

URBAN WOMEN'S

HEALTH BRIEF

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Toward Urban Women's Health LEADERSHIP

CityMatCH is strongly committed to act as both catalyst and advocate for urban women's health. Improving the health of urban women offers many unique challenges, and over the course of time, CityMatCH has identified three leading edge issues that influence the health of urban women: leadership, access, and resources. This issue brief is dedicated to understanding

leadership, with a primary focus on implications for assuring the health of urban women. This issue brief offers a review of leadership components specific to MCH professionals; shares quotes and perspectives from MCH leaders; highlights the importance of political will and explores how effective leadership can have impact; considers the effects of social and health policies on women's health;

and finally articulates a vision of women's health that embraces and expands upon the traditional maternal role.

CityMatCH encourages you to embrace leadership, an essential component of our roles as change agents and advocates for the health of women, children, and families in our communities.

LEADERSHIP ISSUES

L Political will and leadership are needed to make a difference in urban women's health.

Leadership is needed if the health and well-being of women is to be improved. Leadership, vision, and political will are essential elements to create environments where women can be healthy. Women's health will improve if they have the opportunity to live in communities that value and promote health. Leaders are needed who support community-based health promotion, create and maintain

healthy environments and increase access to quality health care.

Much has been written and said about leadership. Many definitions, resources, and ideas have been presented over recent years.

The American Heritage Dictionary defines **Lead** as:

- To show the way by going in advance;
- To guide or direct in a course;
- To direct the performance or activities;
- To inspire the conduct of;
- To play a principal or guiding role in.

It can be intimidating to be confronted with so much, sometimes conflicting information. Yet, it is important to consider how this body of knowledge may help us improve the health of women in our communities. Knowledge of leadership, and more importantly, actively engaging in leadership, allows us to show the way, guide, direct, or inspire activities in our community that can result in healthier women.

Leadership is not an exclusive club. You don't have to be Martin Luther King, Susan B Anthony, or Abraham Lincoln to be a leader. We all know leaders: the nursing director who successfully led the charge to improve immunization rates in her home town; the environmental health activist in his community who caused change around air quality standards; or the adolescent health coordinator who brought together a diverse group

of community leaders to reduce teen pregnancy.

Traditional views of leadership often emphasized the relationship between leadership and authority. Authority and leadership are often found together, though simply having organizational authority to get something done does not ensure action. Unfortunately, we all have examples of individuals with organizational authority, whom we would not classify as effective leaders. On the other hand, we probably all know people who lack formal authority, yet have accomplished amazing things. We may also know of groups who engage in collaborative leadership, leading to significant changes in their communities. We just as surely can think of people who are actively setting the vision, driving the agenda, or taking the lead when it is time to get the work done.

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Credo's Refrain -

Have you heard about the new National Public Radio series *This I Believe*? It “invites Americans from all walks of life to write about and discuss the core beliefs that guide their daily lives”¹ Each Monday, a 600 word essay is aired in the voice of its author. The original *This I Believe* was a 1950’s radio show hosted by the great journalist Edward R. Murrow. The series grew into a nationally distributed weekly newspaper column, was translated for broadcast around the world, and eventually became a popular book of essays. Great women and men like Helen Keller, Jackie Robinson, and Eleanor Roosevelt, and not so famous folks who taught school and drove taxicabs “distilled into a few minutes the guiding principles by which they lived.” It has been said that nearly 40 million Americans gathered ‘round radios each week to hear from the ordinary and the extraordinary.

Most Mondays just before work or heading home, in the kitchen or still in the car, I’m glued to NPR, straining to taste every word of the latest sweet essay. Once again as was then, each dares to state aloud in crystal words of conscience, language of the soul sent straight through the heart. When authentic voices tell clear, core stories, their aftersounds linger.

Over the past few weeks, one question keeps coming back: so, what do *I* believe? I mean really, *really* believe? ... About the world in which I live and where it seems headed. About the work in which I have been engaged so long for the greater good of women and children. About beginning and end of life choices, equality and equity in health care and housing, about wealth and hunger, about persistent disparities and all the other root issues we still haven’t figured out. I have not been shy of late about voicing indignation when others declare sole claim to “family values,” yet to be fair, one can ask: Have I been forthcoming about my own? I have been on credo “auto pilot,” distracted by so much doing, assuming my actions to speak for themselves.

Knowing and telling one’s core beliefs is a fundamental obligation of every leader. They are notes of personal calling to be sung aloud. Listening to the revived *This I Believe* series has challenged me as a leader in my community and in my field to rediscover and reclaim my core song.

Mine is grounded in ancient melody. I am commanded to heal the world, to perform acts of loving kindness, to leave unrepaid the corners of the fields so that poor not go hungry, to not stand idly by as my neighbor bleeds, to protect the widow and the orphan, to fight injustice wherever it manifests. Contemporary conditions shape its current lyrics. Specific to women’s health, some of my guiding verses are basic and clear.

I believe that every woman has both a responsibility and a right to know her body, understand her health, and make primary decisions about her body and her health. I believe as stated in the United Nations Universal Declaration of Human Rights² that *motherhood and childhood are entitled to special care and assistance*, and that maternal and child health should remain a distinct domain within public health to give visibility and focus to more vulnerable populations. I believe that every woman is greater than the sum of her reproductive parts and differential diagnoses. She deserves our full attention and very best care before, during, and beyond pregnancy, independent of the immediate status of her womb or ovaries. And while most women put their own health last, I believe we can be of greater service to our children, our families, and ourselves when we move toward the front of the line.

The National Public Health Leadership Network lists *identification, articulation, and modeling of professional values, beliefs, and ethics* as among the core transformational competencies of effective public health leadership.³ The Public Health Leadership Society has defined *Principles of the Ethical Practice of Public Health*⁴, with clearly articulated values and beliefs underlying its 12 principles. The Institute of Medicine’s recommended use of the “ecological model” as a unifying framework for public health practice reflects the core value of interdependence of people, and communities, institutions, and systems.⁵ Frameworks abound, tools are at hand; they are sextons of our service. What is often missing is the fundamental act of defining one’s own creed to anchor our work for the public’s health.

So, I ask you as a colleague and champion of women’s health: Are you ready to stand in the public square and declare the core beliefs that drive your public health practice for optimal women’s health and well-being? This is no easy task, nor is it void of risk. Leaders who dare to be vocal about controversial issues in reproductive health, who speak out for women’s rights, who insist on using scientific foundations for best practices and policies to achieve women’s health, may meet resistance or be trumped by powerful others’ non-negotiable truths.

I believe we are entering a time in which there will be greater consequences for women if we do not speak out based on our public health knowledge and core value of justice. National Public Radio’s website explains that “in *reviving and reinvigorating This I Believe*, our goal is not to persuade Americans to agree on the same beliefs. Rather, we hope to encourage people to begin the much more difficult task of developing respect for beliefs different from their own.” As artful public health leaders with special dedication to improving the health and well-being of all women and children, may we create viable, safe spaces for civil public discourse and foster vibrant, thoughtful dialogue about what really matters. May we find the ways and means to identify and articulate our guiding values and beliefs, and model them in our daily work. May each unleash the leader within who is ready to sing the verses of her creed.

Magda G. Peck

The first responsibility of a leader is to define reality. The last is to say thank you. In between the two, the leader must become a servant and a debtor. That sums up the progress of an artful leader.

Max DePree, *Leadership is an Art*

¹ National Public Radio, www.npr.org

² United Nations General Assembly, Universal Declaration of Human Rights, 1948.

³ National Public Health Leadership Network, Public Health Competencies Framework, April 1997.

⁴ Public Health Leadership Society, Principles of the Ethical Practice of Public Health, Version 2.2, 2002.

⁵ Institute of Medicine, National Academy of Sciences, Public Health for the 21st Century, 2003.

So what do we know ABOUT LEADERSHIP?



We know that it tends to arise when the need, desired results, and timing call for it. We know that leadership is a set of skills that can be learned and taught, and that management and leadership are *not* the same things. They may or may not be found together. It is an old chestnut, but often the best way to differentiate between the two is to recognize that “managers do things right, but leaders do the right things.”

Leadership typically begins with a situation that needs to be addressed. The leader is willing to take responsibility and to be accountable for what needs to happen. Having a vision for how to address a particular situation is another key component of leadership.

So if we begin with a motivated person who is willing to lead and has a vision of healthy women living and working in healthy communities, what else do we need to translate vision? We need to be able to describe our vision for healthy women in our community. What would it look like? How would we know when it has been achieved? We need the knowledge, skills and ability to share our passion and articulate our vision in a way that engages and inspires others to join us in creating a new reality.

“It takes many to create change, but only a few to get started. Although grounding in science and knowledge of effective strategies are necessary, political will is needed for change to happen”

—MCH leader

We have a motivated person with a vision that can be clearly articulated, but something is missing. That “something” is of course, people. Leadership exists in the context of others, and an effective leader understands that you “manage things, but lead people.” So much of leadership is about engaging others in the vision, securing their support and trust, and encouraging them to develop their own skills and abilities to move both the vision and themselves forward.

Once the vision has been articulated, it must be turned from a dream into an achievable plan with the help of others. What is needed to improve the health of women in our communities? What goals, activities, and action steps are necessary? What resources will be required? What opportunities already exist? What barriers impede the way? What strengths and weakness need to be considered? Who must do what, and by when? The leader listens, involves others, provides structure, ensures accountability, shares authority, and creates situations where work can be done.

The plan is then initiated, activities are begun, committees convened, deadlines met, problems encountered and resolved, goals accomplished, and successes celebrated. It is expected that the team meets all these milestones with grace, endurance, humor, flexibility, and continued commitment to meeting the health needs of women in their community.

Does the process of leadership end there, all neat and tidy? No, new situations arise, and new ways of addressing problems are always needed. Leadership is a process of evolution, characterized by continuous learning about motivation, communication, delegation, team-building, and management. Good leaders enhance their personal skill sets and empower others around them to do the same. Ongoing retooling of systems and structures assures effective response. Thus when the next leadership challenge emerges, (This is the nature of public health) a dedicated leader is ready.

“Loeb and Kindel state that leadership is the set of qualities that causes people to follow. Leadership is a set of disciplines involving the formulation of a vision, the development of a plan, the execution of a mission and the reaching of a goal. Modern leadership is built on teamwork which is based upon cooperation.”

Our inherited legacy of leadership in MCH both inspires and challenges us as we strive to responsibly advocate, align constituencies, build and use data capacities for need assessment and evaluation, question our premises, identify and courageously confront pressing health and social issues, and continue our efforts to formulate and articulate a vision for the future of MCH. (Greg Alexander, **Our legacy for leadership in MCH. Alexander GR.** Journal of Maternal Child Health 2003 Sep;7(3):145-50)

Leadership OVERVIEW

In the winter of 2004, an informal query was sent to some of the remarkable public health and maternal and child health leaders associated with CityMatCH and its sister organizations. Respondents were encouraged to forward the survey to other MCH leaders to assure a broad range of responses. The survey was simple, asking just four questions:

- What do you perceive as some of the most important qualities of a leader in maternal and child health today?
- What advice would you offer others about being an effective leader within maternal and child health?
- What resources (books, trainings, etc.) would you recommend for someone who wishes to strengthen their leadership skills?
- What information about leadership would you find useful and recommend be included in the Urban Women’s Health Leadership Issue Brief?

CityMatCH is grateful to the respondents for their replies, as their perspective influenced the direction of this issue brief, though it is by no means limited to their responses. You’ll find selected quotes scattered throughout this issue, and the next pages incorporate a summary of their collective wisdom regarding twenty-two qualities they felt an MCH leader should possess.

MCH Leaders Are:

- Ready to take risks and sometimes fail;
- Willing to take on the status quo and appropriately challenge the system to bring about needed change, and fight for women and children;
- Able to develop and use strong political savvy;
- Able to assure his/her voice is heard;
- Willing to challenge authority and tradition to bring about needed change;
- Transformers, creatively addressing conflict and transforming conflicts into positive changes;
- Prepared to stick his/her neck out when necessary.

*THE MATERNAL AND CHILD HEALTH (MCH) LEADER**

Vision is essential; much of what we do is to see the future and the impact of today's events on the children of women tomorrow.

— MCH leader

1. Advocates for women and children.

2. Builds bridges.

- Partners, partners, partners!
- Works to understand the internal philosophy and goals of different organizations and groups, to establish areas of common interest, and to move forward in public health changes;
- Collaborates with others to accomplish common goals;
- Builds networks and support within and beyond the MCH/public health field.

3. Forms coalitions and collaborative partnerships to accomplish common goals.

- Facilitates complex processes that involve multiple partners, defines results, and sets strategies to achieve the results;
- Engages a wide variety of people from community residents, stakeholders, business and policy makers;
- Is a good facilitator and consensus builder.

4. Embraces change.

- Is not afraid of it;
- Accepts it gracefully;
- Recognizes creative opportunities for MCH within that change.

5. Communicates well.

- Is able to braid science with compassion and craft solutions that touch the lives of women and children in valuable ways;
- Possesses excellent speaking and writing abilities;
- Connects global issues to community concerns;
- Translates complex technical research into practical, action-oriented strategies;
- Conveys enthusiasm and engages others in accomplishing the work;
- “Sells” the agency’s products/programs.

6. Demonstrates creativity.

- Willing to use new and innovative approaches grounded in research.

7. Competent and credible MCH professional.

- Possesses the knowledge, skill, and technical expertise needed to accomplish the work;
- Knows the field of MCH, its history, scope, and current critical issues;
- Maintains visibility and credibility with MCH professionals in the field; possesses working knowledge of public and private health care systems/resources that provide MCH services within the community;
- Aware/knowledgeable about the wide

array of factors affecting health and health care access and utilization among families and children;

- Is competent and credible.

8. Possesses courage.

- Does the right thing, in the right way, for the right reasons;
- Speaks out about root causes of poor health and the necessity for social justice.

9. Reaches good decisions.

- Takes the time to reflect and think;
- Looks and listens prior to action;
- Is not afraid to take action when it is needed;
- Studies issues carefully and understands all perspectives;
- Uses clean and concise data to justify program development and evaluation and backs up their convictions with good science;
- Does not reinvent the wheel, but researches effective programs and applies best practices;
- Delegates technical and certain managerial tasks, so as to leave sufficient time/energy to tackle systems issues;
- Trusts others to do what is needed.

10. Operates fairly.

- Sets, articulates, and models standards;
- Holds all accountable to the same measure;
- Focuses on quality and outcomes.

11. Strives for social justice.

- Shows compassion;
- Has others best interests at heart.

12. Uses humor effectively.

- Reduces stress by simply having fun.

13. Acts with integrity.

- Models consistency between actions and deeply felt values and beliefs;
- Keeps promises and commitments;
- Accountable, reliable, trustworthy, and consistent.

14. Personally committed to life-long learning.

- Understands that knowledge changes rapidly and retooling is essential.

15. Listens to others.

- Especially young people about ways to do things differently;
- Absorbs diverse perspectives.

16. Mentors others.

- Serves as a role model;
- Mentors younger professionals;

- Builds the next generation of MCH leaders.

17. Possesses people skills.

- Brings disparate partners from diverse backgrounds together to focus on health issues;
- Maintains credible connections with key MCH, political, business, and community leaders;
- Develops and nurtures relationships in various arenas;
- Empathetic and puts the needs of others first;
- Remembers the importance of relationships (on all levels);
- Remembers partnerships and collaborations are essential to success.

18. Flexible, patient and persistent.

- Knows that change takes time;
- Stays with things, even when the going gets rough;
- Is able to forge ahead with realistic, but positive attitude, in tough political and budgetary times.

19. Self-confident.

- Believes in himself/herself.

Learn how to build trust with others; you will need to work across cultures, professions and geographic areas- others need to know that you can be trusted.

— MCH leader

20. Self-aware.

- Understands personal motivations, biases, preferred behavioral styles, and their impact on others, beliefs, values, etc. (*Lacking this, it is not possible to be an honest leader, and it will catch up to you when you least expect it.*)

21. Models teambuilding skills.

- Works as a team leader, as well as a team member;
- Values input from all levels, and is inclusive;
- Supports staff and others; motivates and encourages others and models what is expected of others.

22. Shares personal passion and vision.

- Uses this same passion, intensity, and persistence to get the job done;
- Creates a shared vision, bringing together key partners to build vision, focus, and action;
- Pursues the vision together while learning and changing;
- Remembers it is the individuals we serve.

*Leading Edge Issues Influencing Urban Women's Health: Leadership in MCH, E-query of select public health and MCH leaders. April 2005. Omaha, NE: CityMatCH at the University of Nebraska Medical Center.

Essential Leadership Skills, Competencies and Capacities



According to the **Turning Point's Leadership Development National Excellence Collaborative** in their document *Collaborative Leadership and Health: A Review of the Literature*⁶ the more commonly cited leadership skills, competencies and capacities that emerge from the literature include:

"An effective MCH leader must be able to think and create at the systems level, seeing the connections between public health and education, economic development, public safety, criminal justice, child welfare, and other system components that impact the wellbeing of women, children, and families."
— MCH leader

Building vision is the most commonly cited leadership competency. Vision is the capacity to see the future by mastering the essentials of

imagining the ideal and intuiting the future. It implies a movement beyond current mental boundaries. Not only does it move beyond current thinking and practice, it understands the obstacles embedded in current contexts that call for new vision.

Managing change is a component of a leader's capacity to be proactive, dedicated, and politically astute through impending change. Change often creates ambiguous situations, as well as clouded goals, structures, and lines of authority.

Collaboration competencies help leaders in all spheres to think and work across boundaries, to both build collaborative visions and accomplish those visions together through joint goal setting and active pursuit of those goals. Collaboration is based on the belief that if you bring the appropriate people together in constructive ways with good information, they will create

authentic visions and strategies for addressing the shared concerns of the organization or community. The kinds of skills called upon in this process include: keeping stakeholders at the table through periods of frustration and skepticism, acknowledging small successes along the way, helping stakeholders negotiate difficult points, and enforcing group norms and ground rules. Empowerment and power sharing are central to collaborative work. It also involves the capacity to trust others' perspectives and have confidence in others' competencies to perform within the collaboration.

Communication competencies help leaders adequately deal with the complexities of issues being addressed. Not only are face-to-face interactions increased in the new world of collaboration, but the need for diverse communication skills of leaders, from writing to public speaking to group dialogue to interpersonal communication has also grown exponentially. Both the broader leadership literature and health focused literature, call for a wide array of communication competencies and capacities.

Team leadership skills are often at the core of systems that rely on one another for production or delivery of

services. Group or team leadership skills and competencies are seen as one of the keys to success of a team group culture. Process dynamics and structures, and change dynamics are important for skill development in team leadership.

Management competencies are about coping with complexity. Although distinctions are made between leadership and management, the skills are seen as complimentary. Leadership competencies in the area of management most cited in the literature include: systems thinking and organizing ideas, resources, and people.

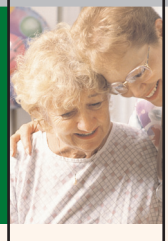
Political competencies assures that the leader can navigate the complexities of interagency alliances and collaborations, particularly in the public or civic realm. These competencies include an understanding of political and legislative processes and operations on the federal, state and local levels. Competencies in advocacy, community organizing, community education and marketing are called forth. Public health leaders are also called upon to understand the legal and regulatory issues associated with government, as well as financial and operational procedures of their organizations.

Leadership Development Resources

In 1988, the Institute of Medicine's report, *The Future of Public Health* stated that the public health system was in disarray. Leadership development was identified as a key factor in this dilemma. The call for leadership development was repeated in 2002 with the *Future of the Public's Health in the 21st Century, Assuring the Health of the Public in the 21st Century*. Federal, state, and local government public health agencies are called upon to prioritize leadership training, support, and development within government public health agencies and the academic institutions that prepare the workforce. Government and private funders of community health initiatives are asked to focus on long-lasting change by supporting ongoing community engagement and leadership through supportive mechanisms and realistic expectations.

⁶ (http://turningpointprogram.org/Pages/devlead_lit_review.pdf)

Training in leadership at different points throughout one's career is important. A variety of currently available resources to help develop and enhance leadership skills are described below.



Public health leadership and management competencies are outlined in the **Competencies for Public Health Workers: A Collection of Competency Sets of Public Health-Related Occupations and Professions**. Public health competencies for both leadership and management are available in this comprehensive tool developed by the Office of Workforce Policy and Planning, Centers for Disease Control and Prevention.
<http://www.phppo.cdc.gov/owpp/docs/compgrid0829.pdf>

Public Health Leadership Institutes and Programs

In response to the call for leadership development, a number of state, regional, and national public health leadership institutes and programs have been developed. Nearly every state has access to a state/regional leadership institute or program. The activities utilized in these programs are designed to provide unique learning experiences for a broad array of public health professionals, and seek to develop and enhance individual and organizational leadership and management skills. Programs and institutes are academic and practice collaborations between schools of public health and state health departments. They are also

You aren't a leader unless you rock the boat and get people to continuously improve and be challenged. Change can be vital for a leader to accomplish his or her goals, but never institute change for change sake or to make your mark – this is not leadership.

— MCH leader

supported by the Centers for Disease Control and Prevention (CDC), Public Health Program and Practice Office. To learn about a program near you, go to the National Public Health Leadership Development Network at <http://www.slu.edu/organizations/nln>.

CityMatCH Urban MCH DaTA Institute
Numerous MCH leaders recommended this training model developed by CityMatCH in

collaboration with CDC to build skills in translating urban maternal and child health data to action. During the year-long training, selected “data use teams” participate in activities and learn leadership and data use skills in the areas of scientific thinking, data methods, planning, evaluation, political strategy, and more. Skills learned are applied to a project of importance to the team’s home community throughout the year.
<http://www.citymatch.org>

CityMatCH Urban MCH Leadership Conference

CityMatCH annually showcases new science, promising practices, leadership skills-building sessions, and emerging MCH issues in a highly interactive and collegial design.

The National MCH Leadership Conference

is sponsored by the School of Public Health, University of Illinois at Chicago University and funded by the USDHHS, Maternal and Child Health Bureau.
http://www.uic.edu/sph/mch/ce/mch_leadership/main.htm

The Maternal and Child Health Leadership Skills Training Institute

is offered several times each year and offers learning opportunities in the areas of planning, implementing, and evaluating, as well as systems to staff members of State Title V programs.
<http://www.mchb.hrsa.gov/training/projectInfo.asp?id=180&pg=P>

University and College Courses

A number of schools of public health have designed their curriculum to

Leadership Development Planning

- Engage in reflection regarding your leadership aspirations;
- Assess your strengths and areas that need improvement;
- Determine your leadership goals;
- Develop, implement, evaluate, and then update your learning plan;
- Seek feedback from trusted advisors throughout the process.

include leadership training. Distance learning provides opportunities for people in communities lacking these resources.

Community-based leadership training programs

Look for one sponsored by your local Chamber of Commerce.

Leadership development workshops and training sessions

These opportunities provide familiar ways to learn new and further develop existing skills.

“These ever-present leadership competencies encompass an ability for MCH leaders to effectively marry emotional intelligence, knowledge, skills, and professional expertise critical to building and sustaining long-term collaborative relationships that serve to positively impact the health outcomes of women and child.”

— MCH leader

Mentoring

Mentoring, for leadership development was recommended by many MCH leaders. These structured opportunities pair people who have varying levels of leadership/management experience with a person with more experience.

Coaching

Coaching has been defined as the “the facilitation of learning.” This focused and specific method of leadership development is often employed by experienced leaders. Individuals receive tailored support and advice enabling them to develop and achieve leadership goals. Coaching is a highly personal approach to leadership development.

RESOURCES You Can Use



The Center for Health Leadership & Practice (CHLP), a Center of the Public Health Institute, is a non-profit leadership training, consultation, and resource center serving domestic and international health leaders and organizations. The Center has been a pioneer in leadership development programs and consultation since 1991. <http://www.cfhl.org/index.jsp>.

The Collaborative Leadership Website is a product of Turning Point and its Leadership Development National Excellence Collaborative and is designed for public health leaders. The website provides information and products regarding collaborative leadership. Collaborative leadership is a way of leading that relies on working together to solve agreed upon issues. The site offers tools, resources, bibliography and training information about collaborative leadership, with a special focus on developing public health leaders. <http://www.collaborativeleadership.org/>

The Community Tool Box provides over 6,000 pages of practical information to support the promotion of community health and development. This website is created and maintained by the Work Group on Health Promotion and Community

Development at the University of Kansas in Lawrence. [Part E. Leadership, Management, and Group Facilitation, Chapters 13 – 16](#), provide information about the core functions of leadership (e.g., building relationships, influencing people), management (e.g., providing supervision and support), and group facilitation (e.g., leading meetings). <http://ctb.ku.edu>

infed (the informal education homepage) The site provides a space for people to explore the theory and practice of informal education and lifelong learning. It seeks to encourage educators to develop ways of working and being that foster association, conversation, and relationship. This not-for-profit site is part of the United Kingdom's National Grid for Learning. http://www.infed.org/about_us.htm. Shared leadership is discussed at http://www.infed.org/leadership/shared_leadership.htm A discussion on classical leadership models is found at http://www.infed.org/leadership/traditional_leadership.htm.

The mission of **Turning Point** is the transformation and strengthening of the United States public health system making it more community-based and collaborative. Launched in 1997 as an initiative of The Robert Wood Johnson

Foundation and the W.K. Kellogg Foundation, Turning Point was developed as a response to concerns about the capacity of the public health system to respond to emerging challenges in public health. <http://www.turningpointprogram.org>. The Turning Point website is located at <http://turningpointprogram.org/Pages/developlead.html>. An excellent resource, **Collaborative Leadership and Health: A Review of the Literature** can be found at http://www.turningpointprogram.org/Pages/devlead_lit_review.pdf.

The Center for Health Leadership & Practice provides a list of suggested leadership development resources at <http://www.cfhl.org/FileServlet?id=1>

MCH Leaders recommend these books:

- *7 Habits of Highly Effective People* by Stephen R. Covey
- *Enlightened Leadership* by Ed Oakley
- *Gifts of Leadership: Team Building Through Focus and Empathy* by Art Horn
- *Imagine the Power: Getting to Success Faster* by Terah Stearns
- *Journey to Leadership: Profiles of Women Leaders in Public Health* by Carol Spain Woltring and Carole Barlas
- *Leaders* by Warren Bennis and Burt Nanus
- *The Leadership Challenge* by James M. Kouzes and Barry Z. Posner
- *Leadership for Dummies* by Mashall Loeb and Stephen Kindel
- *Leadership is an Art* by Max Depree
- *Positive Leadership* by Mike Magee
- *Public Health Leadership and Management: Cases and Context* by Stuart A. Capper, Peter M. Ginter, and Linda E. Swayne (this is a text book)
- *Transitions* by William Bridges
- *When Teams Work Best* by Frank La Fasto and Carl Larson
- *Who Moved My Cheese? An Amazing Way to Deal with Change in Your Work and in our Life* by Spencer Johnson, Kenneth H. Blanchard, and John Kotter

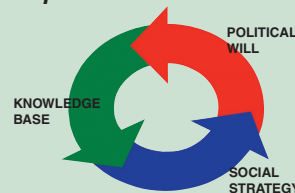
Political Will and the CityMatCH DATA USE TRIANGLE

None of the great social movements of our time occurred until the political will was great enough to demand a shift in public policy. The civil rights movement in the 1960s and the women's suffrage movement at the turn of the twentieth century are examples of the power of political well-being generated by active citizens. Dedicated leadership and citizen demand catalyze the process of creating political will.

Many public health professionals are adept at generating and analyzing data, we are also skilled at translating that data into well thought out reports with insightful recommendations and achievable action steps. Often we are challenged to take action to make our goal a reality. None of us wants to create yet another report that sits on the shelf or takes up room on the hard drive. We want action, we want results, and we want to make a measurable difference.

CityMatCH is about being an agent for change and enabling members to be leaders of change personally, institutionally, within our communities, and at the systems level. We translate data into action, build local capacity, and figure out what really works to get measurable intended results. When the DaTA Institute was developed, a data use triangle was created as a framework for bringing analytic, programmatic, and policy people together to create the critical mass needed for change. This triangle is based upon a simple, yet profound model developed by Dr. Julius Richmond at the Harvard School of Public Health.

Turning Data Into Action: ...Spin the Wheel



continued on page 8

Political Will and the CityMatCH DATA USE TRIANGLE *continued*

The model contains three elements:

Knowledge Base

The scientific or administrative database upon which to make health care decisions.

Social Strategy

The blueprint to accomplish worthwhile goals; our action.

Political Will

The ability to have society's desire and commitment to support or modify old programs or create new programs.

According to Dr Richmond, the critical dimension of leadership is hope. Hope is a psychological process not often mentioned, though it is very important for future thinking and planning. Dr. Richmond developed this model in part because it relates to hope. In terms of program effectiveness, one needs to have a conceptual roadmap that provides an opportunity to create.

The model identifies three elements that influence the development of health policy. Each element of the cycle is vital and if one is weak, the entire model becomes weakened. The model provides useful insights into barriers and opportunities that impact our success. Thoughtful analysis of each leg of the triangle can lead to strategic thinking about what needs to be done to make a difference. Certain groups and individuals may need to take leadership at different points in the process. For example, those strong in gathering and interpreting data and information will move forward the knowledge base, those skilled at visioning and strategic planning will assist by developing the social strategy, and those with strengths in communication, advocacy, policy development, and persuasion will take the lead when developing political will.

Active political will supportive of our public health initiatives at the city, county, state, or national level varies from time to time and place to place. When political will is not strong, we can still take action by taking steps to build political will by working with decision makers and members of our community. We can provide the data and help shape the vision of healthy women within our community. We can advocate for this vision and work with community members to make it a reality. We can summarize the knowledge base, translate it into a vision with effective evidence-based strategies and see that the infrastructure is in place to inform political will. If you have a vision of what you want to do, you can make progress even when political will is not in your favor. When the political will changes, when opportunities come around, you are then ready for action.⁷

Bringing Policy Change to Your Community

The Center for Health Improvement (CHI) is a national, nonpartisan, nonprofit health policy center based in Sacramento, California. CHI is dedicated to advancing policies and providing technical assistance services that improve population health and encourage healthy behavior. Their website, **The Health Policy Guide** (formerly the Health Policy Coach) contains a database of policy-based strategies to improve health and well being.

In a CHI resource entitled, **Bringing Policy Change to Your Community**, CHI relates how the health of a community is the shared responsibility of many local organizations and

interests. These partners include: schools, employers, healthcare providers, local health departments, park and recreation departments, city planners, traffic controllers, and the people of the community, to name just a few. Negotiating the interests of such a diverse group of concerned citizens and stakeholders is essentially a political process that generates political will and policy.

This key section of the website provides a step-by-step guide through the policy-making process. It guides you through the basics of civic involvement — from increasing public awareness and developing community partnerships, to understanding the policy process and educating policymakers at all levels. For additional information, go to <http://www.healthpolicycoach.org/advocacy.asp?id=23>.

Confused about the difference between advocacy and lobbying? You are not alone. According to the **Center for an Urban Future**, “*Advocacy* refers to any activity that attempts to change government policy. *Lobbying* is a subset of advocacy that aims to influence specific legislation, which means it is aimed at a legislative body.” The Center for an Urban Future has created a resource entitled **Speak Up: Tips on Advocacy for Publicly Funded Nonprofits**. For more information on advocacy go to their website at: <https://secure12.cfxhosting.com/nycfutureorg/assets/images/speakup.pdf>

How to be a WOMEN'S HEALTH ADVOCATE



The American Heritage® Dictionary of the English Language, Fourth Edition defines advocacy as, “the action of advocating, pleading for, or supporting a cause or proposal.” We all can be women’s health advocates as part of our jobs or as community members. Staying well-informed, understanding your audience and being able to convey tailored and compelling messages to different groups will enable you to be more readily heard and understood. The following are some ways to personally and professionally advocate for women’s health:

- **Share your passion.** Your own conviction is vitally important in convincing others.
- **Educate others about why women’s health is important.** Talk to others in your workplace, neighborhood, and community.
- **Work with other community organizations.** Be a resource to others interested in the health and well-being of women.
- **Keep informed.** Read the paper, watch the news, and attend community meetings.
- **Communicate well.** When you have a good understanding of your audience, it enhances your ability to really communicate. Knowing your audience, their interests and backgrounds will make a difference. Know how to clarify misinformation and misconceptions about youth. Use verifiable examples, statistics, and stories.
- **Work with the media.** Meet and get to know editors and reporters. Be quick to praise media efforts that support women’s health. Respond in a polite and timely fashion when news coverage is to be challenged or expanded.
- **Participate in the public policy development process.** Learn about the rules that apply to advocacy in your workplace. As a citizen, exercise your right to vote and participate in the democratic process.

LEADERSHIP ISSUES *continued*

II Health and social policies strongly influence women’s health needs. A woman’s inability to afford health care services, health insurance, safe housing, nutritious food, and other basic necessities can seriously compromise her health and well-being. The causes and resolution of many of the social and health problems affecting women are complicated and interrelated. These issues must be addressed if women’s health is to be enhanced.

According to the National Institutes of Health, numerous reports from the Institute of Medicine, and National Research Council have pointed to the importance of social and cultural factors for health and the opportunities for improving health through a better understanding of mechanisms linking the social and cultural environment to specific health outcomes. Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviors, the effectiveness of health promotion efforts, and access to, availability of, and quality of health care. Social and cultural factors also play a role in shaping perceptions of and responses to health problems and the impact of poor

health on individuals’ lives and wellbeing. In addition, such factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival, and mortality.

According to Minkovitz and Baldwin, despite significant gains in narrowing the gaps in social indicators for men and women and for women of different racial backgrounds, discrepancies persist with regard to life expectancy, educational attainment, employment, and earnings. Improving the social climate that affects women’s health necessitates addressing these fundamental differences between women and men, as well as among women of different socioeconomic groups. The social context of women’s health sets the stage for interpreting socioeconomic and racial differences in morbidity, mortality, the use of preventive services, the adoption of health promoting behaviors, and access to health-enhancing services. An understanding of this social context is also essential for designing, implementing, and evaluating policies aimed at improving the health of women in the United States.⁸

Improving women’s health requires an awareness of the multiple roles, relationships, and responsibilities that place demands on today’s women. Women spend significant amounts of time and often forgo wages to provide care to needy children and aging parents. According to the Kaiser Family Foundation, caring for their families can come at an economic cost for many working mothers, with half losing pay to care for sick children. In particular, low income and single mothers, who are poorer to begin with, are more likely to suffer lost pay and concern about negative job evaluations. One in ten women provides care to a sick or disabled family member. Women’s role as the primary caregivers to the elderly, disabled, and the young must be considered when developing health and social policy. Many women who act as caregivers have health problems of their own, and a considerable proportion are in low-income families. Even though they provide care to others, many caregivers are uninsured and have problems getting their own health care, due to expense or time constraints.⁹

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⁸ Grason H., Hutchins, J., Silver, G. *Charting a Course for the Future of Women’s and Perinatal Health Part 2, The Social Context of Women’s Health* page 5. (1997). <http://www.jhsph.edu/WCHPC/Publications/volume2.pdf>

⁹ *KFF Women, Work, and Family Health: A Balancing Act*, April 2003

Influencing social factors that affect women's health

The development of policies that address economic and social well-being requires the involvement of many sectors of society. Policymakers are vital to developing legislation to address these important issues. Depending on the topic area, a number of businesses, private and public organizations, consumers, and advocates can be encouraged to take the lead in supporting efforts to improve women's health and well-being. The areas to consider include: increasing economic security of women; improving access to affordable housing and health insurance; increasing the number of women who graduate from high school and college; addressing child- and elder-care needs; and other areas. Change to improve the social well-being of many women will be brought about through education, economic development, advocacy, public policy interventions activities, and in some cases legislation.

The following excerpt from *Charting a Course for the Future of Women's and Perinatal Health-Volume I: Concepts, Findings, and Recommendations*¹⁰ elucidate the impact of social concerns on women's health.

The Social Context of Women's and Perinatal Health

Familiarity with recent social and demographic trends that affect women is essential for understanding the context of women's and perinatal health in the United States. Social, economic, and political forces help shape women's health by influencing trends in population characteristics, education and employment, reproduction and family composition, and household economic status.

In turn, these demographic trends, help shape the roles women play in their families, the workforce, and society in general. For example, the population of women in the United States will continue to age and become more ethnically diverse in the coming decades. Women are participating in the labor force more than ever before, and they are more likely to delay childbearing and marriage than in the past. The proportion of single-parent households headed by women continues to rise. In addition, all of these demographic factors and trends contribute to women's

predisposition for chronic disease, access to health care, and personal health beliefs and behavior. Moreover, these factors are highly interrelated; for instance, limited educational achievement constrains job opportunities and earnings, which affect access to adequate health care.

While women as a group have achieved significant improvements in such areas as educational attainment and economic earnings in recent decades, substantial variation persists among women of different races and cultural backgrounds. In addition, with the majority of women active in the workforce, policymakers are just beginning to recognize the importance of women's multiple roles in society — working for pay outside the home, performing unpaid work at home, and serving as caregivers for dependent children and aging parents — and the effect this has on women's health. These realities have important implications for formulating social and health policy, designing health services, and developing research agendas.

Familiarity with recent social and demographic trends that affect women is essential for understanding the context of women's health in the US and other developed countries. Social, economic, and political forces shape women's health by influencing trends in population characteristics, education and employment of women, reproduction, family composition and household economic status. These trends contribute to women's predisposition to chronic diseases, and influence health beliefs and behaviors and access to health care.

Six major social and economic changes, important to understanding women's health in the U.S. today and in the future, are:

1. aging of the female population;
2. increased ethnic and racial diversity of the population;
3. increasing labor force participation of women, particularly among women with children;
4. delay in marriage and childbearing of women;
5. a rise in female headed single parent families; and
6. continued economic disparities between men and women and racial and ethnic groups.

Context

Health care policy evolves within the larger context of social policies that affect women and their health. The historical social inequality of women in the United States has meant that women have been poorer, less well-educated, and less able to assume positions of authority — in politics, the medical professions, and business — where policy decisions are made. This gender inequity is particularly pronounced for minority and poor women. Because women are under-represented in these arenas, special attention to gender issues in health and social policy is warranted to ensure greater equality in the future.

The major demographic shifts taking place — an aging population, a changing ethnic and racial make-up of the country, and increasing gaps in income — will mean new challenges for both social and health policy. In addition, the increasing recognition of the environmental influences on health generally necessitates a closer look at the effects of women's multiple roles in their family and work environments.

For example, welfare reform places new stresses on women and the health and social service systems that serve them, even as it may provide opportunities to help women become economically self-sufficient. Within the field itself, perinatal health and women's health advocacy and programs have evolved independently with different emphases and ideological underpinnings. Sometimes the perspectives of the two groups regarding social policy issues appear to be at odds with one another — for instance, in regard to incarceration of pregnant women who abuse drugs. Such divergence in outlooks and interests can threaten the development within the field of a coherent national health policy agenda for women, thereby diminishing the constituency for promoting the health of women.

Policy Goals

Support policies to improve women's access to resources that are related to improved health and safe community environments — including in the realms of higher education, jobs, housing, health care coverage, pay equity, economic development, child care, domestic violence laws, and gun control. Support processes for developing health policies and health

¹⁰ Grason H., Hutchins, J., Silver, G. *Charting a Course for the Future of Women's and Perinatal Health-Volume I: Concepts, Findings, and Recommendations*. (1999). <http://www.jhsph.edu/WCHPC/Publications/volume2.pdf>



services for women that actively engage women, encourage them to speak out, and facilitate processes that help women make their own choices.

Strategies

Develop structures and processes to enhance coordination and collaboration among the diverse array of constituency groups concerned with women’s and children’s health and well-being. For example, both women’s and children’s advocacy groups should encourage coordinated plans and support systems for women and children experiencing abuse.

At the federal and state level, policy and program coordinating committees, with broad representation of constituency groups, should be convened and given authority and accountability for ensuring integrated women’s and children’s health policy.

Require federal agencies to prepare formal statements identifying any effects a proposed social policy may have on women’s health and/or access to care. Like environmental impact statements, the objective would be to prevent avoidable, unintended bad effects. For instance, an impact statement on the recent welfare reform legislation would have identified inherently inconsistent policies related to (1) out-of-wedlock births/teen pregnancy (in which a family cap was promoted and family planning services were not), and (2) reducing access to Medicaid-covered health services for immigrant women, particularly prenatal care.

- Promote informed decision-making and appropriate legal protections for women to improve access to health services;
- Protect women’s rights to access health information and services and to make health decisions on their own behalf without restrictions on their autonomy — for instance, gag rules applied to medical/health professionals, spousal permission requirements for reproductive health services, waiting periods for abortion, and the criminalization of pregnant women’s behavior in attempts to protect fetuses.
- Ensure that female children and adolescents have access to health information and services, as well as support from parents/guardians, other

family members, and health professionals to make informed health decisions.

- Establish safeguards within integrated health systems to protect the privacy of personal health data from groups such as employers and immigration authorities. Of particular concern are those requirements related to mandatory reporting of domestic violence and other personally sensitive health issues such as sexually transmitted diseases and psychiatric disorders.
- Address the health concerns resulting from changes in the ethnic, cultural, and racial make-up of the U.S. population:
 - Promote understanding of, and provide services for, the unique health needs of the many diverse groups of women; and
 - Support and extend national initiatives to eliminate disparities in health status among subgroups of women.

Research Implications

Recent social policies (e.g., welfare reform, State Children’s Health Insurance Program) must be analyzed with respect to impact on women’s access to health care in communities and resulting health status. The very complexity and enormity of these policy issues means that any effective change would require efforts sustained over many years. In addition, the responsibility for changing these social policies is diffuse; it is difficult to pinpoint which institutions are accountable and which are in positions to exert leadership. In the current conservative political and social climate, some health concerns will be difficult to address, particularly those related to reproductive health and immigration policy. This challenge is coupled with the modest political will exhibited to allocate scarce public resources to these problems.

On the other hand, women have more political strength now than ever before. They vote in greater numbers. Their greater participation in the workforce has made some changes in social and health policies economically imperative. And, as women gain leadership positions in government, health care, and business, they wield greater influence in policy.

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

The third area associated with leadership identified by CityMatCH has been the need to take a more wide-ranging view of urban women’s health within MCH. This view should include the traditional maternal role and take a comprehensive view of women’s health throughout the lifespan. We encourage you to advocate for this expanded view of women’s health within your agency.

The maternal role has long been valued within MCH, and it is accepted that a healthy mother is more likely to have a healthy infant. Caring for women immediately prior to or during their pregnancy is vital, but it is not enough. When we think about women’s health, we do not always consider that urban women start out as urban girls. Perinatal outcomes are not just determined in those years surrounding when women have children, they also have much to do with the choices of urban girls and with the teachings of urban grandmothers. Mounting evidence demands that we address women’s health much earlier if we wish to impact pregnancy outcomes. The habits learned in childhood, the environment encountered growing up, the health lessons learned, and the behaviors exhibited as a youth all influence the perinatal outcomes of woman.

Maternal and child health professionals have appropriately focused on helping women have healthy pregnancies, but there are compelling reasons to take a broader view of women’s health. Although pregnancy and the maternal role are vitally important components of many women’s health, an exclusive focus on these issues leads to missed opportunities to promote well-being throughout a woman’s life. A focus on women’s health is a rational response to growing scientific knowledge about how health is created, maintained, and diminished. We know that certain health conditions disproportionately (such as autoimmune diseases) and differently affect women (such as heart disease). Preventive efforts can delay and possibly

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LEADERSHIP ISSUES *continued*

avoid the onset of conditions that greatly affect a woman's well-being and reduce her ability to participate fully in daily life, at an adverse cost to the woman and to her community.

Health is much more than not being ill, it involves physical and mental well-being. A woman's individual biology, as well as her socio-cultural, economic, and physical environments influences her health. A view of women's health encompasses physical and mental well-being, relationships, and roles. Health needs change throughout life with childhood, youth, adolescence, adulthood, and maturity each providing different opportunities and challenges. A broad view of health acknowledges that environmental, political, economic, cultural, and social conditions all have an influence on women's health. It also recognizes the nontraditional risk factors such as institutional, interpersonal, and internalized racism also influence health.

By embracing a broader view of women's health within MCH, we are able to maintain a vision of healthy women, healthy families, and healthy communities. The health of women matters regardless of their childbearing decisions, because women matter. They matter as individuals, as members of communities, as family members, as workers, and for any number of other roles they play in society. We know that where women's status is more equitable

to men's status, men's health status is improved. By focusing on a woman's health, we can influence her health, as well as her family. Thus a broad focus on the health of women reverberates into family, schools, workplace, and the community.

Summary

Leadership is needed to improve the health and well-being of women. We need MCH leaders who embrace a broader view of maternal and child health working in local communities as change agents. MCH Leaders know the importance of caring for women when they are pregnant, but also recognize the importance of caring for urban girls, urban women, and urban grandmothers. The true MCH leader can express the concerns of urban women, take calculated risks, and do the work that must be done to extend services and resources to improve the health of women in urban communities as well as the health of the many individuals their lives touch.

This Urban Women's Health Issue Brief has outlined some of the leadership challenges associated with assuring the health of urban women and hopefully made clear the impact of political will on crafting change, the effects of social and health policies on women's health, and shared a vision for women's health that reaches beyond the traditionally defined maternal role. It is our hope that you have

also found new information, resources, and tools to supplement your personal leadership toolkit and that you will accept the challenge to be a leader and advocate for the health and well-being of women in your community.

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