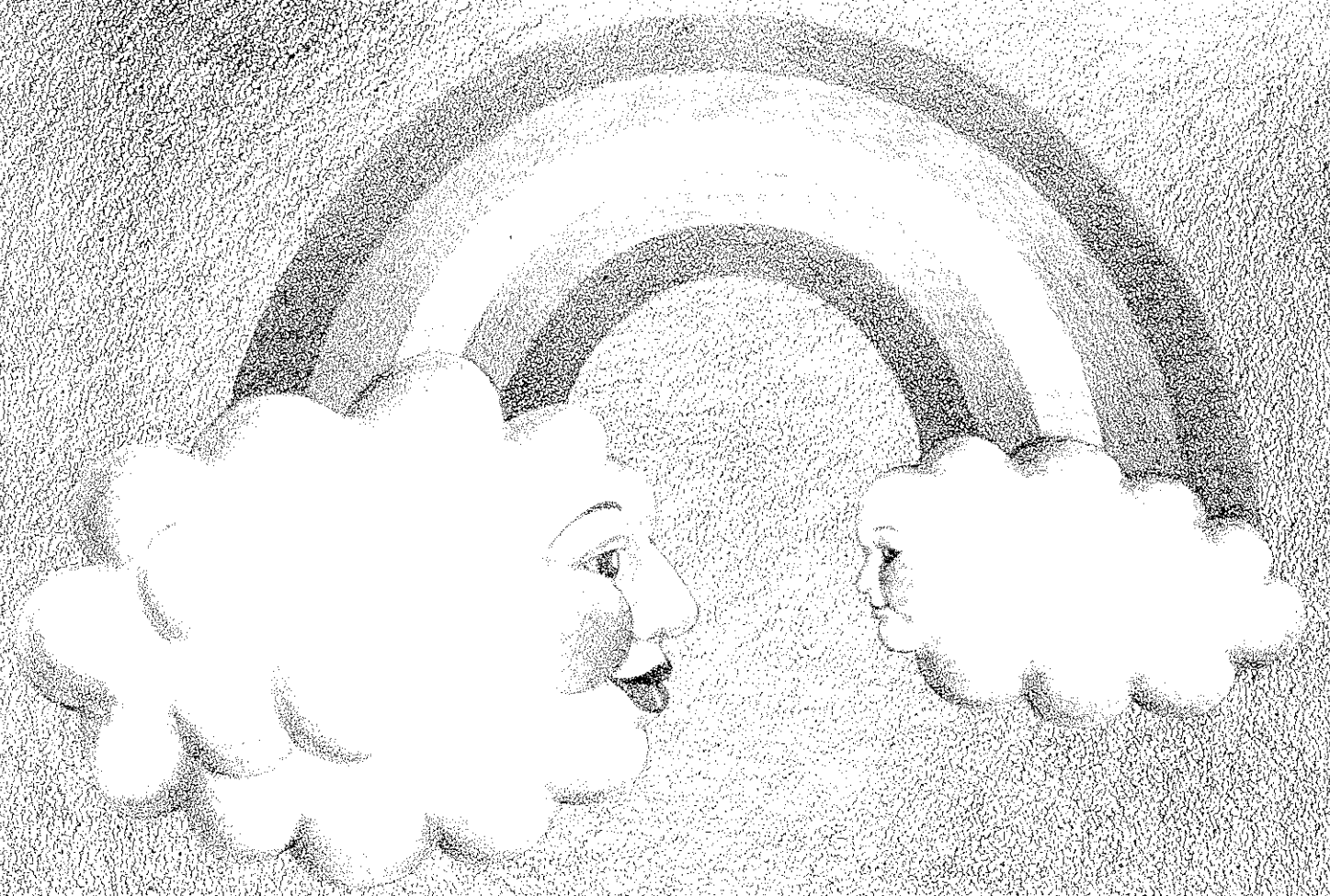
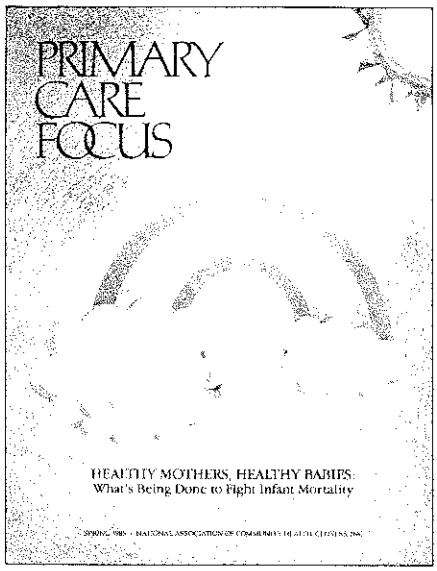
PRIMARY CARE FOCUS



HEALTHY MOTHERS, HEALTHY BABIES:
What's Being Done to Fight Infant Mortality

SPRING 1985 • NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

IN FOCUS



COVER ILLUSTRATION BY SASHA GEORGEVITCH

PCF: A NEW FOCUS ON PRIMARY CARE

Dear Reader:

Welcome to the inaugural issue of the new *Primary Care Focus!* We hope you'll like the changes in contents and style you'll find on these pages.

In this first issue we focus on maternal and child health issues, specifically on the national Healthy Mothers, Healthy Babies Coalition and the work of the state coalitions that bring primary care to high risk populations. *PCF* staff spoke with participants at all levels of this private-public partnership in order to provide what we believe is the most comprehensive article yet written on this fast growing cooperative initiative. We also discuss the critical problems of health and housing for migrant workers and report on the innovative efforts of one community-based primary care organization. You'll also find the story of how a lead poisoning mystery was solved by the painstaking detective work of local health clinic staff.

Reviews of important legal developments affecting federally assisted primary care centers, abstracts of recent publications, job and meeting announcements and more are in this issue and will be regularly featured in future issues.

In addition to using the *PCF* as a major source of up-to-date information on primary care, we hope you will also use it as a vehicle through which you will share your wealth of knowledge and expertise with your health care colleagues by contributing feature articles and job, meeting and service announcements.

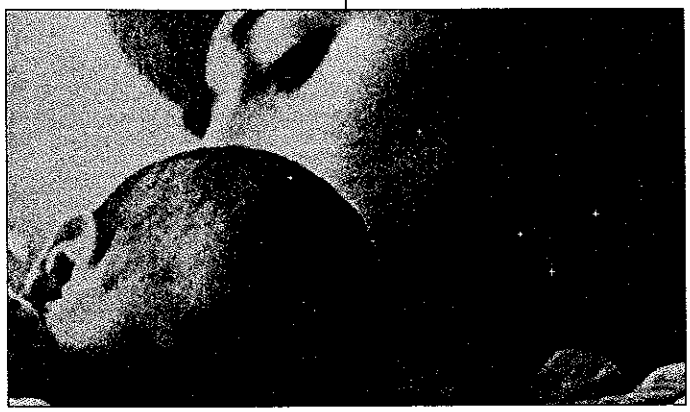
There are not many health care publications which focus on the practical, human interest side of primary care and that is where the new *Primary Care Focus* fits in. Whether you are a community-oriented health care center practitioner in a rural or urban area, corporate health manager, health department official or university-based researcher, the new *Primary Care Focus* will have much to offer you.

Please let us know what you think of the new *Primary Care Focus* and the features you'd like to see in the issues ahead.

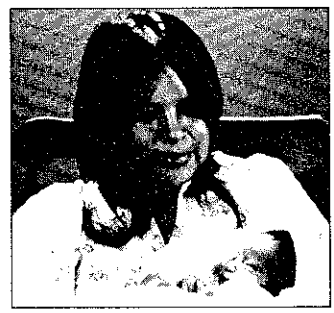
PRIMARY CARE FOCUS

SPRING 1985 • NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

FEATURES



DEPARTMENTS



PCF STAFF

Primary Care Focus (ISSN 0732-1260) is published quarterly by the National Association of Community Health Centers, Inc., 1625 I Street, NW, Suite 420, Washington, DC 20006. (202)833-9280. Subscription rates: Organizational members, $37.50; Individual members, $40.00; Nonmembers, $50.00.

LAWS & ORDERS

Significant decisions from the DHHS Grant Appeals Board compiled by Jacqueline C. Leifer

Community Health Center Must Refund Federal Share of Property Upon Sale

In a new ruling, the Public Health Service (PHS) determined that the Family Care Center of Carondelet (FCCC) owed the government a share of the $25,000 proceeds from a property sale which had been financed with Community Health Center (CHC) grant funds.

Using $50,000 from private donations for the down payment and $180,000 in Federal grant funds for the loan, the FCCC had bought two buildings for a single purchase price of $230,000. When they sold one of them, a schoolhouse which they couldn't use, the FCCC assumed the $25,000 proceeds would be counted as part of their non-Federal share.

But the FCCC was wrong. PHS requested a refund of the Federal share of the sale proceeds, minus administrative expenses and plus a pro rata share reflecting the $50,000 donation.

The Center appealed the ruling, arguing that they had not purchased the schoolhouse with Federal funds, the sales contract had been signed prior to recieving the federal grant, and the lending bank had released its interest in the schoolhouse at the time of sale.

However, because Federal grant funds had been used to finance the entire transaction and not just the larger building, the Grant Appeals Board held that the ruling was sound. Not only had there been only one sales contract, but the two buildings were not individually valued. The seller had refused to divide the property and the mortgage covered the entire property.

The Board concluded that the $50,000 donation was simply a portion of the total property cost. The FCCC would have been avoiding their responsibility to refund Federal grant money by considering the donation as payment only for the schoolhouse.

Bonus for Medical Center Administrator Denied

PHS ruled that an extra 2% bonus paid to a Goshen Medical Center administrator in 1982 must be withdrawn because the award was not calculated according to a formal bonus policy.

Both the Center's administrator and secretary received a bonus in 1980 of $150 and $100, respectively. All employees except the administrator were given a bonus in 1981. But in 1982 when employees received a 2% bonus, the administrator received an extra 2% because he had received no bonus in 1981.

Because the administrator had done an outstanding job and because Goshen traditionally awarded annual bonuses to its employees and higher bonuses to its administrator, they appealed the Grant Appeals Board's decision.

However, ruling that a 'tradition' of awarding bonuses does not satisfy the Policy Statement requirement for an "established plan" or "consistent adherence to an established plan" as stated in OMB Circular A-122, the Board rejected the appeal. The Goshen Medical Center was thereafter advised to re-evaluate its bonus policy.

Excess Program Income May be used to Cover Otherwise Unallowable Expenses

PHS disallowed the Anchorage Neighborhood Health Center's $9,967 interest payments from 1981 but did not question their interest payments of $37,977 made in 1982. Claiming that the ruling was inconsistent with PHS's 1982 allowance for the same type of costs, Anchorage appealed the decision.

The Center had earned $310,434 in program income in 1981 but had budgeted $510,090 for its non-Federal share. The following year, the Center earned $546,325, exceeding its budgeted non-Federal share of $497,847.

The Grant Appeals Board sustained the disallowance. It agreed with PHS that, under 45 C.F.R. Part 74, App. F, §G(18)(a), interest payments are not allowed and the Center had erred in applying budgeted program income to such expenses.

But because Anchorage had generated excess program income in 1982, the extra funds could be used to support otherwise unallowable costs, such as interest payments.

Purchase of Supplies in Excess of Budget and for Use After Expiration of Grant Disallowed

Based on the findings of an independent auditor, PHS disallowed the Dooly Health Care Association's $15,481 purchase of supplies which exceeded the Association's budget and which were to be used after their grant expired.

Dooly contended that it had made a year-end purchase of $42,892 in supplies in excess of their $10,300 budget as part of an agreement with a doctor and dentist who had been affiliated with the Association. The affiliates had agreed to continue their services privately after phase-out of the grant, provided several months' worth of supplies were stocked for their use. The Association claimed that PHS officials had verbally authorized the purchase.

The Grant Appeals Board was unsympathetic, maintaining that the costs were not allocable to the grant because the supplies were not used during the budget period. Moreover, Dooly failed to credit the grant for the fair market value of unused supplies exceeding $1,000 which were not needed for a Federally-supported program.

Finally, the CHC project officer testified against the Association. He claimed he had only authorized the purchase of supplies to be used during the grant phase-out period.

Funds Spent in Excess of Authorized Grant Must Be Repaid

An audit of the Community Action Commission (CAC) of Belmont County revealed that during one year the organization had withdrawn $59,915 in excess of their authorized grant and that at the end of their sixth operating year $27,137 remained unspent. Although PHS initially sought a refund for both amounts, subsequent investigation by the Grant Appeals Board allowed CAC to retain the $17,137 of unspent funds.

CAC had recieved a total of $9,451,172 over a 6-year period. Yearly grant amounts calculated by PHS had been based on CAC's final expenditure reports for each year.

CAC admitted they had withdrawn funds in excess of their authorized grant, but argued they were no longer liable to PHS under the 6-year Federal statute of limitations on contract actions. CAC claimed PHS had contributed to the problem by failing to adjust their yearly grant awards and close out the prior year's grant in a timely manner.

The funds had been spent in good faith, claimed CAC officials, and com-

continued on page 15

Jacqueline C. Leifer is an attorney with the Washington, DC firm of Klores, Feldesman, & Tucker.

SECOND OPINIONS

CAUSE OF DEATH: POVERTY

Colman McCarthy

Longevity medicine is back on the front pages. A mechanical heart is now the life-support technology for a third recipient, a 58-year-old retired auto worker whose cardiological diseases had brought him to the edge of death.

Physicians who successfully fight back mortality are a glamor industry, with a patient like William Schroeder, receiver number two, giving us Medicine Americana by drinking from a can of Coors beer to show that, fake ventricles and all, he's still all heart.

At the same time that the wonders of organ replacement were again a national fascination, or at least promoted that way by much of the media, the public was told that other unhealthy citizens hover near death. Their longevity concerns involve trying to survive childhood proverty.

According to the Children's Defense Fund, a Washington group whose sense of justice has not wavered in 15 years of advocacy, the nation's worst child-killer is poverty: "More American children die each year from poverty than from traffic fatalities and suicide combined," its report said. "Twice more children die from poverty than from cancer and heart disease combined."

It takes some thought adjustment to see poverty as a cause of death. Poor people, we know, die of cancer, heart disease and accidents like everyone else. Where, then, does poverty come in? For the poor, death becomes closer in proportion to health care being further removed. Mothers who can't get prenatal care have babies who die more easily in the first month of life. Poor nutrition weakens children's resistance to disease. Homeless children — 22 percent of the people in shelters — suffer from exposure. Two-thirds of poor children lack regular health insurance. Anemia, lead poisoning and death by fires from kerosene heaters and other health risks of growing up poor.

Federal statistics are kept on numerous health categories but not on childhood mortality among the nation's 13 million poor children. All that's available to date is one overlooked 1983 study by the Maine Department of Human Services. For poor children from 8 days to 17 years old, the death rate is three times that of other children. The Children's Defense Fund estimates that "over a five-year period more children die from poverty than the total number of American battle deaths in the Vietnam War."

The two branches of medicine that deal with primary health care for poor children and with the extraordinariness of mechanical-heart transplants offer stark choices about life-support systems.

Is the longevity of one middle-aged man so valuable a technological advance that it deserves greater respect than an inner-city health clinic that treats thousands of infants each year with low birth weight?

Why is medical heroism conferred on the transplant surgeons who save one life for a few months or a year and not on the general practitioner in Appalachia who adds combined thousands of years to his patients' lives by applying the simplest health techniques? Will the evening news programs ever lead off with the press conference of a South Bronx doctor, dressed in surgical greens, explaining how he just saved the life of a homeless man who nearly froze to death?

Occasionally the costs and benefits of American

medicine are examined in a way that considers routine care against heroic care. Harvey Fineberg, the dean of the Harvard School of Public Health, writes in a recent issue of Technology Review that "the way we pose questions about medical expenditures is all-important. If asked 'what is it worth paying to safe a life?' we are tempted to respond 'whatever it takes.' A more pertinent question is 'where will additional dollars produce the greatest health benefits?' . . . Policymakers cannot attend to more basic value judgments about whether the public can afford to pay for new procedures, whether current policies are fair to all patients, and whether other uses of the same resources might be more worthwhile." Shouldn't the finite health-care dollar be directed toward such groups as the nation's 13 million poor children rather than the latest transplant extravagancy?

For the nurses and doctors who have chosen to do whatever it takes, say, to eliminate low birth weight in poor children, federal funding continues to be withdrawn. The Children's Defense Fund estimates that the 1986 Reagan budget would take away $5.2 billion from poor children and their families. That is added to $10 billion in cuts since 1980. Money also is a life-support system.

ON THE DEATH OF POOR BABIES

Dr. Edward N. Brandt Jr., until recently the Assistant Secretary of Health and Human Services, finds some new public health data "disquieting." He had thought America's declining infant mortality rate would reach 9 deaths for each 1,000 births, almost as low as that of Japan and six European countries. "My prediction was wrong," he says, "flat wrong." The rate seems to be leveling off at 11 deaths per 1,000.

That may come as a surprise to Dr. Brandt, but not to many health professionals aware of the Reagan Administration's continuing approach to basic health services: Cut them. What elevates the infant mortality rate? Figures like these: 21 of every 1,000 babies born in the Bronx's Morrisania section will die before their first birthday (compared with 6.2 in Astoria, Queens). So will 17 of those born in New Haven; 22 in Trenton; 55 in the Avalon Park section of Chicago. What these places have in common is poverty.

Three-fourths of all neonatal deaths are related to low birth weight — and that is in turn related to poor maternal nutrition and prenatal care. And the incidence of low-birth-weight babies remains high. More are living beyond their first month, thanks to special hospital neonatal units, but dying before their first birthday. Such deaths, the Public health Service says, are a serious concern because they're "most susceptible to preventive efforts." Now consider some other figures. The Administration folded maternal and child health programs into a block grant in 1982 and cut spending 18 percent. It cut spending for community health centers 13 percent.

continued on page 15

HEALTH CENTER SOLVES LEAD POISONING MYSTERY

Jeffrey Tirengel and Deborah Baer

It began as a medical mystery. Just how Maria, the 2-year-old daughter of Hispanic migrant farmworkers from Greeley, Colorado, had contracted lead poisoning was beyond the staff of the Sunrise Community Health Center.

Maria's illness was discovered during a routine screening for lead poisoning. Yet Alan Ackerman, the Center's nutritionist, had had a hard time convincing staff members that lead screening was a worthwhile cause.

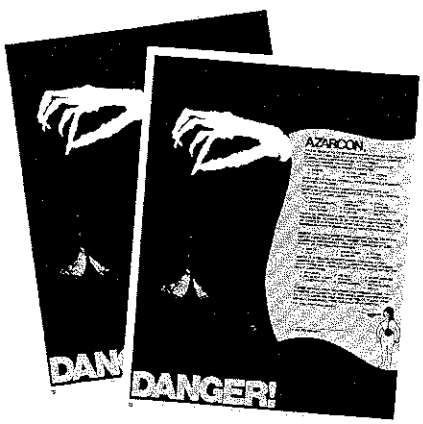
Even Ackerman, who had applied for the free federal funds for nationwide screening, was surprised when three of the 100 northern Colorado children screened showed high lead levels.

East Coast children are exposed to lead-based paints and high levels of lead from automobiles in large urban centers. In Greeley, Colorado you don't find lead paint, and the small urban farming community had few reported cases of lead poisoning.

Two of the children were not severely poisoned, and received follow-up care from the health center for lead poisoning acquired by eating paint chips from residences along their migratory route.

Maria, the third child, came to Dr. David Simmons, Sunrise's medical director, for additional clinical treatment.

Prior to treatment, the Center sent two field workers from the Colorado health department to check for possible sources of lead at Maria's home on a farm near Greeley. They found little evidence of lead-based paint and Maria's parents denied that she had eaten any paint chips. No lead was entering the child's food from improperly glazed ceramic dishes.



Posters used for nationwide educational campaign concerning lead-poisoning.

When Maria came in for her second treatment, Simmons was alarmed to find that her lead level had risen. He had no idea where the lead was coming from. The only possibility seemed to be a lead-painted picket fence near the house.

It was Ackerman who stumbled on the key to the puzzle when he read a Centers for Disease Control (CDC) report on a four-month-old baby in Los Angeles. High levels of lead tetroxide in the baby's stomach had been traced to an Hispanic folk remedy. The baby's parents had treated their child's upset stomach with "azarcon." And azarcon is lead tetroxide, a bright orange powder.

Ackerman and Dorothy Rodman, a head nurse at Sunrise with a bicultural upbringing, immediately visited Maria's family to ask about azarcon use.

Yes, Maria had had "empacho," or stomach problems. And yes, they nodded, they had given their child azarcon to relieve her symptoms. The mother produced the orange-colored powder she called azarcon, which lab tests confirmed was indeed lead tetroxide, with a lead content greater than 90 percent. Maria was hospitalized for further therapy and has apparently made a full recovery.

In the Mexican folk medicine system, azarcon is believed to help relieve digestion problems. And sometimes it does work for a short period, but over the long term, says Simmons, lead *causes* poor digestion and can result in repeated administration of this folk remedy. Maria's parents were unwittingly poisoning their daughter when they continued to give her azarcon for her persistent stomach ache. The cure and the illness had become a vicious cycle.

The center acted quickly to inform the community. Rodman translated into Spanish a poster written by Ackerman. It read: "Azarcon is a bright orange powder used to treat empacho. It is a poison. If you or anyone you know has used this powder, please tell the nurse."

The poster was displayed prominently in the clinic waiting room at Sunrise. A local Hispanic woman visiting the Sunrise clinic read it. She was a "curandera," a Spanish folk healer.

Sunrise CHC staff member counsels patients on dangers of using lead-based folk remedies.

"You're wrong," she told the nurse at the desk. "The powder is not orange, it's yellow. And it's called 'greta.' That's what I use to cure empacho." She produced a sample which she had purchased in Texas.

A few days later Ackerman read the lab results. The curandera's yellow powder was lead monoxide, with a 90 percent lead content.

The discovery led to confirmation of the sale of greta in Texas, and, ultimately, to the Food and Drug Administration's prohibition of the medicinal use of azarcon and greta in the United States.

That summer, Ackerman and the nursing staff at Sunrise conducted a survey of the migrant farming community of Greeley. They studied housing conditions, general living and sanitary arrangements, and specific experiences with lead compounds.

The staff discovered that seven percent of the migrant children had been exposed to lead-based folk remedies for empacho. Meanwhile, the Center uncovered other questionable compounds (as well as some highly beneficial compounds) that were used as folk remedies.

In cooperation with the University of Arizona and other community health centers, Sunrise began a nationwide poster campaign, funded by Chevron, USA, to educate both the public and professionals to the dangers of azarcon and other folk medicines. These posters are available from the Sunrise Community Health Center, 1028 5th Avenue, Greeley, Colorado 80631.

Sunrise's approach to Maria's illness demonstrates yet again the importance of cultural and environmental factors in the treatment of patients. The health center's story reflects community-based primary care at its best.

RISING TO THE CHALLENGE OF MIGRANT HOUSING

by Connee Canfield and James Arnold

The Migrant and Rural Community Health Association (MARCHA) is faced with a health care problem caused by housing shortages for migrant workers in Michigan. While the solution requires great patience and skill in the face of bureaucratic obstructions, the outlook is promising.

Michigan agriculture relies upon enormous numbers of migrant laborers. To help provide for their health needs, MARCHA operates four clinics serving 12,000 migrant patients. This past summer, intake workers noticed an increase in illnesses due to environmental factors. Overcrowding in seasonal housing units encouraged the spread of viral diseases. Entire families became sick. Entire residential facilities became infected.

The Michigan Migrant Health Act provided a mandate for MARCHA intervention. The Act authorized environmental health services, including the "detection and alleviation of unhealthful conditions" associated with such problems as water supply, waste treatment and sanitation. Responding to this mandate, MARCHA investigators took action.

MARCHA quickly determined that the area suffered a major housing shortage. Discussion with Michigan growers and public health officials revealed that between 1980 and 1983, the supply of licensed camp housing declined by 12%. Simultaneously, large numbers of migrant laborers continued to arrive in Michigan because they heard work opportunities were good. In the resulting scramble for housing, many workers had to settle for substandard, overcrowded conditions. The predictable consequences of poor health conditions prompted MARCHA to intervene.

How does a health care agency tackle housing problems? "It was a Board decision to seek Farmers' Home Administration (FmHA) funding and create an avenue for construction of new rental housing for the farmworkers that come into our area every spring," stated Sandra Avery, President of MARCHA's Board of Directors. "Given the state of affairs, we felt we had a responsibility to act." With this commendable resolve, MARCHA took its initiative.

Early efforts were foiled by the all-too-common bureaucratic barriers that torment community health centers.

"It seemed that we kept hitting hard walls. It was then that we decided to seek special funding in order to involve the total community," said MARCHA's Executive Director, E. Roberta Ryder. The traditional approach was rejected and an alternative plan was implemented.

Using money from its Community Sponsored Activity Funds, MARCHA hired a housing specialist. The specialist formed an affiliate community organization to upgrade farmworker housing and initiate new construction. The Rural Initiatives for Shelter and Education (RISE) was born.

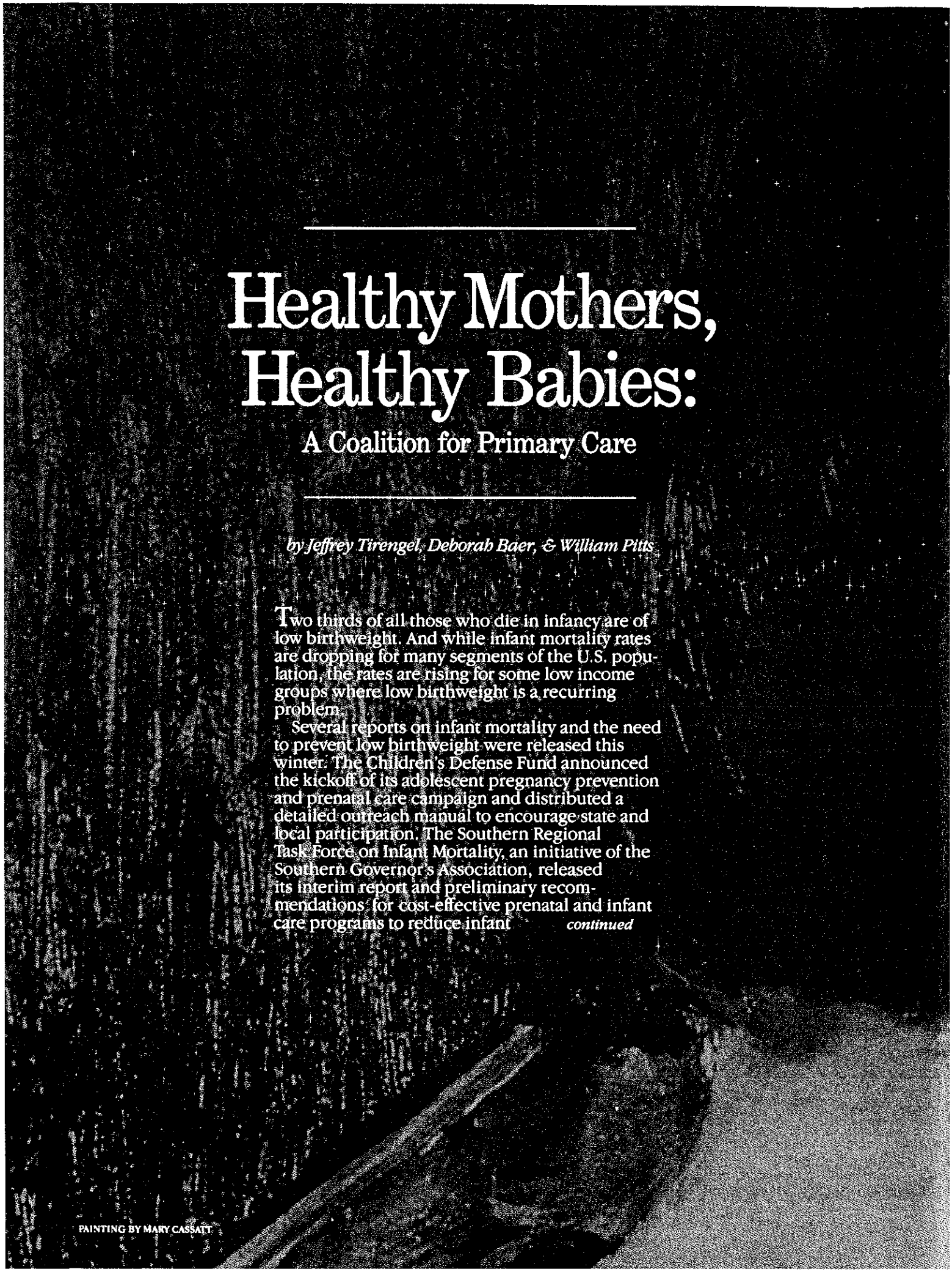
However, it is one thing to build an organization and another to get results. RISE met this challenge. It submitted a pre-application to FmHA for the construction of 20 seasonal farmworker housing units. After several months, RISE's patience was rewarded when the pre-application passed FmHA funding eligibility. A significant hurdle had been cleared.

Meanwhile, RISE developed two video presentations, a documentary entitled "Available Farmworker Housing" to educate both the public and health care staff regarding the need for improved migrant housing and "Agricultural Labor Camp Sanitation," a film seeking to sensitize viewers to a camp's environmental health needs. This film emphasized that environmental health is the joint responsibility of the Health Department, growers, and migrants.

RISE is a new organization addressing an old problem. As it pilots its funding application for new construction through winding government channels, it will also seek funding to upgrade existing housing.

RISE will promote community awareness of the migrant housing problem by arranging public presentations and developing additional educational materials. RISE also plans to offer technical assistance to other groups who work to improve migrant housing.

RISE recognizes that even when they receive funding for 20 housing units, it will make only a small dent in the housing shortage. But, by combining real construction progress with vigorous community awareness programs, RISE intends to create a problem solving nucleus whose example will stimulate further efforts to take on the challenge of improving migrant housing.



Healthy Mothers, Healthy Babies:

A Coalition for Primary Care

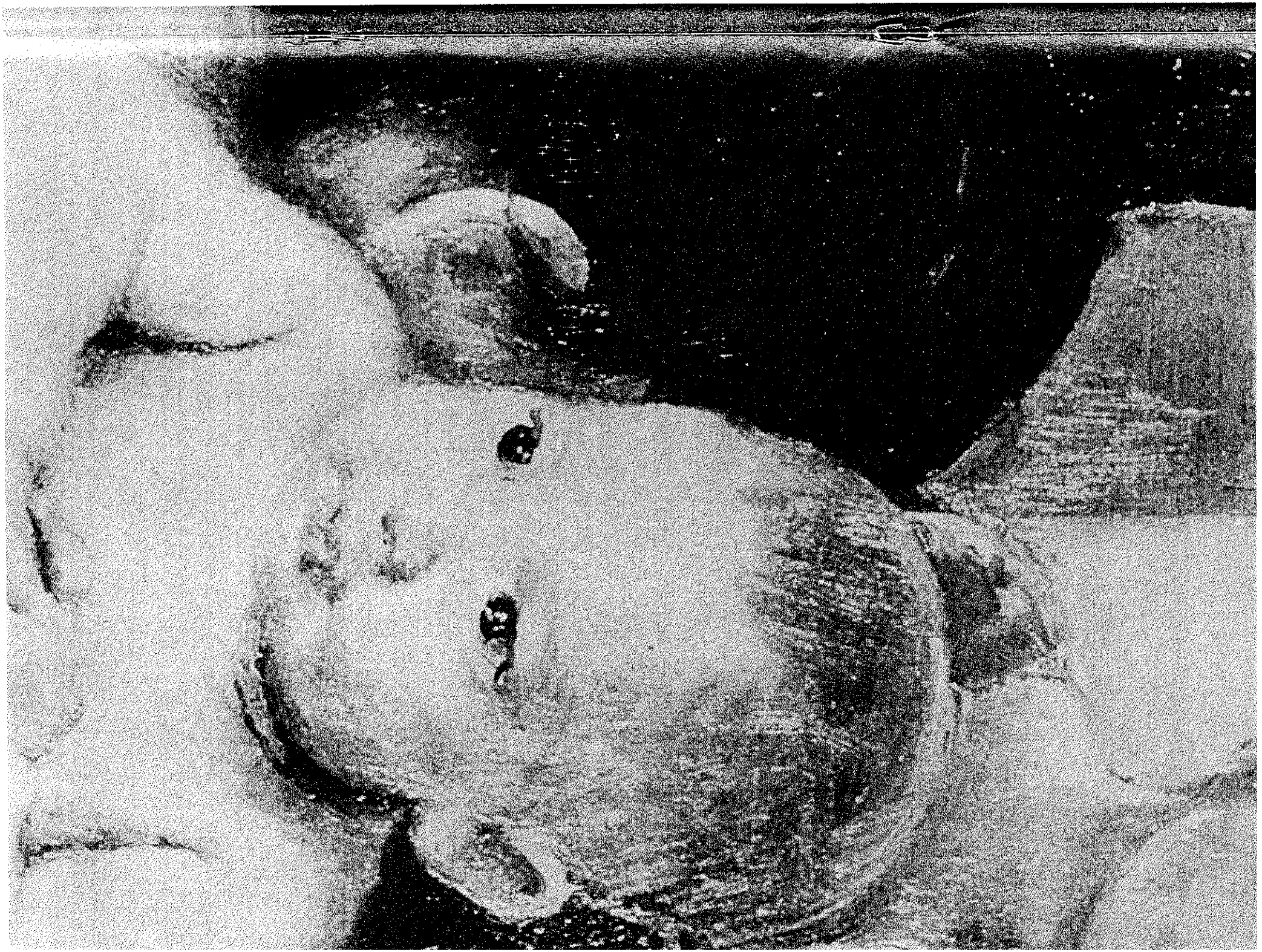
by Jeffrey Tirengel, Deborah Baer, & William Pitts

Two thirds of all those who die in infancy are of low birthweight. And while infant mortality rates are dropping for many segments of the U.S. population, the rates are rising for some low income groups where low birthweight is a recurring problem.

Several reports on infant mortality and the need to prevent low birthweight were released this winter. The Children's Defense Fund announced the kickoff of its adolescent pregnancy prevention and prenatal care campaign and distributed a detailed outreach manual to encourage state and local participation. The Southern Regional Task Force on Infant Mortality, an initiative of the Southern Governor's Association, released its interim report and preliminary recommendations for cost-effective prenatal and infant care programs to reduce infant

continued

PAINTING BY MARY CASSATT



"Two thirds of all those who die in infancy are of low birthweight."

Healthy Mothers, Healthy Babies, a guide to community planning and organizing.

illness and death. And The Institute of Medicine (IOM), chartered by the National Academy of Sciences, completed its two-year study on the importance of preventing low birthweight, recognizing the need to provide nonwhite, adolescent, and undereducated women with better prenatal and infant care.

All three reports reached similar conclusions: that there is an immediate need for increased public awareness and expanded risk reduction programs.

"The Committee to Study the Prevention of Low Birthweight urges that the leadership responsibility for these programs be assumed by the Healthy Mothers, Healthy Babies Coalition," concludes the IOM.

THE COALITION

Formed in 1981 as a result of a conference of representatives from over 30 national voluntary, professional, and government organizations, the Healthy Mothers, Healthy Babies (HM, HB) Coalition developed due to a growing awareness nationwide that better methods of sharing information were needed to address the problem of high infant mortality in the United States.

"Fewer than nine deaths per 1,000 live births and continuing improvement in maternal and infant health is the 1990 goal," stated the Public Health Service in its 1980 report on health objectives for the nation.

Coalition members pledge to:

- Have a charter, purpose, or constituency that is national in scope or broadly represents a special population group or groups and have a significant commitment to maternal, prenatal, and/or infant care.
- Encompass a structure of state or local affiliates or another type of network to reach constituents at the regional, state , or local level.
- Make a commitment to help disseminate materials and information about Healthy Mothers, Healthy Babies.

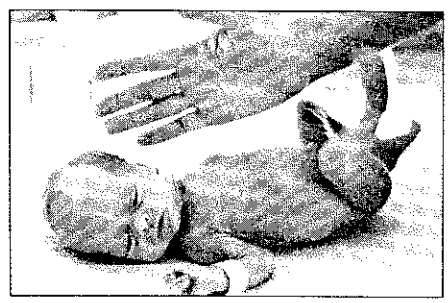
By devising better methods of sharing information, especially about educational materials and programs that have proven to be effective, and working together to disseminate materials through different channels to reach target audiences – such as pregnant women, women planning pregnancy, teenagers, fathers and other family members, and minorities – the HM, HB Coalition promises to effect a positive change.

THE FLORIDA COALITION

An important measure of the Coalition's success is its ability to translate good will at the national level to organizational action through state involvement. Over 40 states have begun their own coalitions.

"The goal for the coming year is to reduce the number of low birthweight babies by increasing public knowledge of the problem," says Cathy Nell, Florida's coalition coordinator.

Florida's rural areas suffer from a lack of primary care providers, and



Nell claims that many hospitals are reluctant to admit low income women with no insurance. Of the 160,000 births in Florida last year, 61,000 were by low income women, and as many as 6,500 went medically unserved. The Coalition wants to convince state legislators that a relatively modest investment in prenatal care for these women can bring in a big return.

"We want to make them aware of the problem and we plan to do that by providing each state representative with a profile book that lists vital statistics on teenage pregnancies, infant mortality, and low birthweight. We're going to rank the 67 counties from best to worst in terms of birth outcomes. We hope this will embarrass them into taking action," Nell told PCF.

The Florida group has also initiated a media campaign in the form of a six-part television series on infant health and low birthweight babies. Nell is now working on getting statewide exposure for the award-winning documentary and Florida's own HM, HB newsletter and coalition brochure have been distributed statewide.

THE TENNESSEE COALITION

"We feel good about what we're doing," Jan Scanlon told *Primary Care Focus.*

As Tennessee's director of public affairs for the state health department, Scanlan has a lot to say about the state-funded Healthy Children Initiative, a major element of the Tennessee State Coalition.

Since the Initiative was formed in 1983 as a recommendation of a Task Force appointed by the Governor and chaired by Mrs. Honey Alexander, the Governor's wife, it has become one of the most successful programs of its type.

"This is the first time a public and private coalition has affected public policy. We've been able to translate academic concerns and knowledge into what we should be doing in public policy," says Scanlan.

She credits the success of the Healthy Children Initiative to three leading factors:

1. **Networking.** By inviting public and private groups across the state to share resources to support common issues, each group benefits. "Get your *allies*— groups with similar interests – to help you," advises Scanlan.
2. **Community Outreach.** Tennessee's state health department is split into 13 regional offices. The Healthy Children Initiative appointed a Health Children Coordinator for each region to do the "hands-on" work at the community level – putting up posters, submitting news releases, and staging local events to reach individual members of the community. "We make sure that in every county of the state there is a 'Healthy Children' presence," says Scanlan.
3. **Internal Marketing.** "In order to accomplish everything we've done, we've made good use of internal marketing," Scanlan says. She suggests using existing resources – in their case, the 3,000 employees of the Tennessee Department of Health and Environment – to sell your program. "We've educated our employees about what we're doing so they can communicate effectively about it. This has resulted in an

added benefit: existing programs, such as WIC and Medicare, are being reexamined to see if they can be used to support the Initiative."

Two years ago the Tennessee regional health departments were serving 2,000 women in prenatal and infant care programs. As of 1985, that number increased to 15,000. The Initiative met its first-year goal of establishing a prenatal program in every county of the state.

Goals for 1985-86 focus on making sure infants *stay* healthy. Called "Infant Follow-Up," one program involves working with the Tennessee Medical Association and the Pediatric Society to develop a "medical home" for each child, that is, an established place for needy infants to receive regular and consistent health care.

"Keep Your Babies Health on Track" will be the theme for an upcoming public awareness campaign, an extensive effort to reach not only parents, but doctors, volunteer groups, and relevant organizations about updated infant health care plans.

Scanlan stresses that the campaign materials can be used by Coalition members of any state, since the Initiative carefully omitted references to Tennessee in both printed and spoken matter. She invites all those interested to write for free promotional material at P.O. Box 1030, Nashville, Tennessee 37202.

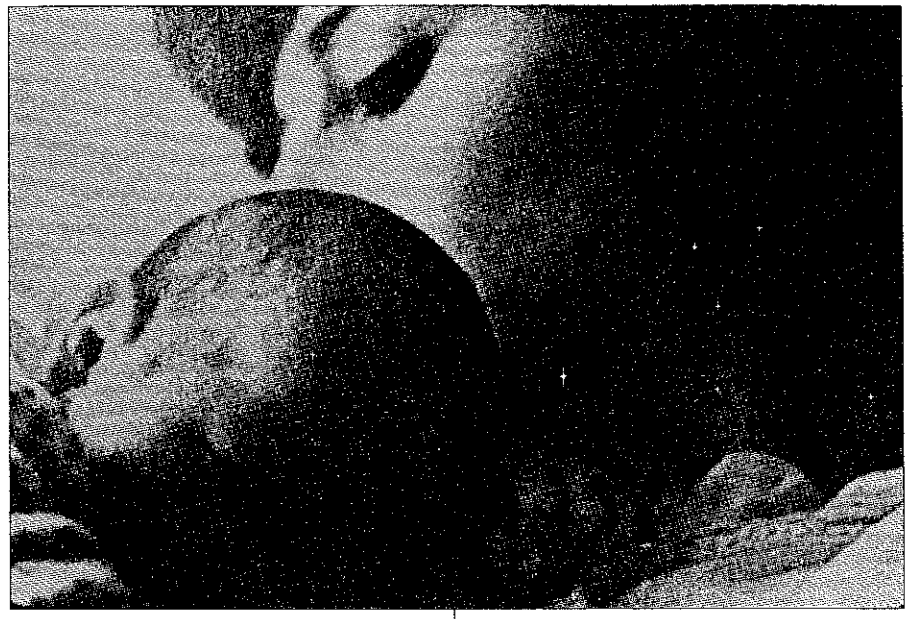
THE MARYLAND COALITION

"Start right from the beginning to take care of yourself and your baby," and "Start Right, Start Now," is the main message of the media campaign kicking off May 1 in Baltimore City. City residents will be able to dial "889-BABY" and get a referral to a local community health center (CHC) for prenatal care.

The campaign is sponsored by the Maryland Primary Health Care Association's (MPHCA) Start Right program, an infant mortality risk reduction plan which received substantial state funding in November 1984. MPHCA is a member of the Maryland Coalition, which is assisting in this effort.

"We're really moving ahead. Our ultimate goal will be to have some impact on the city's IMR (infant mortality rate). To do this we have to increase the number of people who use their community health centers," says Diana Smith, program coordinator of Start Right.

While infant mortality rates in the areas of Baltimore's five federally-funded CHC's are low, the overall rate for the city was 16.9, compared to the national rate of 11.2. Even worse, for nonwhite women in Baltimore the rate was 19.0.



Clearly, CHC's have a positive impact on the city's infant mortality figures, but Smith says that more women need to be made aware of the available services and of their personal responsibility to seek help.

Start Right's four-phase plan involves:

1. **Increasing** utilization of CHC's prenatal services by area residents;
2. **Enrolling** newborn infants of high risk women in CHC pediatric services;
3. **Educating** women in communities about the importance of prenatal care; and
4. **Promoting** the prevention of unwanted pregnancies among high risk women of childbearing age.

As a major initiative of the plan, Start Right has appointed a Health Advocate to each of the five community health centers in the city. Advocates will track all infants admitted to the CHC, following them from prenatal through perinatal care, up to one year after birth. They will perform extensive outreach activities, actively seeking out mothers who neglect their medical responsibilities and encouraging families to use CHC facilities.

Both the Governor of Maryland and Mayor of Baltimore pledged their support to the Maryland Coalition in January and the approximately 30 state agencies that are now members of the Coalition have generated a wide range of activities across the state.

A public information campaign was conducted in January featuring statewide radio and television public service announcements with messages about good health practices during pregnancy and a March of Dimes (MOD) telephone number for public inquiry.

During 'Nutrition Month' in March, the WIC program co-sponsored with the Coalition public service announcements tagged with a message to call local health departments or WIC program centers for information on prenatal and infant health care, while several counties offered public workshops on subjects such as breastfeeding and Fetal Alcohol Syndrome.

And finally, in support of professional education, a preterm preventive lecture was delivered to health professionals at 30 out of the 36 Maryland hospitals with maternity/delivery units.

"The next step is to get ourselves incorporated. It's necessary in order to get outside funding," says Donna Peterson, chairperson of the Maryland Coalition.

The Coalition's future plans will focus on patient education for the prevention of preterm birth, a follow-up to the health professional lectures. The Coalition is developing a poster for distribution to local health clinics, CHC's, and WIC offices — "anywhere where low income women might see them," says Peterson.

"Our 1985 agenda is a full one, but with the continuing commitment of our members, I have no doubt we'll succeed."

THE SOUTH CAROLINA COALITION

In his press conference of October 1984, Governor Dick Riley offered his support to launch the South Carolina HM, HB Coalition.

The response was a Resource Fair, a gathering of some 50 organizations throughout the state to share materials and exchange ideas about the state's prenatal and infant care problems.

According to Libby Hoyle, a Clemson University foods and nutrition specialist and co-chairman with Joanne Fraser of South Carolina's HM, HB Steering Committee, South Carolina has the highest rate of infant mortality in the nation.

"Many countries have little or no community health services, and in rural communities the rate of teenage pregnancy is high," says Hoyle.

As a result of the Resource Fair, prospects are brightening. Hoyle discussed recent HM, HB activities within certain counties in the state:

- **In Allendale County**— This is the poorest, most rural county in the state; not even one hospital exists in the county. While community HM, HB members are working to bring a doctor to the area, they have already set up learning centers in local schools aimed at teenagers of both sexes. The centers provide information on teenage pregnancy, nutritional guides, and infant care methods.
- **In Charleston County** – A "Baby Fair" was sponsored at a local shopping mall, supported by HM, HB workers and some 12 to 14 local state agencies including the March of Dimes and the American Lung Association. The fair featured infant care exhibits, exercise demonstrations for pregnant women, baby food preparation instructions, and a maternity fashion show. Films and other visuals were also provided.
- **In Clarendon County** – Only one small hospital exists in this area, which lists a high rate of low birthweight babies. The local HM, HB chapter set up free classes for expectant parents to teach them about food requirements and other prenatal and infant care needs. Libby Hoyle reports that the rate of low birthweight babies from the first graduating class of this program was extremely low.

South Carolina's future goals include a regional meeting with the national HM, HB Coalition to target maternal and infant care problems that are shared by southern and rural areas. And in October of 1985, a major mass media campaign is scheduled using local television stations. A short spot will air between 11:00 a.m. and 3:00 p.m., when soap operas are commonly watched. A toll-free number will allow women to receive free information about how to plan a healthy pregnancy.

"One third of South Carolina's counties have active HM, HB networks. Our goal is to get *all* the counties involved, because that's where things are really happening," says Hoyle.

"It is precisely those with the highest risk of having an unhealthy baby who are also least likely to receive adequate prenatal care."

Southern Regional Task Force on Infant Mortality, A Fiscal Imperative: Prenatal and Infant Care

NATIONWIDE

Coalition members across the nation are pooling their resources in a variety of ways to increase public awareness about prenatal care. Recent national efforts include:

- A series of six **posters and information cards** for distribution by clinics serving low income new and expectant mothers on smoking, alcohol and drug use, breast-feeding, nutrition, and the importance of prenatal care;
- A mass media **public awareness campaign** on prenatal care produced by the New York Health Department and sponsored for use in other states by the Public Health Service;
- A **survey of health care providers** concerning strategies to motivate low income women to seek prenatal care;
- A **directory** of educational materials on prenatal and infant care for public and professional use;
- A **kit for health care providers** to promote breast-feeding, and a similar kit on substance use (in production); and
- A **prepackaged television show and radio public service announcement** on prenatal care.

"We want to help the state coalitions get established and we are accomplishing that goal in several ways. By cosponsoring activities with state and regional maternal and infant health groups we can get interested parties together to share ideas and resources," says Elaine Bratic Arkin, Deputy Director of Public Affairs for the Public Health Service and a founding member of the national HM, HB Coalition.

The national Coalition also provides technical assistance to states forming their own Coalition. Following the third national meeting in September 1985, the national Coalition will cosponsor with state counterparts a series of nine regional conferences over the next two years to support and maintain state Coalition growth.

"Our major need is to reduce low birthweight in low income women," says Arkin. "This can only be done at the community level, the level where women who need education and care can contact the providers of care. To do this we need more resources in the communities. The HM, HB Coalition can help gather and pool those resources and target them to needy, high-risk groups."

Healthy Mothers, Healthy Babies resources are listed on page 15.

HOW YOU CAN START AN HM, HB CAMPAIGN

1. Check local resources – has a coalition already been formed in your area?
2. Learn about the health problems of high-risk women in your community.
3. Check community opinion about the subject of healthy mothers and healthy babies.
4. Invite local groups to pool resources to reach your community.
5. Begin a training program for volunteers.
6. Schedule regular meetings to enlist the support of planning and neighborhood groups.
7. Use local media, educational materials, and HM, HB Coalition materials to publicize your program.
8. Publicize your successes and use the documentation to reward individual participation.

MEETINGS & MARKETS

Don't Forget. . . . NACHC's Fourth Annual Clinical Director's Conference will take place in Chicago's McCormick Center Hotel on June 13-15, 1985. The agenda is designed for individuals responsible for clinical management in the health center setting. Sessions will focus on the role of the clinical manager, financial management, development and administration of personnel, and special clinical issues. Executive Directors and Clinical Directors are both encouraged to attend.

San Juan, Puerto Rico will be the site of **NACHC's 16th Annual Convention and Community Health Institute** on September 7-11, 1985. This year's theme is "Primary Care: Promoting Health/Reducing Costs."

For more information or registration materials for either conference, contact the National Association of Community Health Centers; 1625 I Street, N.W.; Suite 420; Washington, DC 20006; (202) 833-9280.

Medical Director — Challenging position available for board certified primary care physician to creatively direct medical services in a progressive, urban community health center located in Indianapolis, IN. Excellent support staff and facilities to provide comprehensive primary care are available. A prepaid program is presently under development. Clinical/administrative experience or ambulatory fellowship training along with orientation towards health promotion and cost containment desirable. Salary negotiable and commensurate with experience. Forward CV to: John L. Murphy; Executive Director; People's Health Center; 2340 East 10th Street; Indianapolis, Indiana 46201.

Medical Director — Board certified or eligible family practice physician to work at the International District Community Health Center in Seattle, Washington. The Health Center is a part of a system of community clinics serving Seattle's low income population. Responsibilities include OB, preceptorship of mid-levels, some evening hours and rotating call schedule. Excellent hospital affiliations and fringe benefits, salary based on experience. Send resume to: Central Seattle Community Health Centers; 1422 34th Avenue; Seattle, Washington 98122; (206) 324-6763.

Medical Director — Patient care and administrative leadership for migrant and rural primary care centers located in Orlando, FL area. Family medicine and experience in supervision and quality assurance. Commensurate salary. Excellent benefits. Affirmative action employer. Send CV, salary expectations and three references to: Cecilia Abt; P.O. Box 1249; Apopka, Florida 32703.

Nurse Midwives — CMN's and CMN Supervisor for primary care centers and hospital adjacent to birthing center located in Orlando, FL area. Spanish and Haitian speaking desirable. Excellent salary and benefits. Affirmative action employer. Send CV, salary expectation and three references to: Cecilia Abt; P.O. Box 1249; Apopka, Florida 32703.

RN Center Manager — Position available in Orlando, FL area to manage overall health center operations. Supervise nursing, front desk and medical records. Supervisory experience, positive personality and strong communication skills. Commensurate salary. Excellent benefits. Affirmative action employer. Send CV, salary expectations and three references to: Cecilia Abt; P.O. Box 1249; Apopka, Florida 32703.

Director of Fiscal Management Services — Urban Community Health Center, newly federally funded. Private non-profit, consumer based board of directors with 16- year track record of providing services. Entry level position. Starting salary in the mid twenties, liberal fringe benefits. Also, percentage of travel expenses for final candidates to be provided. Must have at a minimum a BA or BS in Finance with Health Administration or Business Administration orientation. Must be able to perform financial analysis functions and resulting oriented management procedures. Knowledge of Federal reporting system a plus. Send resumes to: Search Committee; Neighborhood Health Services, Inc. of Kent County Michigan; 220 Cherry, S.E.; Xavier Hall; Room 1013-15; Grand Rapids, Michigan 49503.

Executive Director/Migrant Health — Experienced Health Services Administrator sought for Central Wisconsin Migrant Health Program. Knowledge of federal grant process required. Seek individual with strong planning and primary health care background. Bilingual-bicultural persons encouraged to apply. Salary upper 20s. Resumes/inquiries to: LaClinica; P.O. Box 191; Wild Rose, Wisconsin 54984.

Physician/Internal Medicine — Rapidly growing comprehensive health care facility with a three-physician family-oriented practice is looking for an ambitious internal medicine physician to practice in a rural community. Full time. Salary negotiable. CV to: Wood River Health Services; P.O. Box 1068; Hope Valley, Rhode Island 02832.

Dentist/General — Rapidly growing comprehensive health care facility with a family-oriented practice is looking for an energetic prevention-oriented dentist who appreciates a rural life-style. Modern two-operatory high quality dental office. Full time. Salary negotiable. CV to: Wood River Health Services; P.O. Box 1068; Hope Valley, Rhode Island 02832.

Executive Director — Newly formed Missouri health care state association located in Jefferson City, Missouri. Experience preferred in health field, government regulation, legislative contact, agency management, inter-agency coordination. Graduate degree preferred. Send resume, salary history to: MCPHC; 625 N. Euclid; Ste. 403; St. Louis, Missouri 63108; (314) 361-2330.

Medical Director — Position available in a progressive, community health center located in Rochester, NY. The center is one of the largest in the country with a 16-year tradition of quality health care. Comprehensive health services offered on site include pediatrics, OB/GYN, internal medicine, dental, mental health, alcoholism, nutrition and health education. The center is affiliated with the School of Medicine and Dentistry of the University of Rochester. The successful candidate must meet standards for faculty appointment and must be board certified in a primary care specialty. Community health, public health, health care administration or prepaid group practice experience desired. Wages and benefits competitive, based on experience. Forward CV to: Search Committee; The Anthony L. Jordan Health Center; 82 Holland Street; P.O. Box 876; Rochester, New York 14603.

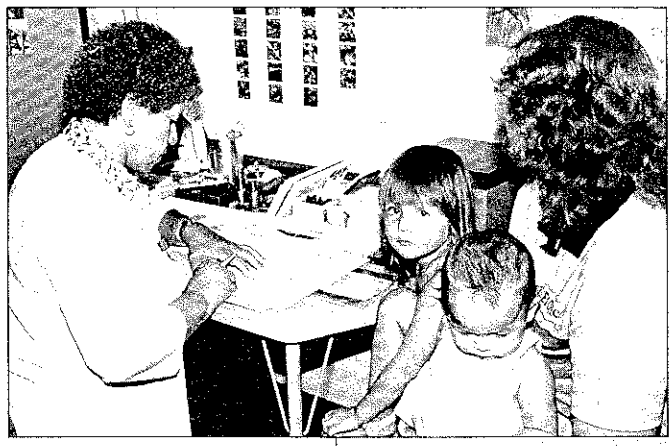
Breastfeeding: A Practical Guide is a new breastfeeding education program endorsed by

continued on page 15

ABSTRACT EXPRESSIONS

SELECTIONS FROM THE RECENT LITERATURE

These Abstracts are prepared by the National Health Information Clearinghouse. NHIC receives support from the US Department of Health and Human Services, Office of Disease Prevention and Health Promotion.



HEART DISEASE

Smoking and Coronary Heart Disease Mortality in the Elderly, by C. L. Jajich, A.M. Ostfeld, and D. H. Freemen, Journal of the American Medical Association, November 23/30, 1984, 252(20), pp. 2831-2834.

Even older persons who have smoked for decades decrease their risk of coronary heart disease (CHD) by quitting smoking, these authors found. Within 1 to 5 years, the elderly ex-smoker's risk of CHD becomes indistinguishable from those who never smoked. The risk of death from CHD for smokers is 52 percent higher. These data come from a longitudinal study of 2,674 persons aged 65 to 74 years. The authors conclude that elderly smokers should be encouraged by their physicians to quit.

Sudden Death in the Framingham Heart Study: Differences in Incidence and Risk Factors by Sex and Coronary Disease Status, by A. Schatzkin, L. A. Cupples, T. Heeren, et al., American Journal of Epidemiology, December 1984, 120(6), pp. 888-899.

The Framingham Study is a prospective study of cardiovascular disease that has followed a sample of 5,209 persons since 1948. A total of 146 men and 50 women died suddenly in its first 26 years. Within this subgroup, the researchers found marked differences between the sexes in cardiovascular risk profiles as well as differences between those who had suffered from prior coronary heart disease (CHD) and those who had not. Men without prior CHD who died suddenly had many of the classic risk factors — left ventricular hypertrophy, age, serum cholesterol, smoking, relative weight, and elevated blood pressure. Women without prior CHD did not exhibit these risk factors; only age, vital capacity, hematocrit, and, marginally, serum cholesterol and glucose emerged as risk factors in this group. Both men and women with prior CHD appeared to have few risk factors, suggesting, say the authors, that the presence of CHD took precedence over the other risk factors. The authors conclude that the differences in risk profiles between men and women were considerable in their study but caution that this analysis was based on a relatively small number of cases and that when more data are available, the picture may change.

CONTRACEPTIVE USE AMONG TEENS

The Influence of Client-Provider Relationships on Teenage Women's Subsequent Use of Contraception, by C. A. Nathanson and M. H. Becker, American Journal of Public Health, January 1985, 75(1), pp. 33-38.

In family planning clinics where the staff's attitudes were characterized as authoritative, average levels of contraceptive use were higher among teenage clients in this study. Derived from data on 2,900 teenage clients at 78 family planning clinics, the findings, say the authors, suggest that the quality of interaction between a clinic's staff and its teenage clients influences contraceptive use. The authors also report that, surprisingly, in clinics where clients were less trusting, contraceptive use was higher. They suggest that compliance is associated with skepticism about medical care. These findings, they conclude, hold implications for a clinic's approach: while the prevailing philosophy in many clinics is to foster the client's independence and freedom of choice, this may not be the best way to encourage effective contraceptive use.

PROSTATE CANCER

Early Detection of Prostate Cancer by Routine Screening, by G. W. Chodak and H. W. Schoenberg, Journal of the American Medical Association, December 21, 1984, 252(33), pp. 3261-3264.

Prostate cancer was detected in 11 of 811 men after routine screening for the disease in a free screening clinic. Noting that prostate cancer is difficult to detect when still confined to the prostate, the authors suggest that routine screening employing the digital rectal examination method may be a cost-effective method for diagnosing the disease in patients with less extensive disease. None of the men, who ranged in age from 50-80, were symptomatic at the time of the examination. Whether early detection of the disease can prolong the survival of the patients remains a question, caution the authors, but they add that their ongoing project, which is following up men diagnosed with prostate cancer, will seek to provide the answers.

ULTRASONOGRAPHY & CANCER

Obstetric Ultrasound and Childhood Malignancies, by L. M. Kinnier Wilson and J. A. H. Waterhouse, The Lancet, November 3, 1984, 11(8410), pp. 997-998. *Ultrasound Examination in Pregnancy and Childhood Cancer*, by R. A. Cartwright, P. A. McKinney, P. A. Hopton, et al., The Lancet, November 3, 1984, 11(8410), pp. 1001-1004.

Neither of these epidemiological studies discovered an association between ultrasonography and cancer, despite what previous laboratory findings have suggested. In the first study, the authors used data from the Oxford Survey of Childhood Cancers to identify 103 children who died of cancer between 1972 and 1981 and 103 matched controls. They found about six percent of the children in both groups had been exposed to ultrasound examinations in utero. Only among children over 6 years of age was there a slight preponderance of prenatal ultrasound exposure in the group that had died of cancer. These were children exposed during the early years of ultrasound, and the authors speculate that since it was then used for abnormal pregnancies, these children may have been at a greater risk of cancer for other reasons. They conclude that diagnostic, obstetric ultrasound examinations are not associated with cancer between birth and 6 years of age.

The second study, which involved a larger population, confirmed the findings of the first. In this analysis of data from the Inter-regional Epidemiological Study of Childhood Cancers, 555 children with cancer diagnosed between 1980 and 1983 were each compared with two matched controls. There was little difference between the two groups: 26 percent of the cases and 27 percent of the controls had been exposed to ultrasound. Children over 6 did not appear to be at a greater risk, in contrast to the Oxford Study. These findings, say the authors, support the view that there is no association between ultrasound and the risk of childhood cancer.

INJURY PREVENTION

The Incidence of Injuries Among 87,000 Massachusetts Children and Adolescents: Results of the 1980-81 Statewide Childhood Injury Prevention Program Surveillance System, by S. S. Gallagher, K. Finison, B. Guyer, et al., American Journal of Public Health, December 1984, 74(12), pp. 1340-1347.

Falls, sports, and cutting and piercing instruments are the most common causes of injuries in children and adoles-

cents, these authors found. Injuries from motor vehicles, burns, and drownings are less common but tend to be of greater severity. These conclusions are based on data from the Massachusetts Statewide Childhood Injury Prevention Program (SCIPP) Surveillance System, which monitored all childhood injuries brought to emergency rooms in 14 communities for a period of 1 year. Of cases studies under the SCIPP Surveillance System, there was a ratio of 45 hospital admissions and one fatality for every 1,300 emergency room visits. Males were the injury victims 1.66 times more often than females. The authors conclude that injury prevention programs which emphasize the prevention of serious injuries should expand their efforts to target the less serious injuries, which occur more frequently.

AIDS INCIDENCE RATES

The Incidence Rate of Acquired Immunodeficiency Syndrome in Specific Populations, by A. M. Hardy, J. R. Allen, W. M. Morgan, et al., Journal of the American Medical Association, January 11, 1985, 253(2), pp. 215-220.

Incidence rates for AIDS calculated in this study confirm that groups appearing to be at high risk are, in fact, groups that have the highest rates of AIDS. These groups include intravenous drug abusers, especially in New York and New Jersey, persons with hemophilia type A, and recent Haitian entrants to the United States. All these groups have incidence rates over 80 per 100,000, compared to the national rate of 1.4 cases per 100,000. Nationally, single men have an incidence about 6 times higher than the average, but single men in Manhattan and San Francisco show incidence approaching or surpassing 200 per 100,000. The authors note that surveillance data indicate that most of the single men with AIDS are homosexual or bisexual. Other groups with rates higher than the average are persons with hemophilia type B, female sexual contacts of male drug abusers, and recipients of blood transfusions. The data are based on the period June 1, 1983 to May 31, 1984.

Continued from page 5

The WIC (Women-Infant-Children) program provides diet supplements and checkups for poor pregnant and nursing women and their children — but it has only enough money to reach a third of those eligible. The Administration now proposes more — a limit on Federal Medicaid grants to the states, and a cut that would drop a million participants from WIC by 1986.

These are cruel and foolish economies. A Federal advisory panel estimates that each dollar spent on prenatal care for women at risk of bearing low-birthweight babies will save as much as $3.38 in specialized care later. Low-birthweight babies are more likely to suffer cerebral palsy, retardation, seizures and vision problems, and to require public funds for treatment. What kind of way is that to save money?

Continued from page 13

ASPO/Lamaze and La Leche League. The two-part film series and detailed teaching manual have won praise from physicians, nutritionists, nurses, and health care educators.

Each part is self-contained and 15 minutes long. Part One addresses PREPARING for breastfeeding. Part Two covers MANAGING breastfeeding. Both parts are complementary and can be used separately or together. The program can be used to provide a concise and comprehensive overview to the practical side of breastfeeding education. Appropriate audiences include parents, patients, staff, and health care providers.

The program is available in any format: 16mm film, ¾" U-matic Videocassette, Betamax, and VHS. Rentals are available, as are previews for those considering purchase. Requests for information should be sent to Motion, Inc.; 3138 Highland Place, NW; Washington, DC 20008; (202) 363-9450.

Continued from page 4

pliance with the request for a refund would cause financial disaster.

The Grant Appeals Board rejected CAC's arguments. Because the Board's decision was an administrative disallowance rather than a court action, the statute of limitations was not applicable. CAC claims, including their fear of 'financial disaster,' did not support a change in the ruling.

However, after auditors discovered final figures could not be obtained for CAC's total expenditures at close-out, the Board did reverse their disallowance of CAC's ending cash balance of $23,137. Only if CAC's total expenditures had been less than the authorized grant would a refund be required.

ILLUSTRATION BY SASHA GEORGEVITCH

HEALTHY MOTHERS, HEALTHY BABIES RESOURCES

Healthy Mothers, Healthy Babies *Newsletter* (free), and The Community Connection: A Guide to Community Planning and Organizing ($2.75), American College of Obstetricians and Gynecologists, Public Affairs Department, 600 Maryland Avenue, S.W., Suite 300, Washington, D.. 20024.

Healthy Mothers, Healthy Babies *Directory of Educational Materials,* National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013-1133 (free).

Posters and information cards for low income and pregnant women on nutrition, smoking, alcohol and drug abuse, breastfeeding, and the importance of prenatal care. Available from clinics, WIC offices and other sites serving low income women.

Market research reports, one on sources of health information for low income women and one on their media habits, and newspaper columns on the importance of prenatal care, use of alcohol and drugs, smoking, and breast-feeding, Public Health Service, P.O. Box 47, Washington, D.C. 20044 (free).

"Reaching Out to the Pregnant Teenager," March of Dimes, 1275 Mamaroneck Avenue, White Plains, New York 10605.

"Outreach," an 8-minute slide/tape or video description of the Coalition, Photographic Division, Office of Governmental and Public Affairs, U.S. Department of Agriculture, South Building, Room 4407, Washington, D.C. 20250 ($29.50).

Tabletop Displays, HM, HB Directory, State Coalitions, HM, HB Materials Order Forms, and Status of Coalition projects/subcommittee membership; Healthy Mothers, Healthy Babies, P.O. Box 47, Washington, D.C. 20044.

Membership and Policy Subcommittee Information, Robert Moran, ASPO/Lamaze, 1840 Wilson Boulevard, Arlington, Virginia 22201.