Getting off to a Healthy Start

A NEWSLETTER OF THE NATIONAL HEALTHY START ASSOCIATION, INC. Fall 2003

NHSA Plans Six Regional Conferences

Earlier this year, the NHSA was pleased to announce that Congress had approved $350,000 for the Association to gather and disseminate information on best practices in the Healthy Start program and to provide technical assistance to Healthy Start grantees. Now, with the Association plan for use of the funds submitted to the Maternal and Child Health Bureau (MCHB), which will oversee the work, the NHSA is quickly putting plans in place to hold six regional conferences and, eventually, to create the National Healthy Start Association Leadership Training Center.

Until now, the NHSA has not had the resources to go beyond electronic surveys and collection of annual conference evaluation forms to assess the technical assistance needs for Healthy Start projects. While it is known that significant differences in technical capability exist across Healthy Start projects, the Association does not have comprehensive information based on more direct knowledge of the strengths and weaknesses of projects from which to judge the most critical issues for assistance.

The NHSA will use the fall of 2003 and spring of 2004 to conduct regional conferences to learn first-hand about program challenges, to assess needs and to develop an implementation plan that will establish a priority for which types of technical assistance are of most importance to Healthy Start projects and will most affect the outcomes of perinatal health disparities. The NHSA will conduct six regional conferences consisting of one-and-a-half days each, and based on combined HRSA regions where Healthy Start projects are located.

Planning teams will be formed for each of the regional conferences. The teams will include the program and logistics coordinators from the NHSA, Healthy Start program staff, Title V representatives, consortia members and consumers. The planning teams will be charged with developing region-specific portions of the agenda for each conference, and implementing the core of each conference.

Consumers to be a part of the conferences

An important aspect of the regional conferences will be the involvement of consumers. Recognizing that Healthy Start is community-based, and that consumers are the foundation of the initiative and are truly the representatives of each community served by a Healthy Start project, the NHSA will ask each project to bring a minimum of two consumers to the regional conferences. Their involvement will foster a sense of community among consumers themselves, and lead towards more consumer involvement in the policy and planning process at the local and national levels.

NHSA will introduce its new toolkits

A wide range of topics will be covered by the conferences. To start the dialogue, the NHSA will introduce four new toolkits that will provide the first step in technical assistance. The toolkits are *The Healthy Start Guide to Program Excellence, The Healthy Start Guide to Evaluating Success and Measuring Program Impact, The Healthy Start Guide to Risk Factor Assessment and How to Communicate about Perinatal Risk to Local Communities* and *The Healthy Start Guide to Financial Sustainability.* The issues covered by this first set of toolkits are anticipated to enhance discussion during the regional conferences.

Continued on page 3

Letter from the President

Dear NHSA Members:

I am pleased to report that the Association is moving into high gear this fall. We recently submitted the proposal required by the Maternal and Child Health Bureau that describes our plans for the $350,000 earmark funds we received from Congress for FY03. *(See page 1.)*

Activities planned for the next twelve months include:

- A special session in September for Healthy Start Project Directors to articulate their technical assistance needs to the Association board,
- A series of six regional conferences to enable Healthy Start project staff, Title V personnel and community leaders to assess the regional needs of projects,
- A written report on the findings of the regional conferences and a retreat for the Association Board to evaluate the needs articulated by projects, and
- A plan to establish technical support for Healthy Start projects under a new National Healthy Start Association "Leadership Training Center."

This fall, the Association will also publish a series of toolkits for Healthy Start projects, covering the issues of financial sustainability, risk assessment and public education, evaluation and program excellence. The toolkits are a much-needed resource and are based on Association efforts to gather the best information and experience that already exists, synthesizing it and producing toolkits that can be updated and enhanced for Healthy Start projects on a regular basis. They will be easily accessible in printed format, posted on the National Healthy Start Association's web site and available on CD Rom. They will also be presented and discussed as part of the regional conferences mentioned above.

We continue to educate the Members of Congress about the importance of Healthy Start. While we anticipate that program funding will remain level for the coming fiscal year, we are pleased that the program can remain stable until we are able to convince Congress that investing in programs to reduce racial and ethnic disparities in perinatal health should be the highest priority for the country.

Lastly, I am pleased to report that at our Sixth Annual Membership Meeting on September 21st, the Nominating Committee will recommend two consumers as part of the slate presented to the membership for election to the NHSA Board. This is a direct outcome of the discussion held at last year's annual meeting and builds on the consumer participation at our Spring Conference this year. We'll introduce all the new Board members in our next newsletter.

Sincerely,

Belinda Pettiford

Belinda Pettiford
President

Belinda Pettiford (02-05), President
Healthy Start Eastern, Northeastern and Triad Baby Love Plus (NC)

Kenn Harris (02-05), Vice President
(Former Project Director)
New Haven Healthy Start (CT)

Clarice Lowe (03-06), Secretary
VNS Healthy Start, Des Moines (IA)

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Deborah Frazier (Former Board Member), Co-Chair
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Mario Drummonds (03-06)
Central Harlem Healthy Start (NY)

Cindi Garcia (03-06)
Healthy Start Laredo (TX)

Rick Haverkate (02-04)
Maajtaag Mnobmaadzid, "A Start of a Healthy Life," Sault Ste. Marie (MI)

Patricia McManus (02-05)
Milwaukee Healthy Beginnings Project (WI)

Wilford A. Payne (03-06)
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The National Healthy Start Association, Inc. is a 501 (c) (3) nonprofit organization. Its mission is to promote the development of community-based maternal and child health programs, particularly those initiatives addressing the issues of infant mortality, low birthweight and racial disparity.

Community Baby Showers for Outreach and Education

Atlantic City Healthy Start (NJ), part of the local Healthy Mothers, Healthy Babies Coalition (HMHB) and Healthy Start Laredo (TX) have held community baby showers, events that combine food, fun, gifts and education. Modeled on traditional baby showers, these events help provide parents with the supplies, equipment and information necessary to have and care for a healthy baby.

HMHB's showers focus on education for their clients, preparing them for childbirth and what to expect after the baby is born. They have held showers for first-time parents and expectant teens. Interactive discussion sessions with nutritionists, pediatricians, family planning experts and nurses are held, and gift-wrapped baby items are supplied through the generosity of local businesses and organizations. These items have included baby bathtubs, newborn clothing, diapers and toiletries.

Other partnering organizations throughout New Jersey have held similar events. In October, the Burlington County Disability Issues Committee is hosting a Pregnant Pause/Baby Shower event to raise awareness about Fetal Alcohol Syndrome and the importance of alcohol-free pregnancies.

The focus of Healthy Start Laredo's baby showers is outreach. To avoid having flyers being ignored on bulletin boards, a small mailing list of pregnant women is gathered from current clients and real baby shower invitations are sent out.

At the event are games, prizes, food and, perhaps most crucial, a presentation about Healthy Start and how it can help pregnant women and their families. As Cindi Garcia, Executive Director of the Laredo project, noted, "The event was non-threatening to our very resistant and skeptical population, but, most importantly, it was fun; therefore, all who attended couldn't wait to join the program – and they did."

Community baby showers can be used to recruit new clients for Healthy Start, keep current clients involved and informed or help parents in the community be better prepared for having and raising their babies.

Let us know the unique ways you do outreach and education at your Healthy Start project.

Regional Conferences, *continued from page 1*

Creation of the NHSA Leadership Training Center

Following the regional conferences, the NHSA will prepare a written report on the findings and, using information from that report, will move forward to create the National Healthy Start Association Leadership Training Center. This center will become the primary mechanism for the NHSA to provide technical assistance to Healthy Start projects.

A range of services are anticipated, such as a peer-to-peer mentoring system where information and suggestions for effectiveness can be shared among and between Healthy Start project staff, local consortium leaders and others; a training curriculum for new Healthy Start staff and refresher courses for those with more experience; special assistance with data collection and analysis; and effective techniques for program evaluation. Ultimately, the Center will serve as the interactive information clearinghouse and base for technical support.

It is important to note that the Center will be a long-term effort by the Association and will require time and resources to build up the professional capacity. The NHSA Board will seek funding and resources necessary to ensure that the Center can be sustained.

Look for more information on the regional conferences in the coming months.

Research News

Birth Rates Down, Low Birthweight Rates Go Up

The National Center for Health Statistics has released *Births: Preliminary Data for 2002,* which reports that the U.S. birth rate fell to the lowest level since national data have been available and that the rate of teen births also fell to a new record low, continuing a decline that began in 1991. The crude birth rate was 13.9 per 1,000 population in 2002. The birth rate for adolescents ages 15-19 dropped by 5% in 2002, a 28% decline since 1990. Among other significant findings:

- The percent of low birthweight babies (infants born weighing less than 2,500 grams) increased to 7.8%, up from 7.7% in 2001 and the highest level in more than 30 years.
- The percent of preterm births (infants born at less than 37 weeks of gestation) increased slightly over 2001, from 11.9% to 12%.
- Access to prenatal care continued a slow and steady increase. In 2002, 83.8% of women began receiving prenatal care in the first trimester of pregnancy, up from 83.4% in 2001 and 75.8% in 1990.
- The number of births to unmarried women ages 15-44 rose by 1% 2002; however, births to unmarried adolescents ages 15-19 dropped by 4%.

The entire report is available at *www.cdc.gov/nchs.*

NFIMR Listserv, July 23, 2003 and *MCH Alert,* July 11, 2003.

Cultural Competence in Addressing Racial and Ethnic Disparities

"Given the strong evidence for sociocultural barriers to care at multiple levels of the health care system, culturally competent care is a key cornerstone in efforts to eliminate racial/ethnic disparities in health and health care," state the authors of an article published in the July-August 2003 issue of *Public Health Reports.* The authors assert that models for operationalizing cultural competence have emphasized particular aspects of the health care delivery system and that a comprehensive approach to thinking about and implementing cultural competency in health care at multiple levels and from multiple perspectives is still needed. The article describes the authors' efforts to practically define cultural competence and to develop a framework that links interventions to an overall approach to eliminating racial and ethnic disparities in health and health care. Among the findings:

- Sociocultural barriers that contribute to racial and ethnic disparities in health and health care include leadership/workforce, processes of care and provider-patient encounter barriers.
- These sociocultural barriers exist at three levels of health care delivery: the organizational, structural and clinical levels.

Given the evidence of sociocultural barriers to health care and the levels of health care delivery at which they exist, the authors suggest a new framework for cultural competence that would include organizational, structural and clinical interventions. Interventions that could assist in the elimination of racial and ethnic disparities in health and health care include the following:

- Organizational efforts to increase the numbers of underrepresented minorities in the health professions and in health care leadership.
- Structural initiatives to design innovative health care systems and structures.
- Clinical interventions to implement educational initiatives to provide health professionals with key tools and skills necessary for delivering quality care to diverse populations.

"While it is unclear what proportion of the disparities seen is due to [sociocultural] barriers, this is where the health care system has the most power to intervene," conclude the authors. They add, "A basic framework and conceptual model that is simple, practical and based on a review of the literature in the field, such as the one presented here, can facilitate targeted interventions."

Betancourt JR, Green AR, Carillo E, et al. 2003. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports* 118(4):293-302. *MCH Alert,* July 11, 2003.

Low-income Women Benefit from Antidepressants and Counseling

Despite concerns that a course of antidepressants and counseling might not benefit low-income minority women with depression, new research released in June shows that these proven therapies are effective in such patients. Either six months of treatment with an antidepressant or at least eight weeks of counseling helped reduce depressive symptoms in low-income mothers, according to the report published in the July 2nd issue of the *Journal of the American Medical Association.* Specifically, the authors found that, relative to depressed women simply referred to community mental health services, women offered medication or psychotherapy reported improvements in their ability to work, to care for their children and perform other duties. Women who received medication also reported improvement in social behavior.

Some researchers have doubted whether such basic solutions would help low-income minority women, whose lives are often characterized by multiple problems. For instance, most of the women participating in the current study lived below the federal poverty level, while almost 40% said they had been raped, and around half reported experiencing domestic violence.

In this study, the researchers offered 267 low-income women with major depression six months treatment with paroxetine (Paxil), at least eight weeks of cognitive behavior therapy or referred them to community mental health services. Ninety-four percent of participants were either Black or Latino. Subjects not responding to paroxetine were offered the option of switching to bupropion (Wellbutrin). Dr. Jeanne Miranda of the UCLA Neuropsychiatric Institute, and one of the authors, noted that women may have benefited less from community services because the services did not offer transportation or childcare. “And without those things, people just didn’t go,” she said. In contract, women offered psychotherapy or medication also received transportation and money for childcare if needed. One significant barrier to providing therapy and medication to depressed, low-income women remains the cost. In the current study, almost 65% of the women did not have health insurance. “I think the issue of providing mental health care for uninsured women is a large problem that needs political attention,” said Miranda.

Journal of the American Medical Association. 2003;290:57-65. Medscape from WebMD, *http://www.medscape.com,* July 1, 2003.

Few Young Women Succeed in Giving Up Smoking

While more than eight of 10 young women who smoke say that can quit whenever they want, only 3% of those who tried succeed, according to new research released in July. The study, which examined women ages 16 to 24, was funded by the American Legacy Foundation, an anti-tobacco group created with money from the 1998 national tobacco settlement. A quarter of the women in that age group smoked cigarettes, the researchers said. Of those in the study, 60% had tried to quit.

The study recommended developing new age-specific techniques to help young women quit. The foundation is beginning a program that uses positive peer pressure.

Baltimore Sun, July 16, 2003.

Black-White Differences in Low Birthweight

The gap in the incidence of low birthweight (LBW) babies (less than 2500 g) between Black and White women in the U.S. has widened over the past two decades. A new study supported by the Agency for Healthcare Research and Quality found that smoking and being uninsured are bigger risk factors for LBW babies among Black women than White women.

Black women are more likely than White women to live in high-poverty, drug-infested neighborhoods with few health care resources. To sort out the impact of neighborhood and access factors from individual risk factors on LBW, researchers examined the association of neighborhood economic indicators, neighborhood quality, access to prenatal care and individual perinatal risk factors and subsequent birthweight among 78,415 Black and 60,346 White residents of New York City (NYC). They used data

from NYC birth records, the 1990 U.S. Census and a NYC community health database.

Overall, Black women were twice as likely as White women to have an LBW baby. When only neighborhood factors were included in the analysis, LBW among babies of Black and White women was strongly associated with living in a neighborhood that was low income, had a high proportion of Black or Hispanic residents and had a high rate of hospitalizations for substance abuse. However, when individual risk factors were included in the analysis, most of the neighborhood effect was eliminated, and odds of Black women having an LBW baby shrunk from 2.9 to 2.1 times higher than White women.

Black women were at 58% higher risk of having LBW babies when they were uninsured, but White women were not. Being uninsured may be a function of neighborhood-level mechanisms that restrict access to health care in Black communities but not in White communities. Also, Black women who smoked were at greater risk of having an LBW infant than White women who smoked (OR 2.40 and 1.61, respectively). Previous studies suggest that Black women are less likely to quit smoking and more likely to smoke higher nicotine cigarette brands.

AHRQ Research Activities, Number 276, August 2003. Study: Jaffee, KD and Perloff, JD. 2003, February. An ecological analysis of racial differences in low birthweight: Implications for maternal and child health social work. *Health & Social Work 29*(1), pp.9-22.

Neural Tube Defects and Young Minority Women

Despite mandatory fortification of foods with folic acid, young minority women do not get enough folic acid and should be counseled to take a daily multivitamin. According to the study, "Neural Tube Defects: Knowledge and Preconceptional Prevention Practices in Minority Women," healthcare providers need to reinforce daily adherence to multivitamin use for the prevention of neural tube defects (NTDs). The study found public health clinics are an invaluable resource of information on the prevention of NTDs in minority young women.

American Academy of Pediatrics, News Briefs, September 2, 2003, *http://www.aap.org.*

Racial and Ethnic Health Care Disparities Legislation

Earlier this year, Senate Majority Leader Bill Frist (R-TN) announced his intention to introduce legislation focused on reducing and eliminating health care disparities for minorities and underserved populations. In the year 2000, Senator Frist sponsored legislation that was signed into law, and which expanded research and education on the factors that contribute to health care disparities through a new office of Minority Health and Health Disparities at the National Institutes of Health (NIH). Now the Senator wishes to move into programs that will make an impact.

While the legislation is still under development, Senator Frist has identified five general areas of focus: (1) expanded access to quality health care; (2) strong national leadership, cooperation and coordination, via the Office of Minority Health that would be formally authorized and expanded; (3) professional education, awareness and training in diversity and cultural sensitivity; (4) enhanced research on racial and ethnic disparities; and (5) clinical disease prevention and management services in areas that disproportionately impact minority and underserved populations. Infant mortality, in particular, is mentioned as a specific focus.

NHSA representatives recently met with the Senator's key staff to brief them on the Healthy Start program and to urge them to call upon the Association for information and experience regarding racial and ethnic disparities in perinatal health and infant mortality issues. The Senator's staff were urged to include sufficient funding authorization in the legislation so that existing successful programs like Healthy Start, which is already in place and

working, can be expanded to cover a wider geographic area of the country.

This summer, at Senator Frist's request, the General Accounting Office (GAO) released a short briefing paper, which states that racial and ethnic health care disparities are "serious and pervasive." Six specific health areas are cited as important to minority health: cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, immunizations and infant mortality, specifically "appropriate prenatal treatment." Two key factors cited as instrumental to differences in health care are unequal access and widely differing provider-patient relationships. Stating the fact that the federal government plays a major role in providing health care to minority populations through Medicaid, Medicare, the military and veterans, the GAO briefing concludes with suggestions that recommend developing new demonstration projects, expanding current programs, strengthening federal leadership and collecting complete and accurate racial and ethnic health care data.

The Association will continue to monitor the development of this legislation and provide further updates.

Stay in Touch!

Be sure to notify the Association if you change project directors or contact information, such as e-mail addresses or phone numbers. This will keep our records up to date so we can easily notify you of important news.

BECOME A FRIEND OF HEALTHY START!

The NHSA depends on contributions from supporters, as well as members. If you would like to become a Friend of Healthy Start, please complete the form below and send it today with your check.

I/we want to be a Friend of Healthy Start and enclose a check to National Healthy Start Association, Inc.

- ☐ $ 25 Individual
- ☐ $ 50 Community-based organizations; local businesses and corporations
- ☐ $100 State or regional organizations, businesses or corporations
- ☐ $200 National organizations, businesses or corporations
- ☐ Additional contribution enclosed $ __________

Name________________________________ Company Name ____________________________

Address ______________________________ City ______________ State _____ Zip _________

E-mail _______________________________

Please return this form with your check to: National Healthy Start Association, Inc., P.O. Box 25227, Baltimore, MD 21229-0327.

The National Healthy Start Association, Inc. is a 501 (c) (3) nonprofit organization. Contributions are tax deductible to the extent allowed by law. Consult your tax advisor.

Copies of NHSA's annual financial report may be obtained by writing to National Healthy Start Association, Inc., P.O. Box 25227, Baltimore, MD 21229-0327.

Documents and information filed under the Maryland charitable organization laws can be obtained, for the cost of copies and postage, from the Office of the Secretary of State, State House, Annapolis, MD 21401, (800) 825-4510 (for residents of Maryland).

Visit the NHSA at *www.healthystartassoc.org!*

The Association's website contains a Healthy Start Communications Directory, regularly updated sources for possible funding and the monthly Maternal & Child Health and Social Services Update, where you can find current research in the MCH field, as well as resources for publications and other materials. Visit us often!

Mark Your Calendars

October 17–19, 2003
Second Annual Black Midwives and Healers Conference, presented by the International Center for Traditional Childbearing, in Portland, Oregon. Information: *www.blackmidwives.org,* email to *ictc@blackmidwives.org* or (503) 460-9324, ext. 2.

April 19–21, 2004
NHSA's Fifth Annual Spring Education Conference
Washington Court Hotel, Washington, DC
New! Extra half-day for workshops and networking and a half-day for sightseeing!

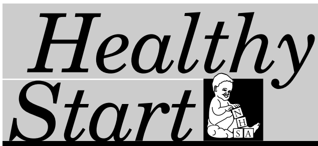
Reminder!

Two NHSA Meetings September 21st:

8:30 a.m. – Project Directors' Session

5:00 p.m. – Sixth Annual Membership Meeting

Both meetings will be held at the Renaissance Washington Hotel, 999 9th Street, Washington, DC, site of the Healthy Start Annual Grantee Meeting.



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