improve the health of urban women. The promising practices illustrate these principles.

1. **Embrace a broader view of women’s health within maternal and child health.**
   Embrace a view of urban women’s health that includes the traditional maternal role and takes a comprehensive view of women’s health throughout the life span. Advocate for this expanded view of women’s health within your agency.

2. **Provide leadership for urban women’s health.**
   Continue to have the resolve and resiliency to be a change agent in improving urban women’s health. Advocate locally for urban women’s health. Educate and train yourself and others about the health needs of women in your community. Provide data and information to illustrate the needs of urban women.

3. **Engage in collaborative activities to improve women’s health.**
   Work with local and state partners to better address women’s health issues. Reach out to new, current, and non-traditional partners focused on women’s health issues such as reproductive health providers or health care access advocates.

4. **Document, disseminate, and implement promising practices to improve urban women’s health.**
   Develop and duplicate promising practices. Respond to requests for promising practices, so that other agencies may benefit from your experiences.

5. **Engage in training and skills-building opportunities.**
   Participate in agency and staff assessments to determine where skill gaps exist. Develop staff and personal skills in areas such as: data analysis, leadership, communications, advocacy, and other needed areas. Use these skills to address women’s health issues.

6. **Advocate for comprehensive women’s health services.**
   Provide needed care in the best manner for your community. Ensure that services are women-centered and women friendly.
Cervical Cancer Prevention and Education Initiative
(continued from page three)

staff, and the health department supplied the overhead costs, and assistance from several departments including epidemiology, finance and information technology. The Director of the Department of Health Services and the Director of the Department of Public Health were key speakers at public functions in support of the Initiative.

What barriers were encountered and how were they overcome?
A large campaign like the CCPEI needs a substantial investment of initial start-up funding to create a successful infrastructure and staffing. Dollars were leveraged from various grants and in kind services. Not all program components needed to be rolled out at the same time.
The hiring of the ethnically-focused marketing firms allowed the CCPEI campaign to reach all of the targeted populations.
Receiving Pap results from the 166 clinics in the network was difficult and labor-intensive. More personnel (including interns) was needed than originally projected.
Although the funding for the Cervical Cancer Prevention and Education Initiative ended in December 2003, the OWH is absorbing elements of the project into the County infrastructure.
Funding is no longer available for the intense marketing and outreach campaign, but the OWH continues to receive pro bono marketing services, i.e. public service announcements. The multilingual hotline continues to link women with needed screening services. The mobile clinic continues to travel throughout the county providing increasingly comprehensive screenings and services to hard-to-reach women.

What else would you like your colleagues to know about this initiative?
Success can be achieved by combining and linking a mass-media campaign with an effective community-based outreach effort.

Conducting a multilingual and multicultural media campaign showed that racial and ethnic groups respond differently to various media sources.
Currently, the Los Angeles County Office of Women’s Health is developing a multi-lingual Prevention Matters awareness, education, advocacy and access campaign with an initial focus on cardiovascular disease, the number one killer of women.

What advice do you have for your colleagues who wish to engage in a similar effort?

• Build upon what services and resources are currently available.
• Include an evaluation component at the planning stages.
• Recognize that fundraising will be an ongoing activity.
• Community collaboration and public/private partnerships are essential.
• It can be challenging to be creative in a large organization but keep trying - the results are worth it!

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Intervention for women with mild depression (Tier one) is relatively easy to implement with existing project personnel who are nurses or social workers with at least a bachelor’s degree. The eight – session CBT/social support model we adapted was first developed and implemented in England with community health workers (nurses) during routine home visits. In our program, we gave existing DHWP staff an initial 3-day training program on use of CBT, with ongoing consultation on a monthly basis. That model focuses on identifying thoughts and behaviors associated with depressed feelings, and development of strategies to deal with those experiences, combined with ongoing support from the case manager. The intervention model we are using for women with moderate depression (Tier two) requires Masters preparation and additional training in infant mental health.

To be effective in identifying women with depression, screening must become a part of routine care. Strong administrative support is necessary for implementing such a change. Staff require both initial training and ongoing support in order to develop the competencies necessary to address this sensitive issue. The development or expansion of treatment services must accompany any screening program.

What was the health department’s role in this promising practice?
DHWP provided leadership and a focal point for bringing together a team that included people from community health, mental health and a local university who could conceptualize and develop an appropriate screening and intervention strategy within the limited funding available through the national Healthy Start initiative. With leadership from the health department, this core group was able to cross disciplinary boundaries and develop an intervention that was home-based, and culturally sensitive to women in the geographic area served by the Detroit Healthy Start Project.

What barriers were encountered and how were they overcome?
The two initial barriers encountered were lack of screening and lack of available services and treatment slots for intervention in perinatal depression. Few obstetrical providers screened for depression during pregnancy and postpartum, and those who did, did not provide treatment. None of the mental health providers in the City of Detroit differentiated between treatment of major depression in the general population and perinatal depression. These barriers were overcome by creating an interdisciplinary team that created the two-tier intervention system that has been described earlier. This required collaboration, mutual understanding, and willingness to go beyond differences in the way the community health and mental health systems function.

Additional barriers included staff reluctance to “add” to their workload by screening women for perinatal depression and a fear that “I might do something wrong and make things worse.” This was true among staff both in the clinics and in the case management team.

This barrier was overcome through ongoing training and consultation.

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CityMatCH is a national organization of urban maternal and child health programs and leaders, dedicated to improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. Initiated in 1988, CityMatCH through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for the addressing health concerns of urban families and children.

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A recent joint NACCHO-CityMatCH member survey identified women’s health as a high priority for a majority of local public health agency leaders. They indicated that key women’s health issues included prenatal care, family planning services, breast cancer prevention, prevention of tobacco use, and general health education. However, respondents indicated that many needs related to women’s health, such as health services access and chronic disease/general health education are not being adequately addressed. Overall, survey respondents reported a need for women’s health best practice information.

In response, CityMatCH is pleased to present “Toward Women’s Health: A Compendium of Promising Practices to Improve Urban Women’s Health.”

This four-issue compendium highlights how CityMatCH members are working to improve the health of women in their communities. Some of the activities described are natural extensions of current services; while others are more involved, requiring new resources and ways of doing business. All are a response to data and address the needs of urban women.

Issue three of this series describes four additional promising practices to improve the health of urban women. The Maternal Depression Screening Program in Boston, Massachusetts describes a screening and intervention program directed at pregnant women enrolled in a Healthy Start Program. The Azalea Project in Jacksonville, Florida highlights an intense multidisciplinary case management program that serves hard-to-reach and difficult-to-serve substance-involved women and their families. A promising practice from Dayton, Ohio describes the joint efforts of community women and health experts to develop a women’s health education symposium. The Amarillo DaTA Institute Project highlights what one Texas community has done to move data to action to improve health. We hope the resourcefulness, commitment and collaboration shown by these stories will provide you with inspiration to implement a promising practice for urban women in your community.

Promising Practices in this Issue

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What is the promising practice?
We are providing depression screening and intervention to reduce perinatal depression among enrolled women.

How did this practice come about?
Focus groups with providers and consumers identified mental health and specifically depression as key issues among women seen within the Boston Healthy Start Initiative (BHSI). In addition to those women who experience postpartum depression, a significant proportion begin their pregnancies depressed. BHSI determined that holistic case management services and creative approaches were needed to address the depression experienced among inner city Healthy Start enrolled women in Boston. An intervention was developed that incorporated mental health case management services for women during pregnancy and through two years postpartum.

What are the primary goals and expected results?
• Screen all pregnant and parenting women to identify depression at an early stage and offer appropriate health services.
• Provide appropriate treatment for women who are identified.

What are the key strategies/activities of this promising practice?
• Train case managers on using the Beck depression-screening tool (21 questions) and the Women's Health Questionnaire (WHQ).
• Screen all pregnant women at intake in the BHSI program at all 14 agencies using both the Beck tool and WHQ.
• Screen women again at eight weeks after delivery and then again one year after delivery using the Beck tool. (eight weeks was chosen, as we want to capture depression and not postpartum depression).
• Screen women using the WHQ at intake, end of first and second year after delivery.
• Identify community resources to refer women for mental health services when required.

The Depression Screening Initiative began in 2001. Women targeted by this intervention are from Boston neighborhoods experiencing racial disparities in perinatal health. Women are Black and from a variety of different cultures: African-American, Haitian, Cape Verdean, African, and Black Latinas. Parenting and pregnant women receive services at one of fourteen Boston Healthy Start funded community health centers and community-based agencies.

Trained case managers (registered nurses or social workers) from the community provide education and support about depression to screened women. Case managers are trained to implement the Beck Depression Inventory tool and to engage in follow-up to women with low and moderate depression. In situations where in-depth mental health treatment is needed, referrals are made to community-based resources. The case managers offer encouragement and reminders to women to attend their mental health appointments.

What specific, measurable results have evaluations shown have been achieved?
• 718 women have been screened. One out of three women scored positive for depression during pregnancy using the Beck Depression Inventory tool. Two out of ten scored positive for depression at postpartum period. Eighteen percent of women were depressed at the one-year interconception time;
• These numbers are consistent with the numbers from the Women's Health Questionnaire screened during pregnancy 13 percent had mild depression, nine percent moderate depression.
and nine percent were severely depressed;

• After adjusting for differences in age, education, alcohol and drug use African Americans still have six times higher risk of depression than Haitians, Latinos have four times, and all other race group has three times higher risk of depression than Haitians. (Source: WHQ data);

• Depression differs across ethnic groups with the lowest prevalence among Haitians. Compared to Haitians, African American women were eight times more likely to be depressed, Latinas were almost six times more likely to be depressed, and all others were three times more likely to be depressed;

• The odds of being depressed are more than three times higher in those born in the US, compared to those born abroad;

• Depression is associated with economic problems, family problems, smoking, substance use and housing problems;

• Surveys on attitudes toward depression were administered to clients. Findings showed that many women scoring high in the BDI do not perceive depression as a problem; and

• The retention rate for women receiving mental health services is 62-67 percent overall.

What else would you like your colleagues to know about this initiative?

Many women are in denial and refuse services even when they score high for being depressed. There are serious barriers to care for women accessing mental health services for women who are not comfortable speaking English. Finding bilingual providers can be difficult and may require waiting lists for appointments. Cultural barriers to accessing mental health must be addressed.

What are the costs associated with this project?

Boston Healthy Start Initiative receives no extra funding for doing the depression screening for these women. It was incorporated as part of a holistic case management model for which BHSI is already funded.

What else would you like your colleagues to know about this initiative?
The BHSI has a strong advisory consortium that includes community residents, staff from local agencies health, and other community agencies. The BHSI Consortium identified a need for a more creative approach to addressing the emotional and physical needs of women. Two new programs are now underway. Sisters’ Circle addresses the emotional and spiritual needs of women through monthly meetings and bimonthly individual coaching. Slim Down Sisters which focus on women’s physical wellbeing. BHSI is also looking at ways to initiate family events and involve fathers more in activities.

What barriers were encountered and how were they overcome?
The BHSI population is consistently exposed to stress. Denial is a factor for many clients. Women do not want to be labeled as depressed due to a fear of the mental health system.

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The Azalea Project
Northeast Healthy Start Coalition
Jacksonville, Florida

What is the promising practice?
The Azalea Project provides intensive multidisciplinary case management services to hard-to-reach and difficult to serve substance-involved women and their families.

What are the primary goals and expected results?
The primary goal of the Azalea Project is to use the window of opportunity created by pregnancy to break the cycle of substance abuse and other risk-taking behavior experienced by African American women of childbearing age. The project attempts to address intergenerational risks by working with women and pre-adolescent girls in their household who are exposed to this lifestyle. Substance abuse is a contributing factor in nearly 25 percent of the poor outcomes in Jacksonville, based on FIMR reviews. By reducing substance abuse and the risky sexual behavior associated with it, the project will contribute to improved birth outcomes and reduced HIV transmission.

How did this practice come about?
The Northeast Healthy Start Coalition identified the need to address drug abuse as a cause of infant mortality. The current approach to delivering case management and related services to these high-risk women was not working. Very few were successfully engaged in services. The Coalition received a planning grant from SAMSHA to address the needs of substance involved women at risk for HIV. The $100,000 grant allowed for one year of planning beginning in February, 2001. Based on the plan developed, the Coalition successfully applied for a three years of service grant to implement proposed strategies.

The planning time allowed the Healthy Start Coalition to bring together a diverse group of partner organizations, including treatment agencies, community organizations, maternal and child health care providers and women in recovery. This inclusive approach led to the Azalea Project’s unique design.

What are the key strategies/activities of this promising practice?
The Azalea Project provides outreach, case management and risk reduction services, group education and support, and youth development activities. Azalea works closely with treatment providers to ensure substance-abusing women receive needed support during treatment and after discharge. The 18-month intervention addresses intergenerational risk by working with substance-involved women and the girls or young women in their households. Clients include women who are parenting, have lost custody of their children, are nonpregnant
or are pregnant. Fifteen of the initial clients completed the set intervention in September 2004.

The Azalea Project is open to women who are court-ordered to participate, as well as, women who volunteer for care. The Azalea Project is housed in a storefront located in a Jacksonville (Florida) neighborhood where drug use is high. As with Azalea’s sister project, the Magnolia Project, the site is attractive, nonthreatening, and inviting. Staff members are compassionate and committed to making a difference and value treating participants with kindness and respect. The office is easily accessible and hours are from 10 am to 6 pm Monday through Friday with staff readily available via pager at other times.

Upon entering the program, women complete a psychosocial assessment that includes self-reporting of substance use. Women are then referred to other community agencies if needed for in-depth substance treatment and to other needed services. Staff works with women to ensure they receive needed services and care. Staff also provides complex case management services of varying degrees of intensity based on individual need.

The focus of case management is to empower the woman to achieve and maintain sobriety and to set achievable goals for her future. Staff function as “life coaches,” providing encouragement and support to participants. Group education is an integral part of Azalea Project activities. Group sessions build skills around substance abuse and HIV prevention.

A multidisciplinary team approach is used to deliver services in the Azalea Project. Rather than the care being the responsibility of one case manager, the case management team takes responsibility for each client. The team concept is working well and the clients like the structure.

The Project has a community committee of neighborhood advisors who provide guidance and engage in local outreach. Women who have completed services may become Azalea Ambassadors and engage in community outreach and case finding.

Services are provided in close collaboration with multiple community agencies. Only one person, Faye Johnson the Project Manager, is a Healthy Start staff person. Other Azalea staff work for different local agencies that contract with the Healthy Start Coalition to provide services. Local contract agencies include treatment facilities, the health department, youth services, and the minority AIDS coalition. The

We have learned over time that if you want to meet the needs of participants, especially high-risk participants, you may need to sacrifice efficiency.

The project evaluator. Contract agencies have also leveraged other funding to supplement SAMHSA-supported staff at the project site. This increases the capacity of the project, while generating additional participants for each agency.

The Azalea Project has four case managers for adults and two for youth, two assessment workers, and two outreach workers. There are two case management teams and each team is responsible for 15 to 22 women and approximately 20 youth.

What specific, measurable results have evaluations shown have been achieved?

More than 300 women have been referred to the project since the doors were open in February 2003. About 80 women have been enrolled in intensive case management provided by the project; the remainder have been linked with other community providers. The program has been overwhelmed with referrals. However, to preserve the integrity of the intervention, limits are set on the number of women who may enroll.

Fifteen women completed the 18-month project intervention to date. The graduates entered the project with an average of 11.1 problems or risks. The most frequent problem (100%) at enrollment was risky sexual behavior (need for HIV education). Education and job training was needed by 83 percent of graduates; 75 percent were substance-involved; 75 percent were in need of employment or job placement, and 67 percent had housing needs. Half of the

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What is the promising practice?  
*Woman Within: Taking Time to Care Symposium* is an educational symposium that offers opportunities for health experts and women in the community to discuss a variety of health topics.

How did this practice come about?  
The Women’s Health Education Program was created in 1998 to address the many health problems affecting minority women. Though women share many similar health problems, in general White women live nearly six years longer than African American and other minority women. Minority women use fewer health services, experience higher rates of premature death, infectious diseases, and face more barriers to life-long good health. To eliminate these disparities, the *Woman Within: Taking Time to Care Symposium* was created. It provides women with an open forum to voice their concerns relating to health care, cultural barriers, social and economic conditions.

What are the primary goals and expected results?  
- To provide a forum, during Women’s Health Month, where women can openly discuss health issues and concerns.
- To empower women to make decisions and take responsibility for their own health and wellbeing.

What are the key strategies/activities of this promising practice?  
These symposiums have been held annually since 1998. The open panel discussion have included subjects such as intimate partner violence, kinship care, elderly care, fitness and staying healthy, sexual health and sexually transmitted diseases, pre-menopause, menopause, and depression. The topics are chosen by a planning committee composed of community lay and professional women.

The 2004 Annual Women’s Health Education Symposium held in September addressed *The Woman Within: Taking Time to Care*. Three hundred invitations were sent to various women’s organizations and women throughout the Dayton, Ohio area. Public service announcement were aired over Radio 1 and WDAO-Radio. News releases were sent to area print media.

Seventy-seven community women registered for the symposium. Four Health District staff and four guest speakers also attended. Each participant received a T-shirt with the *Woman Within: Taking Time to Care* logo embossed on the front.

The Executive Director of the Ohio Commission on Minority Health delivered the keynote address. Ms. Boyce was honored for her outstanding service in working to eliminate health disparities in minority populations throughout Ohio. This was followed by a panel of experts who discussed three concerns: domestic violence, HIV/AIDS, and strategies for effective communications with health care providers. After a brief overview of each topic, the audience engaged in a conversation with each of the panelists.

What specific, measurable results have evaluations shown have been achieved?  
Since its inception in 1998, over 800 inner-city minority women have benefited from the various health screenings provided and gleaned information lifestyle management for optimal health and well-being. The symposiums are consistently well-received by participants who comment on the quality and relevance of the topics.

What are the costs associated with this project?  
This program is partially funded by a small grant from the Wright State University, Centers for Healthy Communities and the Division of Special Services of the Combined Health District of Montgomery County. Total expenditures for this year’s meeting were $5,492 which reflected the costs of the event and related staff time.

What barriers were encountered and how were they overcome?  
The primary barrier was obtaining sufficient funds to finance the event. We received a limited grant of $1,600.00 from the Center for Healthy Communities, for speakers, security, postage, printing of flyers, etc. $160.00 could be used for incentives, therefore other resources had to be identified to provide the needed funds for food and other necessary items.

The second problem we encountered was a lack of Latina
participation. To overcome this problem, we invited a representative from the Latina community to serve on the planning committee and better involve local women.

What advice do you have for your colleagues who wish to engage in a similar effort?
Invite both professional and lay women to serve on your planning committee. If you have a large Hispanic population, find out where they are located and invite a spokesperson from the community to participate in the planning process.

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Additionally, many women are not familiar with variations in mental health issues and believe “you are crazy or you are not.” Women with depression often do not want follow-up, so case managers work to help these women develop a support system. Services are tailored to meet each individual's needs. Case managers make repeated home visits for other issues such as housing or around infant care. The case managers also address depression during that time.

What advice do you have for your colleagues who wish to engage in a similar effort?
We found by doing focus groups that no one wants to be labeled as being depressed, and in some communities, it is not culturally acceptable to be depressed. There are a group of women who are in denial that they are depressed, as they have dealt with it all their life. To address these issues educating the community in a culturally sensitive manner is extremely important. Support groups should be designed not to directly deal with depression, but indirectly through winning the confidence of the women. This is done by the case managers on an ongoing basis.

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Boston Healthy Start Initiative
(continued from page three)
Amarillo DATA Institute Project
The Amarillo Department of Public Health
Amarillo, Texas

What is the promising practice?
This project represents a collaborative effort to reduce infant mortality by engaging in detailed data analysis and using the resulting information for targeted program planning.

How did this practice come about?
The University of Texas School Of Public Health examined linked birth and death records between 1990 and 1997 using five-year rolling averages and birth-weight specific mortality rates. The analysis concluded that the rates of low birthweight (LBW) and very low birthweight (VLBW) infants were significantly higher in Potter and Randall counties than the Texas state average, and were the strongest predictor of infant mortality.

What are the primary goals and expected results?
• To secure and analyze relevant data to determine the reasons for the high rates of infant mortality in the Potter and Randall counties.
• To determine what action the Amarillo Department of Public Health (DPH) could take to reduce poor birth outcome.

What are the key strategies/activities of this promising practice?
A team comprised of staff from the DPH and the Texas Tech University Health Science Center (TTUHSC) participated in the CityMatCH Data Institute. The team engaged in the Perinatal Period of Risk (PPOR) Approach to monitor and investigate fetal-infant mortality and identified major contributors to local infant mortality rates in their community. The team identified maternal health/prematurity factors as the most significant contributing factors. The DPH used this information to design additional data inquiries and to plan a series of community interventions.

The DPH contracted for a Behavioral Risk Factor Surveillance Survey (BRFSS) of the two county area. The TTUHSC 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 suggested that MCH programs targeted on age, race, or ethnicity, might be less effective than those targeting social isolation and unsafe neighborhoods.

Community partners are using the BRFSS results to develop activities focused on empowering urban women to maintain and improve their health. The survey results will also enable the community to better target policy changes.

Another result of the analysis was determining that instead of focusing exclusively on high-risk pregnancies, targeting a larger population of low and moderate risk women of childbearing age would be more productive. A broad-based social marketing campaign would most likely have the greatest impact over time.

The DPH management team, Public Health Authority and Dr. Jim Rohrer, TTUHSC, Division of Healthcare Organization Research engaged in a strategic planning process in November and December 2003. The purpose was to establish priorities for the next three years for the DPH. Data from the PPOR analysis was considered during priority determination. The following questions were posed:

1. What is the size of the problem (how many people are affected)?
2. Is there a public health intervention that could improve the health problem?
3. What resources are available to us to implement interventions?
4. What priorities and interventions would be acceptable to the citizens we serve?

Nine health priorities were identified:

1. Empower people to avoid obesity and achieve at least moderate levels of physical activity;
2. Empower people to minimize smoking;
3. Empower people to avoid dependence of alcohol or other drugs;
4. Empower people to avoid depression, anxiety and deal appropriately with anger;
5. Empower people to avoid injuries;
6. Empower people to adopt responsible sexual behavior;
7. Empower people to avoid vaccine preventable and other communicable diseases;
8. Empower people to improve their oral health; and
9. Protect the public against consequences of natural and manmade disasters.

Staff is developing plans to address these nine priorities. General strategies include:

• Increasing awareness about the issues;
• Partnering with groups who share one or more of these issues as a priority; and
• Providing information to the public in support of a self help approach.

What specific, measurable results have evaluations shown have been achieved?
The analysis and planning efforts have determined that it will be necessary to improve the overall health of women to improve birth outcomes. Specifically, it will be important to address the psychosocial stressors and environmental characteristics that influence women’s health.

The general goal of public health is to create the conditions in which people can be healthy. The DPH leadership believes that by focusing on these priorities, we can improve the quality of life in Potter and Randall Counties for everyone, including women.

The team currently has a better idea of how many people have psychosocial and environmental stressors. Local research revealed that twenty five percent of lower-income health center patients suffer from frequent mental distress. The same study showed that perceived barriers to walking directly affect self-rated health. Current program plans include promoting walking, using existing community resources, such as newly developed hike and bike trails and city park walking paths. The goal is to assist people to overcome perceived barriers to walking. This may improve the health of low-income women and hopefully improve birth outcomes.

What are the costs associated with this project?
The Behavioral Risk Factor Surveillance Survey cost $21,000 for two counties. The Texas Department of Health did the analysis at no cost. The cost of additional analysis by TTUHSC was approximately $10,000.

What else would you like your colleagues to know about this initiative?
The Amarillo DaTA project was a collaborative effort between the Amarillo Department of Public Health and Texas Tech University Health Science Center. One of the most exciting aspects of the project was the exchange of ideas and philosophy between the two agencies that occurred during the course of the project.

Another outcome of the PPOR process was the development of a Community Health Observatory. The Community Health Observatory will institutionalize regular collaboration and analysis of relevant data. It will monitor community health throughout the Texas Panhandle using public data and surveys. The Observatory will also provide training in the use of community health data. Go to http://amarillopublichealth.com/observatory.htm for more information about the Observatory.

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CityMatCH has identified six ways to improve the health of urban women. The promising practices illustrate these principles.

1. **Embrace a broader view of women’s health within maternal and child health.**
   Embrace a view of urban women’s health that includes the traditional maternal role and takes a comprehensive view of women’s health throughout the life span. Advocate for this expanded view of women’s health within your agency.

2. **Provide leadership for urban women’s health.**
   Continue to have the resolve and resiliency to be a change agent in improving urban women’s health. Advocate locally for urban women’s health. Educate and train yourself and others about the health needs of women in your community. Provide data and information to illustrate the needs of urban women.

3. **Engage in collaborative activities to improve women’s health.**
   Work with local and state partners to better address women’s health issues. Reach out to new, current, and non-traditional partners focused on women’s health issues such as reproductive health providers or health care access advocates.

4. **Document, disseminate, and implement promising practices to improve urban women’s health.**
   Develop and duplicate promising practices. Respond to requests for promising practices, so that other agencies may benefit from your experiences.

5. **Engage in training and skills-building opportunities.**
   Participate in agency and staff assessments to determine where skill gaps exist. Develop staff and personal skills in areas such as: data analysis, leadership, communications, advocacy, and other needed areas. Use these skills to address women’s health issues.

6. **Advocate for comprehensive women’s health services.**
   Provide needed care in the best manner for your community. Ensure that services are women-centered and women friendly.

**What advice do you have for your colleagues who wish to engage in a similar effort?**
A broad vision that attracts a diverse group of community partners is important. Leveraging existing resources with a focus on improving the overall health status of the community is essential.

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 challenging.

Think ‘outside the box’ of personal health services. Change the environment, so more women will choose to be healthy. Do not be trapped into ‘blaming the victim’ for unhealthy behaviors that are reinforced by unhealthy environments.

**Whom can we contact for additional information about this initiative?**

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graduates reported that they were sexually abused as a child and 67 percent reported having sex against their wills. At closure, participants completing the 18-month intervention successfully managed or resolved 59 percent of the risks or problems identified at program entry.

There were five babies born to project graduates during their enrollment in the project. All of the babies were born weighing more than 2,500 grams; one was born substance-exposed (methadone). There were no HIV positive babies born to program graduates.

What are the costs associated with this project?
The Azalea Project receives $350,000 a year from SAMHSA. An additional $80,000 in state funding is provided annually by the Healthy Start Coalition. Two full-time positions are funded by the contract agencies with state and federal support.

What else would you like your colleagues to know about this initiative?
• Location is very important;
• Let staff know they are valued;
• Be able nurture team members so that they can nurture clients;
• Staff must be very welcoming;
• Clients respond to a non-judging and loving environment; and
• Involve the participants in outreach and community awareness.

What barriers were encountered and how were they overcome?
We learn a great deal from our partners. Collaboration is hard work and difficult to do.

What advice do you have for your colleagues who wish to engage in a similar effort?
In our situation, smaller is better. It allows us to be flexible and open to new ideas. When things don't work, we change our approach. We have learned over time that if you want to meet the needs of participants, especially high-risk participants, you may need to sacrifice efficiency.

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CityMatCH is a national organization of urban maternal and child health programs and leaders, dedicated to improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. Initiated in 1988, CityMatCH through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for the addressing health concerns of urban families and children.

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A recent joint NACCHO-CityMatCH member survey identified women’s health as a high priority for a majority of local public health agency leaders. They indicated that key women’s health issues included prenatal care, family planning services, breast cancer prevention, prevention of tobacco use, and general health education. However, respondents indicated that many needs related to women’s health, such as health services access and chronic disease/general health education are not being adequately addressed. Overall, survey respondents reported a need for women’s health best practice information.

In response, CityMatCH is pleased to present “Toward Women’s Health: A Compendium of Promising Practices to Improve Urban Women’s Health.” This four-issue compendium highlights how CityMatCH members are working to improve the health of women in their communities. Some of the activities described are natural extensions of current services; while others are more involved, requiring new resources and ways of doing business. All are a response to data and address the needs of urban women.

The Compendium’s final issue highlights five practices directed at various aspects of women’s health. In the communities surrounding Raleigh, North Carolina, a coalition of citizens and community health professionals came together and developed a Women’s Health Improvement Plan. An Interconceptional Education and Counseling Initiative was implemented within the St. Petersburg, Florida Healthy Start Program. Contra Costa, California provides an example of what can be done by a community-wide coalition to reduce health disparities associated with breast cancer in their Women’s Health Partnership to Reduce Breast Cancer Program. Finally, in Little Rock Arkansas you will learn about a Service Integration Project to reduce barriers to services used by community women. We hope the resourcefulness, commitment and collaboration shown by these stories will provide you with inspiration to implement a promising practice for urban women in your community.

### Promising Practices in this Issue

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What is the promising practice?
A coalition of community professionals and citizens developed a community-wide women’s health improvement plan. The health improvement plan led to the development of a Lay Health Worker program directed at improving the health of community women.

How did this practice come about?
Wake County, which includes the Raleigh area and several rural towns, has a population of nearly 700,000, making it the second most populous county in North Carolina. The county is predominately White with approximately twenty percent African American and five percent Hispanic/Latino. Wake County is rich in resources, but continues to experience significant white and minority disparities, as well health care access issues.

Wake County Perinatal Periods of Risk (PPOR) data indicated that poor birth outcomes associated with African-American women, who often begin their pregnancy in poor health, was driving infant mortality rates in Wake County. The Healthy Mothers, Healthy Babies Coalition, the Wake County Human Services (the departments of health, social services, and mental health), March of Dimes, a local college, and sixteen other community partners decided that if you want healthy babies, you need healthy women, so they took action.

What are the primary goals and expected results?
- Improve the overall health of women in Wake County, particularly those who have low incomes and are African American.
- Improve birth outcomes.
- Enhance collaboration among community partners to better address the health needs of women.

What are the key strategies/activities of this promising practice?
The Wake County PPOR committee asked community members, “What is your vision for women’s health in Wake County?” This question led to a community-wide women’s health improvement process begun in January, 2002.

A Health Forum was held in November 2002 entitled “Healthy Women, Healthy Communities: Strengths, Challenges, and Opportunities.” Eighty-five participants attended, with 47 people representing 25 local agencies, and 38 community residents. Health Forum participants identified the major women’s health issues in their communities and strategies for health improvement. Participants developed a women’s health improvement plan with 21 action items associated with five major goals issues:
1. Increase knowledge of health advocacy among grassroots community;
2. Increase quality/quantity of childcare;
3. Address racism/discrimination within the delivery of care system;
4. Create opportunities for women to support women; and
5. Increase access to women’s health services.

The Healthy Mothers Healthy Babies Coalition initiated a new program in response to the women’s health improvement plan. The Woman 2 Woman Project provides training, support, and resources to lay community leaders to enable them to educate and support women and their families around healthy lifestyles. Each of the Lay Health Advisors is a community leader who receives regular training on health issues, and works at least ten hours a month in her community. The Advisors work in seven low resource communities throughout the county. The Lay Health Advisors provide information, resources, and needed referrals to women at any time they need assistance, not just when they are pregnant.

Lay Health Advisors report that women are interested in knowing more about physical, emotional, and mental health. Women want to know about weight, depression, stress, housing employment, domestic violence, financial needs, childcare, and affordable medical care. Community women often mention the need for economic stability as an aspect of health.

**What specific, measurable results have evaluations shown have been achieved?**
Project evaluation is underway. The Woman 2 Woman Project reaches about 313 women and their families and provides 82 needed referrals each month. Lay health advisors participate in neighborhood outreach going door-to-door or reaching women by phone. They also arrange house meetings, engage in street outreach, do presentations, and participate in health fairs and other community events. Records show the subjects most commonly addressed with women are: emergency assistance, health insurance, child care, and housing.

**What are the costs associated with this project?**
The Healthy Mothers, Healthy Babies Coalition, Wake County Human Services, March of Dimes, Wake AHEC, Wake County Child Fatality Team, St. Augustine’s College, and other community partners provided financial and in-kind support to the Health Forum. Grant funding originally supported the Woman 2 Woman Project, and it is now funded through Wake County Human Services. The project has a half time paid coordinator, and each Lay Health Advisor receives a stipend.

**What else would you like your colleagues to know about this initiative?**
The positive results include 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.

**What advice do you have for your colleagues who wish to engage in a similar effort?**
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. Community engagement can be challenging but the positive results justify the needed time, creativity, and effort.

**Whom can we contact for additional information about this initiative?**
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Community women often mention the need for economic stability as an aspect of health.
Interconceptional Education and Counseling Initiative
Pinellas County Health Department Healthy Start
St. Petersburg, Florida

What is the promising practice?
Pinellas County Health Department is providing interconceptional education and counseling as a component of Healthy Start home visiting.

How did this practice come about?
A Perinatal Periods of Risk* (PPOR) study for 1998-2000 revealed that addressing maternal health was vital to reducing the poor birth outcomes experienced in Pinellas County. The Pinellas County Health Department and the local Healthy Start Coalition of Pinellas agreed that including an educational component as part of Florida’s Healthy Start Programs would benefit women of child bearing age by providing an opportunity to reduce or eliminate important personal risk factors prior to the woman’s next pregnancy.

* The Perinatal Periods of Risk approach has been used in developing and developed countries through the work of the Centers for Disease Control and Prevention (CDC) to monitor and investigate fetal-infant mortality. Since 1997, in partnership with CDC, the March of Dimes, HRSA/Maternal and Child Health Bureau and over 20 major cities, CityMatCH has led national efforts to validate, enhance and adapt this approach for use in urban communities of the U.S.

What are the primary goals and expected results?
Areas important to women’s health include access to health care, maternal infections including periodontal disease, baby spacing and linkage to family planning, nutrition, physical activity, chronic health problems, substance abuse, smoking, stress and mental health needs, and environmental risk factors.

Two primary goals for home visitors in the program are to ensure the Healthy Start woman receives at least one comprehensive primary/preventive health care visit and to assist the mother to achieve recommended baby spacing.

Women are concerned less for themselves when the baby is born and often forget to pay attention to their own needs.

What are the key strategies/activities of this promising practice?
The Healthy Start Program works with women during their pregnancy and into the postpartum period. Home visiting is provided to high-risk women based on a level of care. Women are typically seen monthly or even more often depending on the intensity of risk. A variety of curriculums can be used to educate the mother. A Women's Health Questionnaire is used to assess the status of the woman’s health and social conditions and education and counseling is tailored around identified risk factors. A risk reduction approach is used to assist the woman to develop strategies to reduce identified risk factors. Frequent and routine assessment of progress is made during home visiting. A set of 10 brochures has been developed for use in the home to prompt discussions in each risk factor topic area.
What specific, measurable results have evaluations shown have been achieved?
Electronic encounters are used to document the number of referrals made and services received over an annual period for each of the 10 risk reduction areas for interconceptional care.

Data is also being gathered on the prevalence of certain risk factors identified on the Women's Health Questionnaire.

What are the costs associated with this project?
Financial support to develop and print the set of 10 brochures was received from a variety of Health Department programs also addressing women's health. Curriculum development was accomplished by work teams of Healthy Start staff.

What else would you like your colleagues to know about this initiative?
Promotion of women's health needs to be a collaborative approach within the medical community and community-at-large. The Pinellas County Health Department is working with other health department programs to build a referral system to address women's health and social needs when woman arrive for care.

What barriers were encountered and how were they overcome?
Home visiting staff participated in multiple training opportunities to enhance their skills in providing interconceptional education and counseling. Statewide agency support was gained through the efforts of the Florida's Perinatal Periods of Risk Practice Collaborative model.

What advice do you have for your colleagues who wish to engage in a similar effort?
Women are concerned less for themselves when the baby is born and often forget to pay attention to their own needs. Interconceptional education and counseling is an opportunity to increase the focus on the entire family.

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What is the promising practice?
Native women participate in a class to learn a traditional craft, and engage in a talking circle about the issues of racial disparities in infant mortality.

How did this practice come about?
Native American women continue to have a high incidence of infant mortality in Seattle and King County. Although the activity is creating the cradleboards, it is an opportunity to reach out to women about an important community issue.

What are the primary goals and expected results?
- To increase awareness within the Native community of the impact of stress on health and birth outcomes and how racism contributes to the load of chronic stress;
- Develop lists of the ways that stress impacts women’s lives, and identify community buffers that would provide support to mediate their stress; and
- An unexpected outcome was that the support that the participants derived from the activity.

What are the key strategies/activities of this promising practice?
Native American Women’s Dialogue on Infant Mortality (NAWDIM) is a nonprofit organization devoted to community mobilization and is the sponsor of this project. The instructor and NAWDIM staff recruited participants through flyers and personal contact at summer pow-wows, as well as through word of mouth. A Native woman who is a seamstress and learned how to make cradleboards teaches the class.

The talking circles have brought together an intergenerational group of women and some male partners. So far, three set of classes have been held, each lasting five weeks. The classes work best with about ten participants. The trained Native American facilitator sets the tone for the taking circle and leads the conversation. A staff person from the health department provides information about infant mortality. Each class is four hours long. Dinner is provided, with the cradleboard class and discussions following. Children are welcome.

Once women have begun constructing their boards, the facilitator leads them in a discussion, conducted as a talking circle. The women are comfortable with the talking circle format, which provides a safe and supportive forum for telling personal stories that might be painful or hard, and for discussing important issues. The sessions build upon the women’s already strong willingness to support each other.

Health department staff discuss the purpose of the class. At the beginning, the talk was data-driven, however this has evolved over time. The group discusses health disparities, what can be done to improve birth outcomes, the impact of stress, and what to do about it. The group also discusses what the community can do to help support women.

These cradleboard classes provide an activity for women that they characterized as “healing” for them on many levels. While cradleboards are not traditional in every Native group, they are a symbol of a traditional craft that honors Native women’s heritage in a personal way, and every woman mentioned how much it means to them to learn this craft from a Native woman, with other Native women. Further, the instructor described this process as healing for her to teach other Native women this craft, in the hopes that they would teach others, spreading this traditional craft and safeguarding this potentially lost symbol of Native culture.

When working with the community, it is important to stay flexible enough to follow community suggestions ... because they are often very different from what was originally planned.

What specific, measurable results have evaluations shown have been achieved?
The first year of this project simply yielded lists of community supports for women around childbearing. The second year of this project (2004) will be evaluated more formally, to assess whether participation increased participants’
knowledge about racial disparities in infant mortality, and the impact of stress on birth outcomes. Also measured will be participants’ satisfaction with the classes/talking circles, and whether their own stress was reduced by participation; assess whether participation in cradleboard classes facilitates participation in the ongoing community dialogue group, further empowering women, reducing their stress and enhancing their health; and identify specific ways that women can be supported in the Native American/Alaska Native community, to buffer the stress in their lives and strengthen their health.

What are the costs associated with this project?
In 2003, an Office of Minority Health grant of $48,000 was received, which was extended until September, 2004.

What is the role of the health department in this initiative?
The health department wrote the grant that supports this project. They also provide the data, staff to present the information at the cradleboard classes, and technical assistance where appropriate. In addition, the health department provides staff to conduct the evaluation.

What else would you like your colleagues to know about this initiative?
The agency that sponsors NAWDIM provides social services for Native American people in the area, and usually defers all health issues to the local Seattle Indian Health Board. This cradleboard class offered the agency an opportunity to understand how this social service focus has a place in efforts to prevent infant mortality and reduce racial disparities in infant mortality in our area.

This concrete activity provides a way for NAWDIM to solidify as a group, and provides opportunities for NAWDIM members to develop their leadership skills. This leadership development indirectly leads to strengthening the health of Native women in our area.

This activity provides a way for women from many different tribes to come together in unity to support each other, enhancing their emotional and mental health, and eventually, their physical health.

What advice do you have for your colleagues who wish to engage in a similar effort?
It is essential to work with community members to plan and implement such a project. We learned that when working with the Native American community, it is most important that members of the community plan and implement this project. Our non-Native health department staff, while well-intentioned, do not know enough about the community, and while well-liked, are not trusted enough by community members, to adequately implement this project. Secondly, when working with the community, it is important to stay flexible enough to follow community suggestions about implementation, because community suggestions are often very different from what was originally planned.

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**Women’s Health Partnership to Reduce Breast Cancer**

Contra Costa Health Services
Martinez, California

**What is the promising practice?**
Creating a community-wide coalition to work together to reduce health disparities associated with early breast cancer detection.

**How did this practice come about?**
Contra Costa Health Services (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 that one of the likely reasons for this poor outcome was the lack of early detection of breast cancer among African American women. Staff also knew that it would require a protracted community-wide effort using a multitude of strategies to make a difference.

**What are the primary goals and expected results**
- To increase the rate of early breast cancer detection among African American women; and
- Coordinate a county-wide community effort to eliminate disparities in cancer detection among community women

**What specific, measurable results have evaluations shown have been achieved?**
In 1992, in Contra Costa County White women were much more likely to have breast cancer than African American women, but African American women were much more likely to die of this disease. Among White Women, 72% of the breast cancers were diagnosed at an early stage compared to only 44% of breast cancers being diagnosed at an early stage among African American women. By 1997, these statistics had changed – the early detection rates for both groups was 71%. The community had been able to achieve parity in breast cancer early detection rates between White and African American women.

**What are the key strategies/activities of this promising practice?**
Contra County staff were committed to eliminating the disparity related to early detection of breast cancer. Instead of going to the public and telling them what needed to be done, they showed up at meeting with studies and asked the community for their perspectives on how to go about fixing the problem. The community responded.

Under CCHS’s leadership, the Costa Breast Cancer Partnership was initiated. It became a diverse coalition of nearly 400 breast cancer survivors, medical providers, health advocates, and community agencies. The Breast Cancer Partnership applied the Spectrum of Prevention through a number of innovative approaches. It also began supplying media advocacy and technical assistance to a number of projects that had preceded its formation, such as BACCIS and a van sponsored by University of California-San Francisco and the Susan G. Komen Foundation that offers free on-site mammography.

In addition to facilitating other agencies’ efforts, the Partnership formed an African American Task Group, a Lesbian Task Force and a Latina Task Group, with each group achieving substantial outreach into their respective communities. Their projects included a widely publicized calendar featuring African American breast cancer survivors, a Lesbian softball team that did outreach to teams and spectators in a city softball league, and creation with two local hospitals of the Patient Navigator Program, which facilitates breast health screenings for non-English-
speaking women. Another result was the creation of a provider network to increase access to free or low-cost breast health services, including regional clinics operated by CCHS.

The Contra Costa Breast Cancer Partnership was funded by the California State Legislature through the state Department of Health Services with grants from the Special Tobacco Tax. The state provided $428,000 total for fiscal years 1998-99 and 1999-2000, and $721,249 total for fiscal years 2000-01 and 2001-02. The county provided approximately $360,000 for the four years, and an additional $285,000 was received from assorted private community funds. In 2002, DHS reduced the available funding and this project was eliminated. The agency is regrouping and looking at ways of sustaining their successes.

What barriers were encountered and how were they overcome
The Partnership resolved many obstacles. They worked to reduce tensions between various local organizations. They helped women address issues related to sexuality and modesty that kept them from getting breast health screenings. They helped community groups focus on improving women’s health rather than any single narrower interests. The project provided staffing to action-oriented Task Groups. The Task Group members set priorities and a vision for each of the tailored approaches. By staffing the Task Groups, the project was able to help overcome barriers to implementing activities, provide administrative support for projects, and allow members to have the greatest voice in establishing their priorities.

What else would you like your colleagues to know about this initiative?
Contra Costa County is addressing new opportunities to keep urban women healthy. They are expanding their efforts to reduce other health disparities among women with cancer. Work is under way to reduce some of the disparities that exist in the early diagnosis and treatment of cervical, ovarian and uterine cancers as well. It is ambitious, but in partnership with the community, they hope to see a difference in at least five years.

What advice do you have for your colleagues who wish to engage in a similar effort?
Health disparities are not inalterable facts of nature. They have causes, which can be identified, and with persistent community-wide efforts, the disparities can be eliminated. Public health and government both have roles to play in improving community health. By collaborating with the community, people will embrace and act on information that improves their health and that of their community.

Whom can we contact for additional information about this initiative?
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Service Integration Project
Arkansas Department of Health, The Pulaski Central Health Unit
Little Rock, Arkansas

What is the practice titled?
This program is the Integration and Co-Location of STD and Family Planning Services.

How did this practice come about?
The Pulaski Central Health Unit is a 30,000 square foot Public Health Clinical facility located in inner-city Little Rock, Arkansas. Little Rock has a population of 183,000 people and is located in Central Arkansas. It is the seat of the State’s Medical Training Center and the state capitol. The Central Health Unit is the largest of four health departments located in Pulaski County. The office serves hundreds of women each week who seek family planning and STD services. Until very recently, these clinical services were offered on different floors in the Health Unit building. The arrangement created a physical barrier to clients who may need both family planning and STD services. The staffs of each of these clinics were also separate and unfamiliar with each other. This affected their ability to work together to ensure good patient care treatment and referral practices.

When was this practice initiated?
The practice was initiated in the fall of 2003 in response to the suggestions of local health unit clinical staff. The staff wanted to remove some of the barriers which clients faced when they needed services other than those traditionally offered by the specialty clinics they happened to be attending.

Who is the target population?
The primary target population is women who utilize Family Planning and STD clinics at the Pulaski Central Health Unit.

What are the primary goals and expected results?
Primary goals:
- To enhance women’s access to more comprehensive women’s health clinical services
- To share provider and material resources of the local health unit clinics which are co-located.

Longer-range goals:
- To reduce the number of unintended pregnancies in the Pulaski Central Health Unit population.
- To reduce the STD rate among women seen through the combined clinical service.

Expected Results:
STD clinicians can now offer family planning services during the same visit to clients receiving care for STDs. The women now have access to a greater range of clinical counseling and material resources. Family planning clinicians can offer quicker access to STD services, including HIV/AIDS client-centered counseling and testing.

What are the key strategies/activities of this promising practice?
The family planning and STD clinics in this large urban health department were relocated next to each other on the first floor of the building. This allows greater access to both of these services for women of reproductive health age who visit the clinics. It also facilitates improved staff interaction and sharing.

Because of the co-location, women receive more comprehensive services when they present to either the STD or family planning clinic at Pulaski Central Health Unit. Services include exams, client-centered counseling, treatment, appropriate contraceptives, and follow-up services. Women no longer have to wait for another appointment, nor do they need to extend their clinic visit time to be seen as a drop-in within the other clinic.

What specific, measurable results have evaluations shown have been achieved?
Client satisfaction surveys are the only form of evaluation done to date. Overwhelmingly, women like the convenience of having the opportunity to get family planning needs met when they visit the STD clinic and vice versa.

What are the costs associated with this project?
This project did require some renovation to the first floor clinic space occupied by the STD clinic to allow for proper client privacy and to assure confidentiality. The costs for the renovation were included in the County government budget of the local health department.

What barriers were encountered and how were they overcome?
Staff reaction to the change overall has been favorable. Although a few staff members initially complained...
CityMatCH has identified six ways to improve the health of urban women. The promising practices illustrate these principles.

1. Embrace a broader view of women’s health within maternal and child health.
Embrace a view of urban women’s health that includes the traditional maternal role and takes a comprehensive view of women’s health throughout the life span. Advocate for this expanded view of women’s health within your agency.

2. Provide leadership for urban women’s health.
Continue to have the resolve and resiliency to be a change agent in improving urban women’s health. Advocate locally for urban women’s health. Educate and train yourself and others about the health needs of women in your community. Provide data and information to illustrate the needs of urban women.

3. Engage in collaborative activities to improve women’s health.
Work with local and state partners to better address women’s health issues. Reach out to new, current, and non-traditional partners focused on women’s health issues such as reproductive health providers or health care access advocates.

4. Document, disseminate, and implement promising practices to improve urban women’s health.
Develop and duplicate promising practices. Respond to requests for promising practices, so that other agencies may benefit from your experiences.

5. Engage in training and skills-building opportunities.
Participate in agency and staff assessments to determine where skill gaps exist. Develop staff and personal skills in areas such as: data analysis, leadership, communications, advocacy, and other needed areas. Use these skills to address women’s health issues.

6. Advocate for comprehensive women’s health services.
Provide needed care in the best manner for your community. Ensure that services are women-centered and women friendly.

Whom can we contact for additional information about this initiative?
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Six Ways to Improve Urban Women’s Health

about the perceived loss of autonomy involved with co-locating the clinics, they have been able to appreciate the benefits co-location offers to clients.

What advice do you have for your colleagues who wish to engage in a similar effort?
Make the effort to get and maintain staff involvement from the beginning of a change like this! Once staff began to brainstorm about strategies to open access to women for a fuller range of services in the health department, the idea to co-locate was born. This would not have occurred without the input and hard work of staff. Family Planning clients did not initially like the change (had to locate the new site in the building, had to adjust to different clinicians, etc), but now like the idea.

What else would you like your colleagues to know about this initiative?
This initiative has helped us to maximize resources. The cross-training of the STD and family planning clinicians has allowed clients access to a fuller range of services. Clients now have shorter wait times and require fewer visits overall.
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CityMatCH is a national organization of urban maternal and child health programs and leaders, dedicated to improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. Initiated in 1988, CityMatCH through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for the addressing health concerns of urban families and children.

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1. Promising Practice information in Urban Women’s Health were presented in this Compendium.  
Disagree Agree
1 2 3 4 5

2. The content of this Compendium will be useful in my work.  
1 2 3 4 5

3. The format and organization of this four-issue Compendium kept my interest.  
1 2 3 4 5

4. The Promising Practice stories held information useful to me.  
1 2 3 4 5

5. Which aspects of the Compendium were most useful?

6. What suggestions can you offer to improve the content/quality of this type of CityMatCH publications?

7. What other topics related to improving Urban Women’s Health would you like CityMatCH to address?

8. Is there any person/organization whom you feel would benefit from this compendium?
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