Healthy Generations

A publication of the Center for Leadership Education in Maternal and Child Public Health

Summer 2014

# MCH Public Health in Action:

## Serving All Communities

University of Minnesota

School of Public Health

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Serving All Communities

*Summer 2014*

## IN THIS ISSUE



## LETTER FROM THE EDITOR

Public health professionals are often asked what "public health" is. We know the formal definition provided by the Centers for Disease Control and Prevention: *"Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases."* I feel that this statement—while technically correct—is dry and incomplete. **Public health is about equity, passion, and connection.**

For almost three decades, I have taught public health principles and conducted public health research. Working in maternal and child health, I have been inspired and educated by public health professionals in the field. These are the people who translate evidence into action. These are the people who educate all of us, with the best intentions, with humility, and with vigor. Every day, public health professionals do their work with passion, vision, and a sense of community.

The late Paul Wellstone, Minnesota's US Senator, said that, "We all do better when we all do better." This belief fuels public health work. In preparing this volume, Shoua Vang (an MCH MPH student) and I intended to display the depth and breadth of public health work. And, like any public health effort, we couldn't do this alone. We met public health and MCH professionals who champion programs and policies that will enable them to remake, rebuild, reform, and re-invigorate the communities and the populations to whom they have dedicated their many skills. As you read this volume, it will be clear how many individuals generously shared their wisdom and their commitment to supporting and improving maternal and child health with us. While they have disparate backgrounds, a variety of talents, and different missions, these public and community health professionals share the ability to see the world as it is and to dream big.

—Wendy L. Hellerstedt, MPH, PhD

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An Interview with Lauren Ryan:

# Addressing Human Trafficking in Minnesota

*by Wendy L. Hellerstedt, MPH, PhD*

*Lauren Ryan is an attorney and the Director of the Minnesota Department of Health's (MDH's)* Safe Harbor/No Wrong Door *efforts. She is responsible for the coordination, implementation, oversight, and evaluation of this program, which ensures that sexually exploited youth are treated as victims rather than criminals and have access to trauma-informed, victim-centered and culturally and age-appropriate services.* No Wrong Door *requires extensive training for professionals and community members, development of a statewide infrastructure for service delivery, creation of statewide model protocols, and multiple systems working collaboratively to identify youth, prosecute traffickers and purchasers, and ensure access to appropriate services. We asked Ryan several questions to help our readers understand her work and the problem of sex trafficking in Minnesota.*

*"We know that sex and labor trafficking is happening in Minnesota. It is happening almost everywhere."*

**Healthy Generations (HG): How did you get involved in working with sexually exploited youth?**

**Lauren Ryan (LR):** As an undergraduate, I interned as a juvenile probation officer and I later coordinated Juvenile Drug Court in North Dakota. I worked directly with adjudicated juveniles with a punitive and corrective focus. I noticed a pattern with the youth I worked with: most had experienced some sort of trauma or instability in their home lives. These experiences led me to law school where I believed I would continue working with youth. Instead I focused on representing victims and learning more about victim services. Before taking this position at MDH, I worked directly with victims and survivors of domestic violence and human trafficking. All of these experiences have prepared me for my current position. I'm very familiar with legal responses to juvenile delinquency and I am familiar with victim services, especially domestic violence and trafficking. I also possess a working knowledge of the strengths and inadequacies of services. Our program [*Safe Harbor/No Wrong Door*] is very unique. It not only is a victim services program but it is changing systematic and societal responses to a particular population. In most contexts, domestic violence/sexual assault survivors are not criminalized due to their victimizations. However trafficking and exploited individuals have been criminalized because of societal perceptions of prostituted persons. This uniqueness is very exciting but also very challenging.

**HG: Could you describe the problem of human trafficking in Minnesota?**

**LR:** This is a great question, but it's difficult to answer. We know that sex and labor trafficking is happening in Minnesota. It is happening almost everywhere, according to law enforcement and service providers. But it is difficult to understand the scope and magnitude of trafficking in Minnesota for several reasons: our understanding of these crimes is relatively new and we have poor and varied definitions of trafficking, there is a general lack of awareness about trafficking, the hidden nature of trafficking, and the lack of victims' self-identifying. What we do know is that sex and labor trafficking occurs in urban and rural areas of Minnesota and that it involves adults and minors, citizens, and undocumented individuals.

**HG: Do you believe there are important misconceptions about human trafficking in Minnesota?**

**LR:** I think there are several misconceptions, including:

- **It only affects foreign-born individuals.** Anyone can be a victim of trafficking, including US citizens, foreign-born individuals, males, females, adults, and minors.
- **Trafficking victims are kidnapped and forcibly kept against their will.** The most common tactics used by traffickers include false promises of a better life, love, or employment; coercion through romantic relationships; and fraud. There are cases where someone is abducted or forced, but they are not the most common cases.
- **Trafficking requires crossing state lines or national borders.** Someone can be trafficking within a city or one geographic location.
- **Prostitution is voluntary and different than trafficking.** In many instances, prostitution and trafficking are one in the same. According to Minnesota law, involvement by a third party who aids the prostitution of an individual is considered trafficking. So anytime someone has a pimp/trafficker (in many instances, a boyfriend or significant other), they are being trafficked.
- **Trafficking only happens in the Twin Cities, nowhere else in Minnesota.** Again, trafficking happens everywhere. Where there is a demand for cheap labor and where there is a demand for purchasing someone for sex, there is trafficking.

**HG: What is Minnesota legislation concerning human trafficking?**

**LR:** Minnesota passed anti-trafficking statutes in 2005, following the national Victims of Trafficking and Violence Protection Act of 2000. Trafficking can be broken down by the A-M-P model, **A**ction, **M**eans, and **P**urpose:

- **A**ction: How did the person get into the trafficking situation?
- **M**eans: How was a person kept in a trafficking situation? Federal law defines means as force, fraud, and coercion. In terms of prostitution, Minnesota law defines it as **any** means that aids in the prostitution of an individual. Importantly, the consent of the victim is not a defense for the trafficker.
- **P**urpose: For what purpose? Sex and labor.

**HG: How do Minnesota laws compare with legislation in other states and/or the nation?**

**LR:** Minnesota's laws are very strong relative to federal law. Federal legislation requires force, fraud, or coercion to define a trafficking situation. In Minnesota, it is easier to charge and prosecute traffickers because we do not need to prove force, fraud, or coercion (i.e., "by any means" [BAM]). Some other states also use BAM, but most state legislation mirrors federal standards. We need to continue to improve and simplify our legislation.

**HG: Tell us about *No Wrong Door.***

**LR:** *No Wrong Door* is Minnesota's service model that supplements and complements Safe Harbor legislation. Safe Harbor was passed in Minnesota in 2011, and went into effect in August 2014. The legislators wanted more than just Safe Harbor, which decriminalizes prostitution charges for youth 17 and younger. They wanted Minnesota to develop a response to help youth leave exploitative and abusive situations and receive the help and services they need. In 2011, legislators directed the Minnesota Department of Public Safety (DPS) to develop and coordinate a Safe Harbor committee. The committee consisted of various stakeholders, including domestic assault/sexual violence advocates and individuals from state agencies, law enforcement, youth-serving organizations, and child protection. *No Wrong Door* was the collective brain child of this group. The DPS published its recommendations for full implementation of *No Wrong Door* in January 2013, stating that, "The *No Wrong Door* approach is a comprehensive, multidisciplinary plan to ensure communities across Minnesota have the knowledge, skills, and resources to effectively identify and serve sexually exploited youth and youth at risk for sexual exploitation." Communities (all systems, professionals, and communities members, a.k.a any **door** they access) should know how to identify sexual exploitation and know where to refer youth to services. Youth will no longer be criminalized for this behavior; rather services will be provided to youth just as services are provided to victims of other crimes. Further, the criminal justice response should focus on the exploiters, the men and women purchasing youth for sexual acts and in some situations the traffickers who are profiting from these acts.

**HG: How is *No Wrong Door* funded and organized?**

**LR:** The *No Wrong Door* report was taken to the legislature in 2013 and funds were sought to fully implement the model statewide. Advocates requested $13 million and the State legislature appropriated $2.8 million. The Minnesota Department of Human Services (DHS) was funded to develop emergency, long term, and permanent housing specifically for sexually exploited youth. The Ramsey County Attorney's Office, through the Department of Public Safety, received funding for statewide training of law enforcement and prosecutors, as well as for developing model protocols for individuals who may encounter an exploited youth and for training professionals on the protocols. The MDH received funding for the statewide director position and regional navigators.

**HG: What is a navigator?**

**LR:** Navigators are essential to *No Wrong Door*, as they are the central point of contact for professionals, community members, law enforcement, and even youth themselves to be connected with age-appropriate, trauma-informed services. They are also regional experts for community members who want training or more information on sexual exploitation. We'll have eight navigators with Minnesota divided into seven regions, so one navigator per region. In addition, we will have one navigator developing a pilot project with three reservations in Minnesota to serve American Indian youth, because this population is disproportionately affected by trafficking and exploitation. During the last legislative session, we (MDH) received funding for comprehensive supportive services and the DHS received more funding for housing. In sum, the theory is that communities will be trained to identify sexual exploitation, refer concerns to a navigator, and the navigator will connect the youth to services that will help them heal from the trauma they've experienced.

**HG: Why is a focus on sexually exploited adolescents, specifically, important?**

**LR:** A few reasons. Targeting people who are 17 and younger rectifies some inconsistencies in our laws. Our state views purchasing a "minor" used in prostitution as a serious offense but, at the same time,

*continued on page 4*

# WHAT IS HUMAN TRAFFICKING?

The United Nations Office on Drug and Crime (UNODC) defines human trafficking as, "The recruitment, transportation, transfer, harboring or receipt of persons, by means of threat, use of force or other means of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the receiving or giving of payment… to a person having control over another person, for the purpose of exploitation."[1]

UNODC states that human trafficking involves a pattern of activities through which people are "…abducted or recruited in their country of origin, transferred through transit regions, and then exploited in the destination country."[2] People may also be trafficked internally, within the borders of their own country. And trafficking can occur without movement from one geographical area to another: people may be trafficked within the area of their home residence. People may even be born into human trafficking situations. Human trafficking always involves **coercion** and **exploitation**. Human trafficking is both a public health and human rights issue that disproportionately affects women and children. It is estimated that almost every country in the world is affected by human trafficking, either as a country of origin, a transit country, or a destination country.[2]

UNODC describes human trafficking as a process, rather than a single offense, that includes:[1]

- **The Act:** Abduction, recruitment, transport, harbor, or receipt of a victim.
- **The Means:** Threat or use of force, coercion, abduction, fraud, etc., to control a victim.
- **The Purpose:** Exploitation of the victim by forcing her/him into sex work, forced labor or organ removal. Such exploitation often involves violence.

As defined in the US Secretary of State's 2014 report on human trafficking, "People may be considered trafficking victims regardless of whether they were born into a state of servitude, were transported to the exploitative situation, previously consented to work for a trafficker, or participated in a crime as a direct result of being trafficked."[3]

There are two major—but not mutually exclusive—forms of human trafficking: sex trafficking and labor trafficking. A less prevalent form of trafficking involves coerced organ donation.

### Sex Trafficking

While definitions of sex trafficking vary, in the US the Trafficking Victims Protection Act (TVPA) of 2000 defines sex trafficking as, "…the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act…" A commercial sex act is any condition in which anything of value is given to or received by any person. Further, "…the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age."[4] It is important to note that this definition clearly states that anyone engaged in a commercial sex act who is younger than 18 years old is by definition a trafficking victim, regardless of circumstances. This means that pimps involved with minors are, by definition, traffickers and they can be prosecuted as such under federal law in the US, with enhanced penalties above what pimps are normally subjected to. Types of sex trafficking may include forced prostitution, child sex trafficking/tourism, exotic dancing/stripping, escort services, and pornography.

### Labor Trafficking

The US Department of State states that the majority of human trafficking is in the form of forced labor. Like sex trafficking, the definitions of labor trafficking are not uniform across agencies, governments, or researchers. In the US, the TVPA of 2000 defines labor trafficking as, "…the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery."[4] Types of labor trafficking include forced labor, bonded labor, debt bondage, child labor, and child soldiers. Reports of labor trafficking may also include sex trafficking. According to the Minnesota Human Trafficking Task Force, labor trafficking often involves labor exploitation, with victims experiencing "…low wages, manipulation of… labor laws by employers to restrict employee benefits, requirement of long working hours, poor and dangerous working conditions without proper safety equipment or precautions, and withholding of wages for equipment or tools."[5]

### For More Information

1. US Department of Health & Human Services, Administration for Children & Families, Office of Refugee Resettlement. End trafficking. Available from: **http://www.acf.hhs.gov/programs/endtrafficking**

2. Alliance to End Slavery and Trafficking. Relevant authorization statutes. Summary of the Trafficking Victims Protection Act (TVPA) and Reauthorizations. Available from: **http://endslaveryandtrafficking.org/fy2014/Relevant-Authorization-Statutes.php**

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4. Ahn R., Alpert EJ, Purcell G, et al. Human trafficking: Review of educational resources for health professionals. Am J Prev Med 2013;44(3): 283-289. Available from: **http://www.ajpmonline.org/cms/attachment/2009165163/2031505292/mmc1.pdf**

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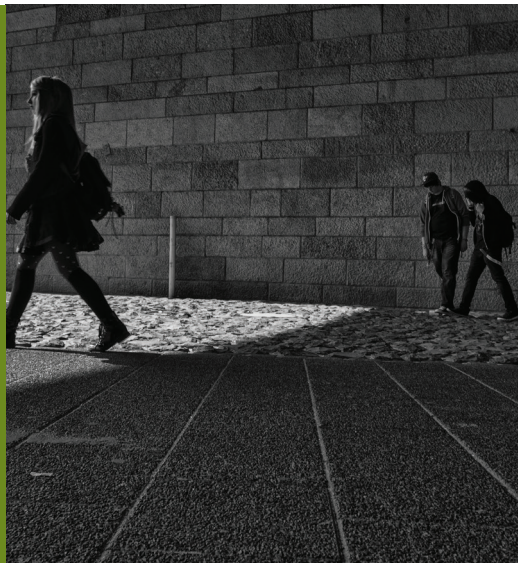

criminalizes the youth engaging in that behavior. Federal sex trafficking laws specifically create exemptions to such criminalization without proof of force, fraud, or coercion when the victim is under 18. Minnesota state law does not require these elements, acknowledging that prostitution among youth is victimization. However, given delinquency statutes, minor prostitutes could still be criminally charged. Currently, the response is focused on minors, but hopefully attention will eventually move to adults. Research, mostly through qualitative studies, tells us that many individuals begin selling themselves when they are minors and age into adulthood. I don't know if decriminalization for adults, such as the Nordic model (same thing as Safe Harbor but for adults engaged in prostitution), is in the cards for Minnesota but the trafficking, exploitation, and abuse of adults engaged in prostitution cannot be overlooked.

The age of consent in Minnesota can also be a source of inconsistency in response to minors engaged in prostitution. The age of consent in Minnesota is 16, so if a 15-year-old had sex with a 25-year-old, he or she could not legally consent to that act. But somehow, if the 15-year-old was selling himself/herself and money changed hands, the exploited youth could be charged with committing a crime, even though he or she could not legally consent to the act.

**HG: What can we expect in terms of activities or products from *No Wrong Door?***

**LR:** Lots! We have chosen eight navigator agencies that started in August 2014. Housing grantees are also preparing to open their shelter and housing programs in early Fall 2014. The Ramsey County Attorney's Office is training law enforcement and prosecutors and in 2015 will be assisting with eight regional conferences in collaboration with navigators. They are working diligently with the Minnesota Coalition Against Sexual Assault to develop statewide protocols for various professionals who interact/engage with youth. These protocols are extremely complex and require substantial time to create. We are also collecting data to describe how many youth are trafficked in Minnesota.

**HG: What do you hope is the ultimate outcome of *No Wrong Door*? Or of Safe Harbor legislation overall?**

**LR:** The goal of Safe Harbor is to treat youth "engaged in prostitution" as victims of a crime, not as offenders. The law strengthens the criminal liability for the buyers (johns) and traffickers, rightfully so. The goal of *No Wrong Door* is to make trauma-informed, age-appropriate services available for sexually exploited youth. Youth engaging in prostitution or survival sex will no longer be locked up or treated as delinquents. Instead they will be referred to services that will enable them them to leave or escape these situations. That is the ultimate outcome.

**HG: What do you think is an important challenge for public health professionals who are doing research, developing programs, and/or creating policy about human trafficking?**

**LR:** Surveillance of any issue can be very challenging, especially in a situation like ours, where there is basically NO surveillance on human trafficking. Public health surveillance was originally designed for tracking infectious disease such as measles. These days anyone with measles will probably end up at a hospital, will probably be diagnosed correctly, and the hospital will probably successfully enter the case into their reporting system as being a case of measles. The challenge with doing surveillance on human trafficking is that most victims will rarely end up in a hospital or with a service provider. If they do, they are highly unlikely to talk about being trafficked, in part because they won't see themselves as victims. In addition, many providers have no training on how to identify cases of trafficking and thus they will miss the signs. The trafficked population is difficult to access for surveillance because of mobility, fear of retaliation or violence, heavy control by perpetrators, isolation, shame, and self-blame. Also, the very nature of human trafficking takes victims away from supportive places where they may be accessed for surveillance (or services). And when trafficked victims are not documented to be in the US, there is no way they will disclose their situation to a data collector. As service providers across the state begin implementing *No Wrong Door* and Safe Harbor, their documentation/tracking will improve surveillance of trafficking greatly. However, we will always have issues of under-reporting in surveillance and under-service of victims unless we, as a society, re-frame trafficking in our collective consciousness so that victim-blaming/criminalizing stops and perpetrator accountability starts.

**HG: What are your hopes for public health work in human trafficking in Minnesota and/or in the nation?**

**LR:** My hope is that we increase awareness and ownership about trafficking and that we receive the same kind of response and attention that other public health issues receive. Minnesota has been very progressive and creative and is ahead of the game in many instances with Safe Harbor legislation, as exemplified by the placement of the navigators, the services we propose, and the establishment of the director position at MDH. As noted earlier, I'm an attorney. My knowledge regarding public health is limited but growing. I was a little confused about the placement of this position at MDH until I learned more about public health. Now I believe it is brilliant! Instead of following the circular motions of the criminal justice response of waiting for someone to commit a crime, arresting, prosecuting, and providing services to the victims, the public health focus will be on preventing the crime or victimization before it occurs. This is a much-welcomed alternative approach. We will collect data to determine the scope of trafficking in Minnesota. We will analyze the data to learn more about trafficking/exploitation, risk factors, commonalities, and other factors that will direct effective prevention measures. We will always bring attention to the issue, by not only focusing on the victims, but by focusing on the demand and what in society allows this behavior to thrive

and continue. Granted, *No Wrong Door* is an intervention model, but prevention is also a priority. I hope public health professionals will see it in the same light.

## For More Information

1. Minnesota Coalition Against Sexual Assault. Available from: **www.mncasa.org**
2. Minnesota Human Trafficking Task Force. Available from: **www.mnhttf.org**
3. Safe Harbor Minnesota. Available from: **www.health.state.mn.us/injury/topic/safeharbor/**
4. To contact Ms. Ryan, email: **Lauren.ryan@state.mn.us**

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## HOW PREVALENT IS HUMAN TRAFFICKING?

International and national data on human trafficking are estimates, often based on incomplete data from non-standardized sources (e.g., police records).[1] Some nations do not recognize the existence of human trafficking and thus have no official records. There are many barriers to prevalence estimates. Trafficking operations and situations are illicit and often covert. Trafficking victims and perpetrators may not be accessible to researchers or law enforcement, because of mobility and/or because they are not registered in formal systems (e.g., census counts). Further, there are no standards for surveillance, including what constitutes "trafficking."[2] Some countries may mix trafficking, smuggling, and irregular migration in their estimates.[2] Further, researchers often do not differentiate between labor and sex trafficking. When evaluating trafficking data, it is thus important to understand how trafficking is defined (e.g., labor trafficking may include sex trafficking) and what the quality of the data sources are in terms of surveillance coverage and age of data. The Government Accountability Office (GAO) identifies three main problems with trafficking data: availability, reliability, and comparability[2] (*see* Table 1).

While there are many—and varied—estimates of the number of trafficked victims worldwide, one often-cited source is the 2012 report of the International Labour Organization (ILO). For this estimate, the ILO considered forced labor to be situations in which "…persons are coerced to work through the use of violence or intimidation, or by more subtle means such as accumulated debt, retention of identity papers or threats of denunciation to immigration authorities. Forced labour, contemporary forms of slavery, debt bondage, and human trafficking are closely related terms though not identical in a legal sense. Most situations of slavery or human trafficking are however covered by ILO's definition of forced labour."[3] Using this definition, the ILO estimated that between 19.5 million and 22.3 million people were victims of forced labor and reported that:

- 11.4 million of the victims were girls or women;[3]
- Almost 19 million victims were exploited by private individuals or enterprises and over 2 million by the state or rebel groups;[3]
- About 4.5 million were victims of forced sexual exploitation;[3]
- Domestic work, agriculture, construction, manufacturing, and entertainment sectors are where most of the victimization is concentrated;[3] and
- Migrant workers and indigenous people are particularly vulnerable to forced labor.[3]

Also at risk are vulnerable and marginalized individuals like runaway and homeless youth, victims of trauma and abuse, sexual minorities, refugees and individuals fleeing conflict or oppression, and impoverished individuals.[2,3]

The ILO concedes that the definition of forced labor is inconsistent worldwide—and that even the ILO has changed its definitions over the years. It recommends that individuals do not over-count forced labor and instead, consider the context of labor. "Not all children who are exposed to hazardous work are 'slaves,' and not all workers who don't receive a fair wage are forced," according to ILO.[4] ILO has convened an expert statistical group to develop a uniform definition of forced labor by 2018.

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2. US General Accounting Office. Human trafficking. Better data, strategy, and reporting needed to enhance US anti-trafficking efforts abroad. Available from: **http://www.gao.gov/new.items/d06825.pdf**
3. International Labour Organization. Forced labour, human trafficking, and slavery. Available from: **http://www.ilo.org/global/topics/forced-labour/lang--en/index.htm**
4. International Labour Organization. Why definitions matter. Available from: **http://www.ilo.org/global/about-the-ilo/newsroom/comment-analysis/WCMS_234854/lang--en/index.htm**

**TABLE 1. GOVERNMENT ACCOUNTABILITY OFFICE: LIMITATIONS TO THE QUALITY OF TRAFFICKING DATA**

| AVAILABILITY | RELIABILITY | COMPARABILITY |
|---|---|---|
| **1.** Trafficking is an illegal activity and victims are afraid to seek help from authorities. | **1.** Capacity for data collection and analysis in countries of origin is often inadequate. | **1.** Countries and organizations define trafficking differently. |
| **2.** Few countries collect data on actual victims on a systematic basis. | **2.** Trafficking convictions in countries of destination are based on victim testimony. | **2.** Official statistics do not make clear distinctions among trafficking, smuggling, and illegal migration. |
| **3.** Data collection is focused on women and children trafficked for sexual exploitation, and other forms of trafficking are likely to be underreported. | **3.** Estimates of trafficking are extrapolated from samples of reported victims, which may not be random and thus may not be representative of all trafficking victims. | **3.** Data are often program-specific and focus on characteristics of victims pertinent to specific agencies. |

***Source:*** Adapted from Table 3: US General Accounting Office, **http://www.gao.gov/new.items/d06825.pdf**[2]

# Promoting the HPV Vaccine:

## Activities at the Minnesota Department of Health

*by Wendy L. Hellerstedt, MPH, PhD*

*In July 2013, the Director of the Centers for Disease Control and Prevention (CDC), Dr. Thomas Frieden, made an impassioned call to action to the nation's health care providers and public health officials. The annual National Immunization Survey had revealed that, while large majorities of adolescents were receiving Tdap (tetanus, diphtheria, and pertussis) and meningococcal vaccines as recommended, uptake of the human papillomavirus (HPV) vaccine was weak—barely over half of teen girls had received even one dose, and only one-third had received all three. The situation with boys was even worse: only a negligible percentage had been vaccinated.*

*"...we believe part of the problem with HPV is that it's perceived as somehow different from other vaccines."*

CDC's concerns echoed throughout the health care world. The President's Cancer Panel called lagging vaccination rates "A serious but correctable threat to progress against cancer." The president of the American Academy of Pediatrics (AAP), Dr. James M. Perrin, stressed that, "A health care provider recommendation is the most influential factor in parents' decision to vaccinate" and designated grant funds for state AAP chapters to implement local HPV vaccine projects. Dr. Reid B. Blackwelder, president of the American Academy of Family Physicians, pointed out that US HPV vaccination rates are lower than those in many less-resourced countries, saying, "We have to do better."

CDC didn't just tell its constituencies to start doing better. It backed up its call to action with money—$7 million out of the Prevention and Public Health Fund, created by the Affordable Care Act. Following a competitive bid by the Minnesota Department of Health (MDH) immunization program, Minnesota was one of eleven sites chosen to take a share of that funding and start pursuing improvement in HPV vaccination uptake.

### Prevention and Public Health Fund Projects

The first thing MDH did was plan a public awareness campaign. "Early on, we made the strategic decision to promote the full adolescent platform—meningococcal and Tdap vaccines as well as HPV—because we believe part of the problem with HPV is that it's perceived as somehow different from other vaccines," explained Stefani Kloiber, head of communications for the MDH infectious disease division. "It's at least as important as the others, but we knew we had to work against the perception that it's a new, special vaccine." (In fact, the national recommendations to give HPV, Tdap, and meningococcal vaccines routinely to adolescents all came within a couple of years of each other.)

Kris Ehresmann, director of MDH's Division of Infectious Disease Epidemiology, Prevention, and Control, added that another reason to address all three adolescent vaccines was to help families gear up for changes coming in the Fall of 2014. "This fall, among other updates to the school immunization rules, kids in seventh grade and older who aren't exempt from the requirements will need to be current on their Tdap and meningococcal vaccines," she said.

"So it made sense to remind parents about those at the same time that we're raising their knowledge about HPV."

MDH contracted with the Minnesota State High School League to advertise at the state tournaments for girls' and boys' basketball, hockey, wrestling, and football. Messages also went out through an advertiser that places electronic displays at high-attendance games throughout the metro area. While these choices might seem more suited to reaching teenagers than pre-teens, meshing sports with messages about vaccination was all part of the plan, according to immunization program manager Margo Roddy. "We've made it a priority in our program to emphasize that following the recommended vaccination schedule is a social norm. There's a lot in the news about families choosing not to follow the schedule, but in reality, the great majority of families do follow it. We want to position immunization among other activities that are healthy and community-oriented, and high school sports is a good example of that," she said. In addition, MDH was aware that many pre-teens and their parents attend high school games.

To achieve message penetration in Greater Minnesota, MDH placed demographically targeted ads on the websites of the StarTribune, the Weather Channel, and local newspapers around the state, as well as on Facebook. And to reach cultural enclaves, MDH placed print and web ads in publications catering to immigrant and non-English-speaking communities, as well as public service announcements in multiple languages on KFAI radio.

To help manage all of this media outreach, MDH hired communications specialist Lara Hilliard for its HPV project team. "We had a lot of considerations to balance in our communications: keeping our language easily readable yet technically accurate, staying within the law that governs how we write about school requirements, and finally making sure we were consistent from one message to the next," Hilliard recounted. "It takes a lot of specialized knowledge to construct what looks like a simple message about vaccines." MDH created a toolkit, which included sample messaging and images developed to promote the campaign, and encouraged organizations, clinics, and local public health departments to use the materials in their own promotions of adolescent vaccination.

Another method of informing the public was more direct: a postcard mailing to almost 120,000 Minnesota households with children aged 11–12-years-old, identified through the state immunization registry. In some areas of the state, there was also a series of additional reminders to teens up to 17 years of age who had not received all doses of the HPV vaccine. "This was by far our largest-ever mailing project," said Sydney Kuramoto, who led the effort. "We took the time to update our address database using a commercial service and are glad we did, because we had a return rate of less than ten percent." MDH is also about to begin placing auto-dialed phone calls to send a verbal reminder to the families of pre-teens in areas that did not receive additional reminder mailings.

Just as important as public education, MDH knew, was to make sure that health care providers were informed about the HPV vaccine. MDH felt that pre-professional programs cover vaccines briefly, if at all. Further, the information providers do receive becomes quickly outdated. MDH decided to recruit a physician-educator, Vince LaPorte, to travel around the state giving Grand Rounds-style lectures and clinic in-services for continuing education credit. He also developed an on-demand webcast based on his presentation, available at **www.wevaxteens.org**. Dr. LaPorte, a recently retired family physician from Marshall, MN, said, "I particularly valued

## THE CASE COMMUNICATION APPROACH: TALKING TO INDIVIDUALS WHO ARE HESITANT ABOUT VACCINATION

The Minnesota Department of Health (MDH) endorses CASE (**C**orroborate, **A**bout Me, **S**cience, and **E**xplain/Advise) as a way to communicate with individuals who have vaccine concerns. Lynn Bahta, Immunization Clinical Nurse Consultant at MDH, explained, "CASE provides a process for making sure that the patient or parent knows that the clinician understands his or her concerns before the clinician delves into the facts and science." The following provides an example of how a professional would use the CASE approach to address a parent's concerns about a child receiving the HPV vaccine:

**C**orroborate—"I understand your questions about vaccinating your child against something he or she will not encounter in the near future."

**A**bout Me—"I want to keep your child healthy today and also prepare her/him to be a healthy adult. As a provider who cares for children, I want to be sure that I'm recommending only what is necessary. I've reviewed the national recommendations and read the clinical trial studies."

**S**cience—"HPV is known to be associated with some cancers. Cervical cancers, for example, are almost 100% associated with HPV. Without the infection, there could be no cancer. Pre-teens' immune systems are very responsive to the vaccine and we expect that giving the vaccine to 11 and 12 year olds will protect them from HPV infection for many years, if not for life. So even though we're not expecting your child to be exposed to HPV for a long time, it's not too early to get that protection in place."

**E**xplain/Advise—"Since there's no advantage to waiting, I recommend that your child get vaccinated today. There are no known health risks associated with the vaccine and, if we do it now, well ahead of the time when your child may be exposed to HPV, we have the best chance of avoiding HPV infection altogether."

**For more information on the CASE approach go RM Jacobson's article, *Making the C.A.S.E. for the human papillomavirus vaccine: how to talk to parents and adolescents*, in Minnesota Medicine 2014;97(2):38-42. Available from: http://www.minnesotamedicine.com/Portals/mnmed/February%202014/Clinical_Jacobson_0214.pdf**

## WHAT IS HUMAN PAPILLOMAVIRUS?

**Strains.** There are more than 100 strains (types) of human papillomavirus (HPV). About 60 types cause warts on the hands or feet. The other 40 or so HPV strains are sexually transmitted and are drawn to the body's mucous membranes, such as the moist layers around the anal and genital areas. Not all of the 40 sexually transmitted strains cause health problems. High-risk sexually transmitted HPV strains include HPV 16 and 18, which cause about 70% of cervical cancers. Strains 6 and 11 are associated with about 90% of all genital warts.

**Sexual Transmission.** Genital HPV is the most common sexually transmitted infection in the US. The Centers for Disease Control and Prevention (CDC) estimates that 79 million Americans are infected with HPV and that there are 14 million new cases every year. Genital HPV can be spread by skin-on-skin contact, including vaginal, anal, or oral sex. In most cases, the body clears an HPV infection on its own and no treatment is necessary. When this does not happen, the infection can progress to cancer.

**Sexually Transmitted HPV-related Health Problems.** Health problems associated with sexually transmitted HPV include genital warts, which affect about 360,000 people every year. HPV is thought to be associated with 100% of cervical cancer cases, of which there are 12,000–14,000 in the US every year. HPV is also associated with anal, vaginal, vulvar, oral, and penile cancers.

**HPV Vaccination.** The HPV vaccine is an anti-cancer vaccine that has been proven safe in multiple clinical trials and post-marketing surveillance. There are two FDA-licensed vaccines in the US: **Cervarix** and **Gardasil.** Both are almost 100% effective against the two HPV types that cause 70% of cervical cancer and varying (but large) proportions of cancers at other HPV-infected sites. Gardasil is also highly efficacious against the two HPV types that cause most cases of genital warts. The vaccine is given in three doses over a six-month period.

Vaccination is recommended for females, ages 9–26, and males, ages 9–21. For men who have sex with men or are immunocompromised, the vaccine is also recommended for 22–26-year-olds if they have not been previously vaccinated. The Advisory Committee on Immunization Practices (ACIP) recommends that the three-dose vaccination be given at ages 11–12 years and for older youth (up to age 26 years) if they had not been vaccinated when they were younger (**http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html**). There are two reasons the ACIP recommends vaccination at 11–12 years of age—one practical and the other biological: (1) for most youth, that represents a time prior to sexual intercourse (and thus HPV infection risk); and (2) the vaccine produces higher antibodies at 11–12 years than it does at older ages. Although there are no known pregnancy-related risks to vaccination, because of uncertainty, HPV vaccination is not recommended for pregnant women. The vaccines are not licensed for individuals who are older than 26-years-old because they have not been studied and vaccine safety and effectiveness has thus not been established.

As a result of the Affordable Care Act, most private health insurance plans must cover the HPV vaccine at no out-of-pocket cost, meaning no co-pay or deductible. Despite the effectiveness, and accessibility, of the HPV vaccine, CDC data show that only about 33% of 13–17-year-old females in the US had received the three doses of the vaccine in 2012.

**For More Information**

1. **http://www.cdc.gov/Std/HPV/default.htm**
2. **http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6229a4.htm**

the opportunity to tell younger colleagues what it was like to treat pertussis, tetanus, meningococcal disease, and HPV-related cancers. I've seen diseases that I hope they never see. If we can get our HPV vaccination rates up, those cancers will become rare."

Dr. LaPorte's talks often included clips from a video on HPV vaccine communication that MDH created for health care providers. "We knew—many of us from personal experience with our own children—that providers tend to talk about HPV a little bit differently than they talk about other vaccines," explained Lisa Randall, who coordinated video production. "The video points this out in a lighthearted way and then goes on to show four scenarios in which a provider recommends the adolescent vaccines, the patient or parent asks a few common questions about HPV vaccine, and the provider uses the CASE method to answer those questions" (*see* page 7).

## Progress through Partnerships

MDH had the advantage of already strong relationships with key cancer prevention and treatment players, including the Minnesota Cancer Alliance (MCA), which in 2012 designated HPV vaccination as one of its top anti-cancer priorities. Leaders of the two organizations co-authored a joint letter to medical clinics in January 2013, encouraging them to work on their HPV vaccination rates and suggesting tactics. MCA also matched the funds MDH had available to defray the costs of clinics that participated in a 2013–2014 project to send immunization reminders to patients who were behind on HPV or other adolescent vaccines.

MCA is currently designing a communications campaign directed at health care providers; patient education materials that are culturally appropriate for Native American tribes in Minnesota and Wisconsin; and a statewide quality measure on HPV vaccination. Heather Hirsch, director of the MDH Comprehensive Cancer Control Program and a liaison to MCA, is pleased with the collaboration. "It's worked out well for the Alliance to coordinate closely with the immunization program," Hirsch said. "Each side brings assets and we don't duplicate our efforts."

Another local force is the Minnesota chapter of the AAP, which won one of the national AAP's grants for HPV projects. The chapter

created medical resident education videos and accompanying slides that represent provider–patient conversations about the HPV vaccine. The educational focus was pediatric and family practice residents and faculty.

All of this activity takes place amid many other efforts to advance HPV vaccination. The Minnesota State High School League agreed to update the language of its standard pre-participation athletic physical clearance form to include HPV vaccine; 48 local public health departments took advantage of an opportunity to get free adolescent vaccines for students in their areas by giving them as part of school-located emergency preparedness drills; and several clinics are taking advantage of the statistical functions of their electronic health record systems to track their HPV vaccination rates.

MDH, in collaboration with many partners is promoting HPV vaccination to a wide audience through many venues and activities. Such a powerful approach is likely to result in success. But, as is always the case with successful vaccine promotion, those who will live their lives free of the health burdens caused by an infectious agent because they were vaccinated will never know it.

## For More Information

1. Minnesota Department of Health, vaccine promotion toolkit, **http://www.health.state.mn.us/divs/idepc/immunize/campaigns/vax4teenskit.pdf**
2. Minnesota Department of Health, information page for teens about vaccination, **http://www.health.state.mn.us/divs/idepc/immunize/adol/index.html**
3. Minnesota Department of Health, information for providers about the HPV vaccination and communications with parents/patients (including training videos), **http://www.health.state.mn.us/divs/idepc/immunize/hcp/adol/index.html**
4. To speak to someone at MDH about its activities to promote the HPV vaccine, please contact the MDH immunization program at 1-800-657-3970 or 651-201-5503. Also visit MDH's Immunization home page at **http://www.health.state.mn.us/divs/idepc/immunize/index.html**
5. Minnesota Cancer Alliance, **http://mncanceralliance.org/policy-advocacy/hpv-vaccine**
6. Centers for Disease Control and Prevention, human papillomavirus (HPV) vaccines, **http://www.cdc.gov/hpv/vaccine.html**

*Wendy L. Hellerstedt, MPH, PhD, is an Associate Professor and Director, Center for Leadership Education in Maternal and Child Public Health, in the Division of Epidemiology & Community Health, School of Public Health, University of Minnesota.*

## INTERDISCIPLINARY INSTITUTE ON THE REPRODUCTIVE HEALTH OF INCARCERATED WOMEN IN MINNESOTA

**October 20, 2014, 8:30 a.m. – 4:00 p.m.**

University of Minnesota, Saint Paul Campus, Continuing Education and Conference Center
1890 Buford Avenue, St. Paul, MN 55108

The Center for Leadership Education in Maternal and Child Public Health will host an institute that will:

- Delineate the major reproductive health issues of incarcerated women.
- Identify best practices and policies to optimize the reproductive health among incarcerated women.
- Identify best practices and polices for prenatal and postpartum care and education for incarcerated women.

The intended **audience** is professionals, students, educators, legislators, and researchers in corrections, maternal and child health, reproductive health, women's health, public health policy, nursing, and medicine. The institute's **format** will include a mix of presentations and small-group case study discussions.

Nationally known speakers will provide **presentations** about topics that will include:

- Incarceration as a public health issue
- Preconception health among incarcerated women
- Prenatal care for incarcerated women (including doula care)
- Best practices for postpartum care for incarcerated women
- Prison nursery programs

**Presenters include:**

- **Mary Byrne,** Professor, Columbia University
- **Danielle Dallaire,** Associate Professor, William & Mary
- **Edward Ehlinger,** Commissioner of Health, State of Minnesota
- **Wendy Hellerstedt**, Associate Professor, University of Minnesota
- **Rebecca Shlafer**, Assistant Professor, University of Minnesota

Participants will examine **case studies**, in a small-group setting, to facilitate discussion about current issues and controversies related to the reproductive health of incarcerated women, including:

- Whether pregnancy should be considered in sentencing decisions
- The practice of shackling during pregnancy and birth
- Breastfeeding policies for incarcerated women
- The cost and benefits of prison nurseries

The registration fee is $20.00 (+$2.09 handling). Breakfast and lunch will be provided. There is public and campus transit to the conference site. For those who drive, free parking will be available in the lot at the conference center.

Individuals who are unable to pay this fee and would like a free/reduced registration, and those who have questions, may contact Sharanya Johnson at sharanya@umn.edu.

**Sponsors**: Center for Leadership Education in Maternal and Child Public Health and the Irving Harris Programs at the University of Minnesota

**Register at: http://z.umn.edu/mchincarceratedwomen**

## The Minnesota Fetal–Infant Mortality Review/HIV Project:

# Reducing the Risk of Perinatal HIV Transmission

*by Wendy L. Hellerstedt, MPH, PhD*

*From 2000–2012, there were eight children who acquired HIV perinatally in Minnesota. Given the results of a pilot study that demonstrated the effectiveness of fetal-infant mortality review (FIMR) in perinatal HIV transmission, the Centers for Disease Control and Prevention (CDC) recommended that some states—including Minnesota—work on HIV-focused FIMR implementation. Two major questions come to mind when one thinks about a FIMR-focused perinatal HIV infection prevention effort in Minnesota:*

- *Why conduct this effort in a state with a low incidence of perinatally acquired HIV, like Minnesota?*
- *Why apply a FIMR framework?*

*"While we don't expect many cases, it is important to identify those rare 'near misses.'"*

Kathy Chinn, BA, and Catherine Patterson, MA, MPH, two public health and health care professionals, can easily answer these and other questions. They are leading the CDC-funded FIMR/HIV project in Minnesota. Chinn has been with the Minnesota Department of Health (MDH) for almost 25 years, most recently as a sexual health program specialist. She is also a certified birth doula. Chinn is the FIMR/HIV project co-leader for MDH. Patterson is the HIV program coordinator at the Minnesota Perinatal & Pediatric HIV program at Children's Hospitals and Clinics of Minnesota. Her role on the project is community co-leader. She recently earned her MPH from the MCH program at the University of Minnesota. Other partners in this effort include Hennepin County Medical Center and the Minneapolis Medical Research Foundation, which is Minnesota's Ryan White Part D grantee. (The federal Ryan White HIV/AIDS Program provides HIV-related services. "Part D" grantees provide family-centered outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS, **http://hab.hrsa.gov/abouthab/aboutprogram.html**).

## Identifying HIV Perinatal Transmission in a Low-incidence State

"Minnesota has a medium to low incidence of HIV," Patterson said. "Compared to other states we have fewer access-to-care issues and we generally expect zero cases of perinatal HIV in any given year. Nonetheless, the social, emotional, and financial costs of an HIV-infected infant are astronomical. We need to prevent even a single case," she emphasized. While Minnesota may have a low incidence of HIV, given the size of its young immigrant population, the state may have a disproportionate number of HIV-positive women who want to become—and do become—pregnant. "Anecdotally, we have heard from neighboring states and the federal Health Resources and Services Administration (HRSA) that Minnesota may have a higher than average percentage of HIV-positive women who become pregnant each year," Patterson said. "For example, the HIV infection rate in our state's African-born population is very high and many African-born women may have high cultural expectations to become pregnant

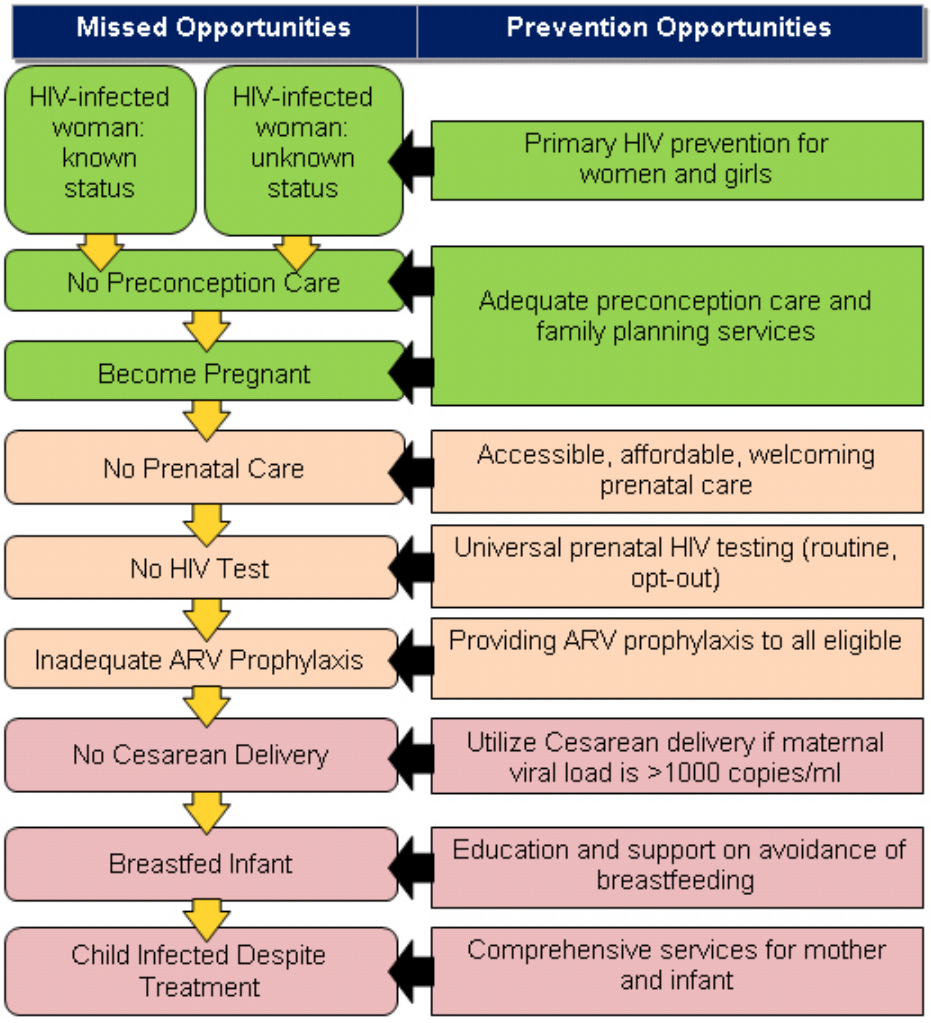



**Figure 1.** Missed Opportunities and Prevention Opportunities for HIV Perinatal Transmission. Source: Centers for Disease Control and Prevention, **http://www.cdc.gov/hiv/images/web/risk_emtc_perinatal_cascade_large_520x585.jpg**

and raise families. "'Pregnancy intention' is an important concept here," Patterson emphasized. In many states, HIV-positive pregnant women may face myriad challenges (e.g., substance abuse, intimate partner violence, socioeconomic issues, mental health disorders). While many women living in Minnesota face similar barriers, "pregnancy expectations among our foreign-born populations present a unique HIV prevention opportunity," Patterson said.

The standard of care for identifying—and treating—HIV-positive women in Minnesota is high. "While we don't expect many cases, it is important to identify those rare 'near misses,'" Chinn said. Identifying "near misses" means identifying HIV-positive women who may have been better served by social or health care systems. In Minnesota, women should receive HIV testing at their first visit in the first trimester (not all women enter care in their first trimester, but more than three-quarters of Minnesota pregnant women do). Further, a test should be given to women who are admitted to the birth center/hospital for delivery who have no HIV test result recorded. Despite relatively good HIV-testing adherence and compliance, "women fall through the cracks," Chinn said.

## Near Misses: Missed Prevention Opportunities

Falling through the cracks—"near misses"—are missed prevention opportunities related to lack of prenatal care (or lack of good prenatal care), late maternal diagnosis (after the infant is born), and lack of treatment with antiretroviral medication. Women may also be offered tests but refuse to be tested for many reasons: they don't believe it is relevant, they are afraid of a positive result, or they do not appreciate its significance.

As identified by the CDC, there are many missed opportunities in the prevention of perinatal HIV transmission (*see* Figure 1).

## Applying a FIMR Framework to Examining Perinatal HIV Transmission

As described by the CDC, the elimination of perinatal HIV transmission requires a multi-faceted approach across national, state, and local health care and public health systems. FIMR is one aspect of this approach (*see* Figure 2).

"HIV infection in infants is considered a 'sentinel event,'" Patterson said. "That is why the FIMR framework is considered a good fit for adaptation to the HIV-infected or exposed population." The FIMR approach has been used for decades to identify potentially preventable fetal and infant deaths. In the traditional FIMR approach, a fetal or infant death is the event that begins the review process. The key to FIMR review is that it is action-oriented, with the aim to identify and continuously monitor community and systems resources that could reduce infant morbidity and mortality. It creates the framework for a continuous quality improvement process: it leads to understanding potential factors that increase fetal and infant risk and it solicits community and other stakeholder involvement to improve systems and supports. If successful, the FIMR approach identifies intervenable gaps in screening and/or care and the mechanisms to eliminate those gaps. The FIMR approach is community-specific, therefore the degree of screening or health-care gaps, as well as the means and methods to resolve them, will vary by community.

The structure of Minnesota's FIMR/HIV project is similar to that described in more detail by the FIMR/HIV Prevention Methodology National Resource Center (**http://www.fimrhiv.org/methodology.php**). It involves five major steps:

1. **Case Identification.** A case is an HIV-exposed infant or fetus, older than 24 weeks' gestation and younger than 24-months-old. Cases are selected based on key indicators of risk (e.g., late maternal HIV diagnosis, lack of/inadequate

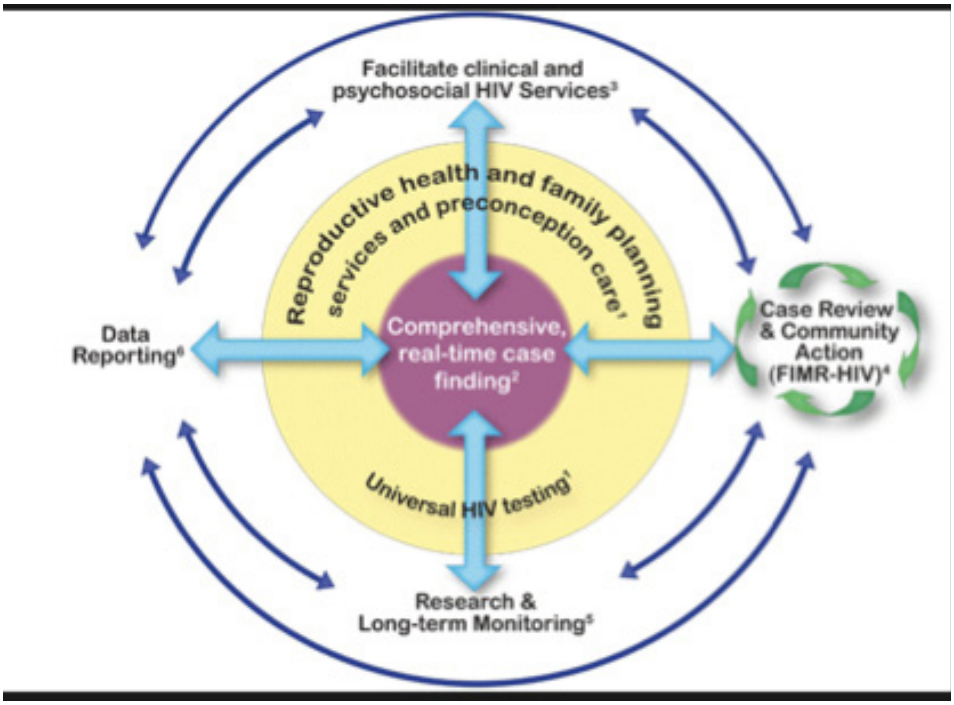



**Figure 2.** CDC Framework to Eliminate Perinatal HIV Transmission. Source: Centers for Disease Control and Prevention, **http://www.cdc.gov/hiv/risk/gender/pregnantwomen/emct.html**

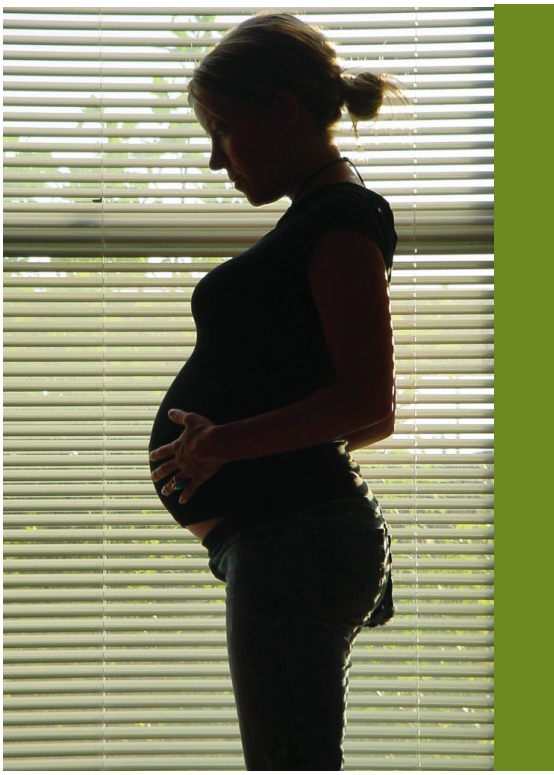
prenatal care). Cases are always de-identified to ensure confidentiality.

2. **Data Abstraction**. Sources include all medical, hospital, case management, and public health records related to maternal prenatal care, labor and delivery, newborn and infant care.
3. **Maternal Interview.** Women are contacted after their HIV diagnosis is confirmed. After receipt of signed, informed consent, women are asked a variety of questions about their HIV risk, prenatal care, and postpartum experiences.
4. **Case Review Team (CRT)**. The CRT includes community stakeholders and a variety of professionals from public and private agencies who provide care to women, infants, and children. The CRT identifies strengths in the care provided to the mother, opportunities for improvements of care, and general systems issues. After reviewing cases, the CRT makes recommendations to improve systems.
5. **Community Action Team (CAT):** CAT members are selected based on their ability to act as champions of the changes recommended by the CRT. They either have political influence in the community, financial resources to facilitate large-scale systems change, or a community perspective to help articulate feasible systems changes.

In summary, the FIMR approach is a comprehensive one, with precise investigative methods that will lead to detailed and, presumably, community-specific and community-centered change that will benefit the health of mothers and their offspring.

## The Public Health Vision of the FIMR/HIV Project in Minnesota

The Minnesota FIMR/HIV project is in its early stages and moving forward. Investigators are completing the first round of protocol development and will be soliciting the involvement of stakeholders and community members for the Community Review Team and the Community Action Team. Even as the program begins, Chinn is thinking ahead about what its ultimate contributions may be. Her perspective about how to gauge public health success reflects her decades of experiences as a public health professional. Chinn firmly believes in the importance of the FIMR/HIV project in Minnesota, but she knows how challenging it will be to articulate its progress. "The prevention of perinatal HIV transmission is already a tremendous public health success in the United States," she said. "With any big public health problem—including perinatal HIV transmission—you have tremendous political and financial leverage when you first start to address it. But once you have had great success, you are left with the difficult task of ultimate elimination of the problem. Addressing the remaining few cases always involves considering the most complex cases—individuals with unique situations that may not be easily, or even feasibly, modified by systems changes," she said. "We are fortunate to have had such success in reducing perinatal HIV transmission. Now we have to ask ourselves if expending the resources on FIMR/HIV for a few 'missed cases' will be worth the effort," Chinn explained, "but we have to remember that projects like this often have impact beyond their major goals. Our work has the potential of addressing larger systems problems and resulting in a better integration of HIV and MCH services in Minnesota," Chinn suggested. "We are not the only state that needs more mutual collaboration and understanding: HIV communities generally need a better understanding of obstetric and reproductive health care. And obstetricians and those who care for pregnant women need to



understand the importance of HIV testing," she stated. "There are not always financial resources attached to improving awareness. By doing this project, we are emphasizing the fact that we cannot isolate the work of MCH and infectious disease professionals in our state or in our practices."

*"We are not the only state that needs more mutual collaboration and understanding: HIV communities generally need a better understanding of obstetric and reproductive health care. And obstetricians and those who care for pregnant women need to understand the importance of HIV testing..."*

The ultimate results of Minnesota's FIMR/HIV project may thus be about more than identifying risks for each individual case and making recommendations. It may clarify the importance of communications and mutual awareness among multiple stakeholders.

"For example," Chinn said, "infectious disease professionals have to realize that they are not just treating an infectious disease when they work with women and men of reproductive age. They must ask about pregnancy planning and intentions."

## For More Information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4. FIMR/HIV Prevention Methodology National Resource Center. Available from: **www.fimr.hiv.org**

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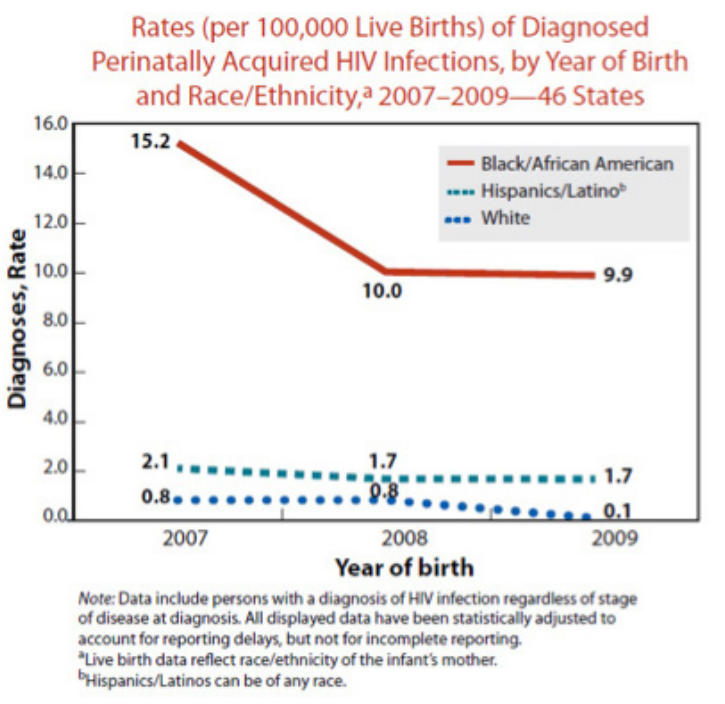
## PERINATAL HIV TRANSMISSION IN THE UNITED STATES




**Source:** Centers for Disease Control and Prevention, **http://www.cdc.gov/hiv/pdf/risk_WIC.pdf**

According to the Centers for Disease Control and Prevention (CDC), "Human Immunodeficiency Virus (HIV) transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given, the virus becomes undetectable, and breastfeeding is avoided."

Data about live births from 46 states in 2010 showed that 162 children were perinatally infected. CDC's goals for the elimination of mother-to-child transmission of HIV are (1) an incident rate of 1/100,000 births, or less than 40 cases in an annual cohort of four million births; and (2) a transmission rate of less than 1% of an estimated 8,700 HIV-exposed infants annually (i.e., mother was HIV positive). These goals would represent a reduction of over 100 cases per year nationally. Since the mid-1990s, HIV testing and preventive interventions have resulted in more than a 90% decline in perinatal HIV infections in the US. The rate of perinatal transmission declined between 2007 and 2009, although the rate is disproportionately high for Black Americans.

# Hmong American Partnership:

## Improving Hmong Women's Breast and Cervical Health

*by Shoua Vang*

*"We recognized that in the Hmong community, women were not getting screened early enough and if they did, it would be at a later cancer stage," said Keo Chang, the Health & Wellness Manager at Hmong American Partnership (HAP). Based in Saint Paul, Minnesota, HAP provides support to Hmong and other refugee communities through various services: economic and community development, children and family services, public policy and advocacy, education and training, and employment.*

In 2011, through funding from the Minnesota Department of Health's Eliminating Health Disparities Initiative grant, HAP launched its *Learn & Live* program to improve breast and cervical health for Hmong women in Minnesota. Data for the Hmong population is scarce, but a report from 2004 showed that compared to other Asian subgroups and non-Hispanic whites, cancer mortality among Hmong women is almost 3 to 4 times higher.[1] In addition, their breast and cervical cancer screening rates are extremely low.[2]

### Barriers to Health in the Hmong Community

A woman's decision about, and attitude toward, breast and cervical health may be influenced by several factors (e.g., cost, transportation, insurance). In the Hmong community, Chang said that family members greatly influence whether a woman seeks screening. A family can provide support and encouragement, but often families do not discuss breast and cervical cancer screening, and some family members actively discourage screening.[3] Many Hmong families living in the US emigrated from Southeast Asia after the Vietnam War. In their native country, preventive health was not a priority or non-existent—which explains why some Hmong are reluctant about taking preventive health measures. In addition, language, skepticism of modern medical practices, and distrust in doctors are major health barriers, Chang said.

**Attendees at a breast and cervical health education workshop hosted by HAP. Several workshops are held throughout the year.**

> *"We want to help the women overcome this feeling and develop a trusting relationship with their doctor."*

According to Chang, it is difficult to encourage older Hmong women to receive cervical and breast screenings because of their cultural beliefs, modesty, and shyness. "We want to help the women overcome this feeling and develop a trusting relationship with their doctor. They need to know that when they get an examination, it's going to be confidential and they should feel better afterward," said Chang. She believes that, to overcome these barriers, it's important for younger generations to encourage their mothers and grandmothers to get screened and be involved in the process.

### *Learn & Live:* Program Goals

The goals of the *Learn & Live* program are to:

- Increase awareness of breast and cervical health among Hmong women ages 16–65-years-old;
- Increase the prevalence of breast exams and Pap tests among Hmong women; and
- Increase the Hmong community's understanding and knowledge of breast and cervical health in order to better advocate for screenings.

"We want to reach out and educate the Hmong community so that they know about early screening, screening frequency, signs

*continued on page 16*

# BREAST AND CERVICAL CANCER

According to the American Cancer Society (ACS), "Cancer starts when cells in a part of the body start to grow out of control. Cancer cell growth is different from normal cell growth. Instead of dying, cancer cells continue to grow and form new, abnormal cells. Cancer cells can also invade (grow into) other tissues, something that normal cells cannot do. Growing out of control and invading other tissues are what makes a cell a cancer cell."[1] Cancer is identified by the part of the body where it starts, even if it spreads to other parts of the body.[1]

**Breast cancer.** "A breast is made up of three main parts: glands, ducts, and connective tissue. The glands produce milk. The ducts are passages that carry milk to the nipple. The connective tissue (which consists of fibrous and fatty tissue) connects and holds everything together."[2] Cancer that starts anywhere in the breast is called *breast cancer*.

**Cervical cancer.** "The cervix is the lower, narrow end of the uterus. The cervix connects the vagina (birth canal) to the upper part of the uterus…The part of the cervix closest to the body of the uterus is called the *endocervix*. The part next to the vagina is the *exocervix* (or *ectocervix*). The two main types of cells covering the cervix are *squamous* cells (on the exocervix) and *glandular* cells (on the endocervix). These two cell types meet at a place called the *transformation zone*. Most cervical cancers start in the transformation zone."[3]

### Risk Factors for Breast and Cervical Cancer

Breast cancer risk factors include: female sex, older age, genetics, family history, dense breast tissue, race and ethnicity, overweight or obesity, and lifestyle-related factors (e.g., having children, birth control-use, long-term use of hormone replacement therapy, alcohol consumption).[4]

Unlike breast cancer, there is one key risk factor for cervical cancer: infection with the human papillomavirus (HPV), a virus that can be passed from person to person during sex. HPV is very common and most people with the virus will experience no symptoms. However, if HPV remains in the body, it may eventually lead to cervical cancer. Other co-factors that may influence cervical cancer risk among people who are infected with HPV include: smoking, having a condition related to immunodeficiency (e.g., AIDS), family history, long-term use of oral contraceptives, and having had three or more full-term pregnancies.[5]

### Breast and Cervical Cancer in the US

Breast cancer prevalence has declined over time, but it is the second most common cancer among women in the US (skin cancer is the most common). It is also the second leading cause of cancer mortality in US women (lung cancer is the leading cause of cancer deaths). According to the American Cancer Society, about 1 in 8 women will develop invasive breast cancer during their lifetimes and about 1 in 36 women will die from breast cancer.[4] In the US, white women have the highest incidence of breast cancer.[2] The risk for breast cancer increases with age: for example, the risk of breast cancer for women who are 60-years-old and older is 3.5% in their next 10 years. The risk for a 30-year-old over the same time period is 0.4%.[6]

Cervical cancer used to be the leading cause of cancer death for women in the US, but the number of cases—and deaths—from cervical cancer have declined significantly in the last 50 years. This large decline is almost entirely related to a preventive activity: women getting regular Pap tests that can detect cervical pre-cancer before it becomes cancer.[3] The CDC estimates that about 11,967 new cases of HPV-associated cervical cancers are diagnosed each year. Unlike breast cancer, cervical cancer is most prevalent among Hispanic and Black women[7] and most cases are diagnosed in women who are younger than 50-years-old.[5]

### Screening and Prevention

The two primary screening methods that are used by clinicians to detect breast cancer are: (1) a mammogram (an x-ray of the breast); and (2) a clinical breast exam (an examination by a doctor or nurse, who use their hands to feel lumps or other changes). The ACS recommends annual mammograms for average-risk women starting at age 40 and a clinical breast exam for women in their 20s and 30s every two-to-three years and annually once women are in their 40s.[8] The US Preventive Services Task Force recommendations differ from those of the ACS, stating that mammogram screening of average-risk women should begin in their 50s (not their 40s) and that routine screening should end when women are 74 years old. Further, it recommends that average-risk women receive mammograms every two years, instead of annually.[9] Given the variation in recommendations, the decision about screening is left to the provider and the woman.

Cervical cancer can be prevented through screening and the HPV vaccine.[10] Screenings are performed via the Pap test (Pap smear), which is used to check the cervix for abnormalities (cell changes) that may become cancerous if not treated properly. Regular Pap tests (every three years) are recommended for women ages 21 and older. The HPV vaccine prevents the types of HPV infection that are most commonly associated with cervical cancer. The vaccine is recommended for all boys and girls at ages 11 or 12, up to age 26 for females and age 21 for males (for men who have sex with men and for men who are immunocompromised, the age limit is 26).[10]

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and symptoms of breast and cervical cancer, and ways to live healthier," Chang said.

## Community Approaches to Better Health

The *Learn & Live* program offers the following services to educate, support, and promote breast and cervical health in the Hmong community:

- **Multi-generational Cohort Training.** Training sessions are conducted two-to-four times a year to educate families about breast and cervical health and encourage participants to educate other family members. Family groups, consisting of three female members representing different generations and at least one male member, are invited to attend. "We invite at least one male family member because we recognize that the males also influence the women's health decisions," Chang explained. "Utilizing a multi-generational approach and involving male family members have been very effective."
- **Community Forums**. The forums engage community members, health professionals, and leaders in addressing health barriers and developing strategies to reduce breast and cervical cancer. "One of the great things about the forum is that we invite cancer survivors to attend and talk about their experiences—their hardships, treatment, and other positive messages," said Chang. Forums are held twice a year.
- **Educational Workshops.** Breast and cervical health education workshops are held several times throughout the year for women, their families, and students. Workshops take place at HAP's office location, conferences, participants' homes, and other community institutions.
- **Navigation Services.** Arrangement of examination appointments, transportation, and language interpretation can be provided through the program.

## *Learn & Live:* Aiming to Change Family and Community Health

In collaboration with SAGE, the American Cancer Society, and UCare, Chang believes the *Learn & Live* program has increased the breast and cervical screening rates for Hmong women in Minnesota, especially for women ages 40 and older. "Our main goal was to increase the screening rates and I believe it's increasing. Today, more Hmong women are aware and less afraid of the procedure," Chang said. HAP hopes to secure more funding to increase the *Learn & Live* program's capacity and, in the future, expand to include other health issues that are relevant to the Hmong community, such as men's health.

Chang acknowledges that there are challenges to working with populations with culturally specific needs; she is also certain that overcoming theses barriers is possible with the right knowledge and approach. Chang advises, "For limited English populations, it's important to have a language component so that individuals understand what some of the complex medical terminology is. Also, having a multi-generational approach is very effective because for communities similar to the Hmong, family members strongly influence an individual's decisions. By using this approach, we can promote changes in health practices at the family and community level."

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# Isuroon:

## Promoting Health and Empowerment for Somali Women

*by Shoua Vang*

*"Our mission is to help Somali women build self-sufficiency and maintain healthy lives," said Fartun Weli, MPH, MAPP. "And, in doing so, ensure that the identity and values of our community are kept." Weli is the founder and executive director of Isuroon, a non-profit organization committed to improving the health and upward mobility of Somali women in Minnesota. Isuroon promotes health and empowerment for Somali women through health education, communication, and advocacy to create policy change.*

Minnesota is home to one of the largest—and growing—Somali populations in the US. According to Weli, Somali women have culturally specific reproductive health beliefs about family planning, prenatal care, childbirth, breastfeeding, and female circumcision that may create barriers to their health and well-being. Isuroon was originally established in 2010 to support Somali women who were unable to conceive. "In the Somali community, infertility is considered a cultural taboo, and as a result, is a source of shame for these women. If a woman cannot have a child, she is considered a nobody," said Weli. The organization facilitated group discussions among the women in an environment where they could freely express their emotions, discuss the challenges of infertility, and discover opportunities to overcome these challenges. When Isuroon became an advocate for addressing infertility in the Somali community, the organization instantly gained acceptance and respect among Somali women of all ages.


**Attendees at an Isuroon event.**

*"Don't expect health inequality and disparities to change unless the community voices are at the center of the conversation."*

### Promoting Health through Community Engagement

Within its first year of establishment, the conversations at Isuroon led to discussions about other concerns including reproductive health, mental health, and systemic issues such as poverty, lack of education, ethnic stereotyping, and racism. In response, Isuroon's mission has grown to address a much wider range of topics that affect the health of Somali women and their families. "We want to make sure Somali women are moving toward self-sufficiency. We want women to escape the poverty trap and become upwardly mobile. We know Isuroon can help women reduce preventable illnesses like depression and cancer, which would otherwise not be addressed because of the cultural belief in a curative medical model where women only seek health care when they get sick," said Weli.

In Somali, "Isuroon" means *a strong woman who can take care of herself.* Traditionally, Somali men and women have different roles in the family and community: men are the

primary decision-makers and wage earners and women are responsible for child-rearing and homemaking. These cultural norms, beliefs, and gender disparities affect Somali women's health. Therefore, Isuroon aims to empower the Somali women in its community and increase women's participation in making the decisions that affect their health. Weli noted, "Traditional roles are changing in Minnesota. Somali women are becoming more empowered and taking on more equal roles in the family structure."

"To engage our community, we have to build trust by showing the [Somali] community that we care and that they are a part of the solution," said Weli. Isuroon provides health education through a range of strategies including in-person and phone conversations with individuals, group training workshops, and conference calls. Oral (versus written) communication is a cultural strength for Somalis because the written language was recently established in the 1970s. According to Weli, their oral communications' strengths mean that most community members want to learn in group settings. In addition to providing health education, Isuroon is strongly committed to addressing the root causes of poverty and minority health disparities through research and policy-based work.

## Participating in Research to Identify Needs and Improve Health Services

Since 2012, Isuroon has completed two Community-Based Participatory Research (CBPR) projects. The initial project studied cultural traditions and the reproductive health of Somali women. The second project studied teen pregnancy prevention and sexual health education. The research projects were qualitative, based on conducting focus groups with Somali women and men [from adolescence through adulthood] using a CBPR framework (CBPR research is similar to other research practices and specifically involves the inclusion of the affected community as full partners, from beginning to end, in research development, conduct, interpretation, and follow-through). "CBPR was key to our success in establishing research as a core competency because it connected us with experts to help us design culturally appropriate questions," Weli said.

Through the initial qualitative CBPR research study, Isuroon identified several cultural factors that influenced Somali women's reproductive health and suggestions for ways in which the US health care system can more effectively support the health care needs of Somali women. "We asked questions about differences in the women's childbirth experiences in Africa and the US; child spacing barriers; and mental health. We also identified cultural strengths," Weli explained. Although the women described "horror stories" about having children in refugee camps, birthing complications, and newborn deaths in Somalia, most women reported that they would still prefer to give birth "back home." Weli said that many research participants spoke about the importance of postpartum community support for the Somali "ummul" (new mother), which the women felt was lacking in the US.

Cesarean delivery was also a concern for most women. According to Weli, cesarean deliveries are not a part of their culture, and are only acceptable if the mother or infant's life is in danger. The women also believe that US physicians generally lack an understanding of female circumcision. "There is a lot of anxiety surrounding labor and delivery because of the practice of female circumcision in our community. Many women believe that physicians avoid vaginal deliveries [and recommend cesarean delivery] because it's easier and risk-free. They feel mistreated because of cultural differences, miscommunication, and even racism," said Weli.

The research about teen pregnancy prevention and sexual health identified major implications for improving the use of preventive services related to sexual health in this community. "It came down to the lack of community involvement in developing a culturally specific approach. Some people felt they were violating their religion and parents felt they had no say about their children [in terms of contraceptive use or sexual practices]," Weli explained. Using the research findings, Isuroon developed a culturally specific sexual health education workshop for Somali parents. "The elder men didn't want to talk about it, but the younger generations wanted Isuroon to take the lead in addressing the issues because of Isuroon's commitment to our cultural values." Through this workshop, Isuroon was able to include education about preventive services to further promote change in health practices in the Somali community.

"Promoting preventive services [such as using contraception or attending sex education classes] is difficult because the social norms [against such services] are stronger than what we're trying to promote," said Weli. "And so we tell the women, 'If you want to talk about moving out of poverty, you have to limit your babies.' We have to change our culture internally and change the norm as a community. If young women are having babies every year, it makes completing their education or entering the job market nearly impossible."

*"If you want to talk about moving out of poverty, you have to limit your babies. We have to change our culture internally and change the norm as a community."*

Isuroon promotes change by empowering the women and actively engaging the men, elders, and faith leaders from their community. It has established a strong rapport with many Twin Cities' Somalis, old and young, female and male. Gaining the trust of the entire Somali community is the cornerstone of Isuroon's credibility and success. Weli explained, "At the beginning, everyone thought Isuroon was only for women and that it would 'Americanize' the women, but the men realized that if their partners are healthy, happy, socially connected, and getting an education, there are positive outcomes from being involved with Isuroon. Now, more than half of our meetings are composed of men and we even have male elders on our board. We've changed some social norms."

## Driving Policy Change through Advocacy

The final pillar of Isuroon's mission is its advocacy work. Isuroon advocates for policies to change the "one size fits all" approach to maternal health. To date, the organization has introduced two bills into the Minnesota Legislature that are centered on addressing the health disparities of Somali women and providing funding for culturally specific women's health programs with improved outcomes. This

legislation has been extremely important in raising the awareness of minority health disparities, social inequality, and funding gaps among policymakers at the state level. Weli tirelessly promotes the needs of Somali women with State legislators and with other interested groups, and believes that advocacy work is critical to driving lasting change. The centerpiece of her efforts is ensuring that the Somali community has a strong voice in the legislative process and "a seat at the table."

## Conclusion

Although Isuroon was established only four years ago, the organization and its goals have grown tremendously. To further address the health needs of the Somali community, Isuroon hopes to develop a health literacy center to bridge the gap between the Somali community and US health care providers, and become a strategic resource for both. "Through the center, our services can have a greater reach and we can learn what the best practices are for promoting health literacy," Weli said. "And we hope to use this space to perform research and evaluation and possibly create standards for enabling culturally specific health services with improved outcomes."

"Our goal is to make sure we're moving *with* the community, not before them," said Weli. Isuroon has successfully managed to operate because it is driven by community initiatives. "The community supports us and they want to know what we're doing," said Weli. Its efforts have been successful because of its strong cultural identity, its focus on research and outcomes, and its Somali leadership.

"When we meet with a mom who needs a friend to have a conversation with, at the end of the conversation, she should be happy and have action steps she can take to improve her life," said Weli. "And, if we can do this, we've removed one obstacle from her journey to get to where she wants to be." Weli says people often inquire about Isuroon's community-based approaches to improving women's health. She says to them, "It's doable. Don't expect health inequality and disparities to change unless the community voices are at the center of the conversation."

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# Evidence-based Youth Development:

## Iowa and the PREP Program

*by Addie Rasmusson, BA*

*Through the federal Personal Responsibility Education Program (PREP) program, the Iowa Department of Public Health (IDPH) is addressing the needs of its highest risk youth. Using PREP funds—and a unique component of PREP that is intended to foster healthy youth development—IDPH hopes that its programs will succeed beyond teen pregnancy and STI prevention. Through implementing evidence-based teen pregnancy prevention curriculum in seven high-risk counties in Iowa, five contractors (local public health agencies and private non-profits) are addressing the myriad needs of young people in order to encourage a healthy start toward adulthood.*

*...addressing the myriad needs of young people in order to encourage a healthy start toward adulthood*

### What Is PREP?

**Funding:** On March 23, 2010, President Obama signed into the law the Patient Protection and Affordable Care Act (ACA). The Act amended Title V of the Social Security Act to include a new formula grant program called the Personal Responsibility Education Program. The Administration on Children, Youth, and Families jointly oversees the program with the Family and Youth Services Bureau. All states and US territories were eligible to receive funding for a five-year project period (FFY2010–FFY2014). Allotments were calculated based on the number of young people in each state or territory.

**Purpose:** PREP provides comprehensive sexuality education to adolescents (ages 10–19) that is medically accurate, culturally and age-appropriate, and evidence-based. PREP is implemented in Iowa with the goal of assisting youth to reduce their risk of pregnancy, HIV/AIDS, and other sexually transmitted infections. In addition to education on abstinence and contraceptive use, PREP requires a unique component that helps prepare young people for a successful adulthood called the Adulthood Preparation Subjects. PREP allows states and territories to receive funding to deliver various evidence-based programs according to what is appropriate for their respective communities.

### Implementation of PREP in Iowa

Iowa's PREP project is managed through IDPH, with five contractors delivering the program in seven high-risk counties in Iowa. IDPH believes in linking youth to quality health services by referrals to health and related services in their community and provides stakeholder education to enhance statewide and local community infrastructure.

IDPH underwent a rigorous prioritization process during the PREP planning phase, examining a number of indicators related to teen pregnancy to determine which counties should be targeted to receive programming. Instead of looking at just the teen birth rate, 14 risk factors related to sexual health (e.g., substance abuse, violence, poverty, academics, mental health, abuse/neglect, delinquency) were analyzed at the county level. After looking at these 14 factors, the counties with the highest scores were identified as the high-risk areas. Then, through a competitive selection process, agencies submitted proposals to deliver

## WHAT ARE PREP'S ADULTHOOD PREPARATION SUBJECTS?

What makes PREP unique is that it is not just a teen pregnancy prevention program. Adulthood Preparation Subjects are topics that are added to the PREP curriculum models to help prepare youth for a successful adulthood. States were asked to choose a minimum of three topics from the six listed in the grant opportunity guidance. Iowa PREP selected healthy life skills, adolescent development, and healthy relationships:

- **Healthy Life Skills**. PREP facilitators deliver one lesson on social media and internet safety. The material helps youth balance the challenges with the benefits of texting, chatting, and social networking. The materials also address cyber bullying and cyber safety.
- **Adolescent Development.** PREP facilitators engage youth in a lesson on depression and suicide. Through scenarios and reflective discussion, the lesson focuses on the action steps individuals should take if they experience symptoms of depression or suicide. It also focuses on how to recognize such signs in a friend and appropriate reactions (e.g., reaching out to a trusted adult).
- **Healthy Relationships.** PREP facilitators engage youth in an activity about dating violence and healthy relationships through an interactive lesson. Participants take on the role of characters who have to make choices about their relationships. They then move through a scenario by reading about interactions with their dating partner, family, friends, and others.

**For More Information**
**www.acf.hhs.gov/programs/fysb/resource/adult-prep-tip-sheet**

PREP in these high-risk counties. Iowa's PREP model focuses on a number of core components for successful implementation.

Beginning in Spring 2012, each PREP contractor identified facilitators who would be delivering the teen pregnancy prevention curricula. These facilitators went through training for their respective curriculum model prior to initiation of the first PREP groups. There is a strong emphasis on maintaining fidelity to the selected evidence-based programs. The three different PREP curricula chosen for Iowa include the Teen Outreach Program® (TOP®), Wise Guys®, and Sisters Informing, Healing, Living, and Empowering (SiHLE).

### Teen Outreach Program (TOP®)

The Wyman Center's Teen Outreach Program® is a comprehensive, evidence-based youth development curriculum that promotes the positive development of adolescents, ages 12–18 years, through a combination of group discussion and community service learning. Core activities across the curriculum include values clarification, healthy relationships, communication, goal-setting, decision-making, development, and sexual health. The most unique aspect of TOP® is the community service learning component, where youth engage in 20 hours of service over the nine-month implementation period. The service projects have included making dog toys for animal shelters, helping to organize a community-wide AIDS walk, and working on a bullying awareness project.

IDPH has two contractors delivering TOP® to roughly 100 youth annually in three Iowa counties: Cerro Gordo County Health Department and Planned Parenthood of the Heartland (in Woodbury and Des Moines counties).

### Wise Guys®

The Wise Guys® model is a 12-week curriculum designed to prevent adolescent pregnancy by helping 11–17-year-old males make better, wiser decisions about sexuality. The evidence-based program is committed to empowering young men with the knowledge they need to make effective decisions, encouraging them to respect themselves and others, helping them to understand the importance of male responsibility, and improving their communication with parents, educators, peers, and others. In an area where adolescent males are the forgotten gender, this curriculum allows them to be at the table discussing sexual health issues.

IDPH has three contractors delivering Wise Guys® to approximately 350 youth annually in three Iowa counties: Bethany for Children & Families (Scott County), Planned Parenthood of the Heartland (Pottawattamie County), and Women's Health Services of Eastern Iowa, Inc (Clinton County).

### Sistering, Informing, Healing, Living, and Empowering (SiHLE)

SiHLE is a small group, peer-led, evidence-based training intervention intended to reduce risky sexual behavior, sexually transmitted infections, and pregnancy among African American adolescent females, ages 14–18 years. Through interactive discussions, SiHLE emphasizes ethnic and gender pride, enhances awareness of HIV risk reduction strategies, and highlights the importance of healthy relationships. Through the use of role-playing and cognitive rehearsal during four 3-hour sessions, the intervention enhances confidence in initiating safer sex conversations, negotiation skills, and refusing unsafe encounters.

IDPH has one contractor, Allen Women's Health, that delivers SiHLE to roughly 25 youth annually in Black Hawk County through PREP.

## Progress and Sustainability

As a result of the PREP program in Iowa, approximately 1,200 youth have participated in evidence-based sexuality education since its implementation. Through programming and infrastructure building, Iowa PREP has worked to ensure sustainability for future programming. PREP staff and colleagues have also conducted formative evaluation to better understand how youth communicate and thus how they may better deliver (and evaluate) educational materials (*see article on page 23*). More important, it is hoped that the work of the five contractors will have long-term effects on the youth they have served, by enabling them to step more confidently into healthy adult lives.

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## National Listserv for MCH Students & Grads

A listserv for current and past Maternal and Child Health (MCH) students (from all disciplines) was made available by the Maternal and Child Health Bureau through the Association of University Centers on Disabilities. This listserv will allow MCH graduates and students to continue the strong connections they have made during their graduate programs and connect with MCH-ers from other disciplines and programs. This listserv is a great opportunity for members to collaborate on research, to network, and to share practices and questions with peers. The listserv subscription form and more information is at: **http://www.aucd.org/resources/alltrainee_subscription.cfm**

## BETHANY FOR CHILDREN & FAMILIES: DELIVERING WISE GUYS® IN SCOTT COUNTY, IOWA

Bethany for Children & Families (**www.bethany-qc.org/education.html**) is a non-sectarian agency that has provided voluntary, not-for-profit services to children and families in western Illinois and eastern Iowa since 1899. It has delivered school-based programs for males in Rock Island County (Illinois) and Scott County (Iowa) for the past 18 years. It recently delivered Wise Guys®, through IDPH's PREP grant, to seventh graders at seven intermediate schools in Scott County, Iowa (six of which are in the Davenport school district). According to Bethany's Mary Ann McLeod, division director, Community Services, "For too many years pregnancy prevention efforts were directed specifically at girls and their needs, without regard for boys and what they were experiencing. It is important for health educators to engage girls and boys in discussions about relationships, goals/dreams, sexuality, STIs, and responsibility. Too frequently, it is assumed that 'boys will be boys.'"

Bethany is well situated to provide programming like Wise Guys®, McLeod said.

"Fortunately, the community recognizes Bethany for Children & Families as a leader in teen pregnancy prevention, with a strong emphasis on male programming," she said. "Schools, juvenile justice prevention programs, and youth organizations welcome the opportunity to offer male programming that utilizes Bethany's experienced staff and past successes in teaching young boys to become responsible men." Bethany's experience with programming for young males and its commitment to them have translated into the successful implementation of Wise Guys®. "The young men have responded very positively [to Wise Guys®]," McLeod said, "and appreciate that they have someone to talk to and acquire accurate information from, as it relates to relationships, being a man, sexuality, and related issues."

To supplement the work Bethany is doing with young males in their area, in Spring 2014 it collaborated with Western Illinois University and held a conference, entitled *What About the Boys?*. One hundred boys in grades 10–12, representing eleven area high schools, attended sessions on education, the criminal justice system, what it means to be a man, giving back to the community, and sex and its consequences.

# Say What?!

## Sexual Health: Adolescent Social Network Characteristics and Communication Patterns

*by Natoshia M. Askelson, MPH, PhD; Jennifer Turchi, MA; Daniel Elchert, BA; Elizabeth Golembiewski, BS; Erika Leicht, BA; and Addie Rasmusson, BA*

*The profound influence of a person's social network on health has been well documented across the lifespan. Studies with adolescent populations demonstrate the influence of relationships with both peers and family members on behavior. Family and peers can influence adolescents' behavior through communication of attitudes or through modeling behavior. Parental attitudes about sexual activity,[1-4] for instance, are related to adolescent sexual behavior. Peer-to-peer attitudes have a similar relationship with adolescent behavior. Peer pressure, a way in which peers share their attitudes about certain behaviors, significantly influences behavioral outcomes across a variety of contexts, including alcohol and tobacco consumption, theft, and sexual attitudes.[1]*

*In popular discourse, adolescent communication is regarded as problematic at best and impossible at worst.*

In popular discourse, adolescent communication is regarded as problematic at best and impossible at worst. Parent–adolescent and peer communication, both generally and with regard to a range of health topics, has been studied.[5,6] Most studies that have examined communication focus on whom adolescents are talking to—parents versus peers—and a narrow set of topics.[7] Research has established a clear association relating important people in adolescents' lives to attributes of the communication between them, but studies on network characteristics and their influence on communication patterns with family and peers are scarce.

This article will describe a study we undertook in Iowa that has a unique perspective on adolescent communications. We assessed the relationship between network characteristics (i.e., density, total network size, and network composition) and communication patterns by examining a diverse range of topics including friendships and romantic relationships, as well as abstinence, birth control, and sexual activity. Our work is a part of a larger effort to evaluate the PREP program in Iowa *(see article on page 20)*.

### Study Participants and Data Collection

Data were from a pre-test survey of 87 adolescents in Iowa before they took part in a PREP program. The mean age of all participants was 14.75 (S.D. = 2.26) years

| Topic | Sex | Network Size | Network Density | Family | Friends | Age | Dating |
|---|---|---|---|---|---|---|---|
| **Friendship** | Girls talk to more people | Those with bigger networks talk to more people | | | | | |
| **Romantic Relationships** | | Those with bigger networks talk to more people | Those with more dense network talk to more people | Those with greater proportion of family members in network talk to fewer people | | | |
| **Sexual Activity** | Girls talk to more people | | | | | Older youth talk to more people | Youth who date talk to more people |
| **Abstinence** | Girls talk to more people | Those with bigger networks talk to more people | | | Those with greater proportion of friends in network talk to more people | | |
| **Birth Control** | Girls talk to more people | Those with bigger networks talk to more people | | | | Older youth talk to more people | |

**Table 1.** Influences on Adolescent Communication about Important Topics, PREP Social Network Study

**Note: Boxes with no text = The variable has no influence on whether teens discuss topic (e.g., sex has no influence on whether teens discuss romantic relationships; network density has no influence on whether teens discuss friendship).**

and the mean grade was 9.26 (S.D. = 1.95). Seventy-one percent were white, 75% were male, 40% lived with two parents, and 26% reported that they were currently dating.

*Network size, proportion of friends and family in a network, dating status, and the sex and age of participants were often associated with who participants talked to about specific topics.*

We asked participants to draw their social networks by writing their name at the center of a poster board and then adding labels of important people in their lives around their name. Participants drew lines connecting individuals who personally knew each other. Interviewers asked the participants questions about nine topics, but only five topics are covered in this paper: friendships, romantic relationships, sexual activity, abstinence, and birth control. The topics were based on subjects covered in PREP programs. For each topic, participants were asked to identify individuals they **have** talked to, **would** talk to, and **would not** talk to, respectively, by placing a unique sticker next to the names of people in their network. The questions were all structured similarly (e.g., "*Sometimes people have questions or concerns about their relationship with friends or their friendships. Have you talked with someone about friendships? Who?*"). For each topic, participants were probed about why they would or would not talk to a person in their network. They were also asked about the content of the communication.

## How Did the Adolescents Describe Their Social Networks?

Participants, on average, listed 8.07 members in their networks, with a range of 1 to 17 members. **Network density** ranges from 0–1 and measures the proportion of network members who know each another. It is derived by dividing the total number of network ties in an individual's network (i.e., the number of people that know one another) by the total number of possible ties in the individual's network. The average network density for participants in this study was 0.51.

Family and friends were the types of individuals most likely to be included in the participants' networks. On average, family members made up 59% of a participant's network. Every participant included at least one family member in his or her network,

usually "mom." Seventy-seven percent of the participants said that a family member was who they talked to the most.

## Communication about Specific Topics

Network size, proportion of friends and family in a network, dating status, and the sex and age of participants were often associated with who participants talked to about specific topics (*see* Table 1):

*Adolescents have social networks and they can be examined as a resource and source of information for program development, implementation, and evaluation.*

- **Friendships**. Girls and those with bigger networks talked to more people about friendships.
- **Romantic relationships.** Network characteristics were important here. Participants with larger networks and greater network density talked to more people about romantic relationships. Those with a greater proportion of family members in their networks talked with fewer people about romantic relationships.
- **Sexual activity.** Older participants reported more people they had talked to and would talk to about sexual activity—and fewer people that they would not talk to. Girls, and participants who said they were dating, reported more people that they had talked to about sexual activity.
- **Abstinence**. Sex and network characteristics were associated with talking about abstinence. Girls were more likely to report they had talked about abstinence. Those with bigger networks—and those who reported a greater proportion of friends in their networks—also reported they had talked to more people about abstinence.
- **Birth control.** Girls reported more people they had talked to—and would talk to—about birth control. Older youth also reported more people they had talked to—and fewer they would not talk to, compared with younger participants. Those with larger networks were more likely to report having had conversations about birth control.

## Implications for Delivering Sexual Health Education to Youth

Our results point to the importance of understanding how networks and communication are related for adolescents. Several factors related to the number of network members participants reported they had talked to (or would talk to) about friendships, romantic relationships, sexual activity, abstinence, and birth control:

- **Sex.** Girls tended to report more communications than boys.
- **Age.** Older youth were more likely than younger participants to have had, or anticipated having, communications about sexual activity and birth control.
- **Network size, density, and composition.** We especially found that participants with a larger network were—not surprisingly—more likely to report that they talked to people about the study topics. Whether a network had more or less family or friend members was also sometimes related to communications.

Surprisingly, dating status, although related to discussions about sexual activity in general, was not associated with communications about birth control or abstinence. Given that only about one-quarter of the participants reported they were dating, it is possible that another sample—with a larger proportion of dating youth—would have yielded different results.

We believe that our findings have several implications for programs like PREP:

- It is important that program staff understand youth networks. Adolescents have social networks and they can be examined as a resource and source of information for program development, implementation, and evaluation.
- Program planners and facilitators can easily collect information about adolescent networks by simply asking youth to draw their networks.
- Program staff should consider how to offer support to adolescents with smaller, less dense networks. Our findings suggest that such youth have fewer people with whom to communicate about important health and social issues.
- Program staff should consider how to use adolescent networks to bolster their programming. Can parents be included in supporting program goals? Can non-traditional network members, like coaches and neighbors, be included?

*Natoshia M. Askelson, MPH, PhD; Jennifer Turchi, MA; Daniel Elchert, BA; Elizabeth Golembiewski, BS; Erika Leicht, BA, are at the Public Policy Center at the University of Iowa. Addie Rasmusson, BA, is at the Iowa Department of Public Health.*

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# Medical Cannabis Legislation in Minnesota:

## An Interview with Minnesota Assistant Health Commissioner Manny Munson-Regala

*by Wendy L. Hellerstedt, MPH, PhD*

Minnesota Assistant Health Commissioner, Manny Munson-Regala

*"By telling all parties what works, what doesn't work, and what unforeseen consequences result from administration of medical cannabis, we hope to ground all decision-making in better data."*

*In May 2014, Minnesota Governor Mark Dayton signed a bipartisan medical marijuana law, making Minnesota the 22nd state in the US to allow some individuals to use medical marijuana with a physician's prescription. Two manufacturers will be certified in 2015 and medical cannabis should be available at eight distribution sites in Minnesota by July 1, 2015. Patients will receive medical cannabis as a liquid, pill, or vaporized delivery method that does not require the use of dried leaves or plant materials. Minnesota's Commissioner of Health, Dr. Ed Ehlinger, has the ability to add other forms of delivery in the future. In August 2014, Michelle Larson became the director of Minnesota's new medical marijuana program, the Office of Medical Cannabis.*

The legislation also has a requirement that patients and their physicians participate in a research study, a provision unique to Minnesota. We spoke with Manny Munson-Regala, Assistant Commissioner for Strategic Initiatives at the Minnesota Department of Health (MDH), about the research requirement and about why this legislation was so strongly supported by family and child advocates in Minnesota.

**Healthy Generations (HG): How will this legislation help families in Minnesota?**

**Manny Munson-Regala (MM-R)**: A number of people in Minnesota have expressed concerns that their medical conditions are not being adequately addressed by current medical therapies. At the same time, there is a growing body of scientific and anecdotal evidence that suggests cannabis may have potential therapeutic use. By setting up a medical cannabis structure focused on consumer protection **and** research, the hope is that patients with significant needs will get access to potentially therapeutic medication in a manner consistent with the best standards of medical care.

**HG: Minnesota is the first state to include medical research as a component of its legalization of medical cannabis. Why?**

**MM-R:** As we talk to patients, providers, policymakers, and individuals in other states, a recurring theme we hear is that there is a lack of data on efficacy, safety, dosage, and potential interactions with other medications. While we will not be doing clinical trials, which would be the best way to get this information, requiring patients to be part of a registry and observational studies will help advance our knowledge about the costs and benefits of legalizing cannabis. We also hope that the approach that we are taking will encourage other states to enhance their evaluation/research efforts so that future policy decisions about legalizing cannabis are better informed.

**HG: What are some of the questions you hope to address through research?**

**MM-R:** Is medical cannabis efficacious? How many people who initiate medical cannabis benefit and how many stop using it? What are some of the side-effects from cannabis use for medical conditions? Does cannabis use decrease use of other drugs? Are their combinations of cannabinoids that are more effective for some conditions than others? What's an effective dose? Do

different delivery methods matter and if so, how? Which of the cannabinoids are relevant? Is there an "entourage" effect?

**HG: What do you mean by "entourage effect?"**

**MM-R:** There are more than 480 natural components in the cannabis plant. Sixty-six of them are classified as "cannabinoids," chemicals that are unique to the plant. Right now there is insufficient research and we do not know the exact role or mechanism for all of these compounds. It is likely that these compounds work better together than they do alone—the interactive or compounding effects of more than one compound is called the "entourage effect."

**HG: How will the research component be operationalized? Who will conduct the research? What if a patient does not want to participate in research?**

**MM-R:** The research will be conducted by MDH or by third parties via contract with MDH. The protocols and operational structure of that work will be more fully fleshed out after we hire our research manager. Patient participation in research studies is required under the law but the specifics of what data, how often they report, and what role providers will have is still to be determined.

**HG: What do you think will be the implications of the research conducted in Minnesota for families, for policymakers, for health-care providers?**

**MM-R:** We hope that as we move forward with research we will better inform the patient experience, provider decision making. and the policy discussions. By telling all parties what works, what doesn't work, and what unforeseen consequences result from administration of medical cannabis, we hope to ground all decision-making in better data.

## For More Information

1. For a copy of Minnesota's medical cannabis legislation, go to: **https://www.revisor.mn.gov/laws/?id=311&year=2014&type=0**

2. For information about the practical ramifications of the legislation, go to the Minnesota Department of Health website, at: **http://www.health.state.mn.us/topics/cannabis/#policy**

## MEDICAL CANNABIS USE IN MINNESOTA

The following information is directly from the Minnesota Department of Health's website about medical cannabis, **http://www.health.state.mn.us/topics/cannabis/#policy**:

"Medical cannabis will be available to Minnesota residents whose health care provider certifies them to be suffering from conditions including:

- Cancer associated with severe/chronic pain, nausea or severe vomiting, or cachexia or severe wasting;
- Glaucoma;
- HIV/AIDS;
- Tourette's Syndrome;
- Amyotrophic Lateral Sclerosis (ALS);
- Seizures, including those characteristic of epilepsy;
- Severe and persistent muscle spasms, including those characteristic of multiple sclerosis;
- Crohn's Disease; and
- Terminal illness, with a life expectancy of less than one year, if the illness or treatment produces severe/chronic pain, nausea or severe vomiting, cachexia or severe wasting.

The bill directs Minnesota's Commissioner of Health to consider the addition of other conditions, particularly intractable pain (as defined in statute) by July 1, 2016."

Minnesotans who want to use medical cannabis to treat one of the qualified medical conditions must:

1. **Receive certification of their condition** from a Minnesota-licensed health care practitioner (a doctor, physician's assistant, or advanced practice nurse).
2. **Submit an application to the Minnesota Department of Health.** After receipt of the application, the Commissioner of Health will enroll the patient in the registry program and issue a registry verification.

After receipt of registry verification, patients may receive medical cannabis at one of eight distribution facilities in Minnesota.

Most registered patients will pay a $200 annual fee. There will be a reduced fee of $50 for Minnesotans receiving Social Security disability, Supplemental Security Insurance payments, medical assistance, or MinnesotaCare. There will also be an additional manufacturer's fee (at press time, this amount was unknown).

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# Not-so Baby-Friendly Minnesota:

## Opportunities and Challenges

*by Wendy L. Hellerstedt, MPH, PhD*


**Juliann Van Liew, MPH, receiving her Delta Omega award in 2014.**

*"Breastfeeding has to begin immediately after birth, and if hospital policies and practices aren't in place to support it then an important opportunity can be missed."*

*Juliann Van Liew took a pragmatic approach to her MPH studies in the Maternal and Child Health (MCH) Program at the University of Minnesota. "I wanted to develop a range of skills, so I sought out several opportunities that allowed me to build my understanding of public health practice in MCH," she said. Van Liew graduated in May 2014, after spending two years in the classroom and in the field. She held positions or internships at the Minnesota Department of Health, the Minnesota Visiting Nurse Agency, the Washington County [Minnesota] Department of Public Health and Environment, WellShare International, the Minnesota Organization on Fetal Alcohol Syndrome, and the Minnesota Breastfeeding Coalition. Upon graduation, she was inducted into the public health honorary society, Delta Omega, as a result of a 4.0 grade-point average and she won the Minnesota Public Health Association's Student Achievement Award.*

Van Liew's pragmatism during her training turned into passion. As she was building skills—and accruing academic honors—Van Liew became a focused and committed advocate for breastfeeding, as a result of her work with the Minnesota Breastfeeding Coalition (MBC). "I began working with the MBC within a couple weeks of beginning my graduate studies. My first task involved leading a table discussion about the "Ban the Bags" initiative [bags of formula given to women as they leave hospitals after delivery] at the MBC's annual meeting, but I soon was given an opportunity to get more involved and conduct some important research."

*... rural sites were significantly less likely than urban sites to show progress in Baby-Friendly designation or to have infant care practices that supported breastfeeding.*

Van Liew knew that the MBC was interested in—and concerned about—the progress of Baby-Friendly Hospital designation in Minnesota, so she volunteered to survey Minnesota hospitals about their challenges and their progress in 2013 and in 2014. "One of the most important places to advocate for breastfeeding is at the hospital or birthing center," she explained. "Breastfeeding has to begin immediately after birth, and if hospital policies and practices aren't in place to support it then an important opportunity can be missed. The experience at MBC was transformative: not only did I get to delve deeply into a topic I am passionate about, but I was also mentored in survey research and in analyses by MBC and by my University advisors," Van Liew said.

### Minnesota Baby-Friendly Status in 2014

"I was involved in two MBC surveys of Minnesota birth centers and hospitals, one in 2013 and one in 2014," Van Liew explained. She led the survey projects, with her MBC and University mentors, from survey development to implementation. "The 2014 data are not only the most

current, but also the most intriguing to me. In 2014, we were able to reach almost every hospital or birth center (94 of the 97 hospitals and birth centers in Minnesota), with an e-mail survey," she said. "I think we had a uniquely high response rate because MBC has so many connections in most of Minnesota's birthing hospitals and centers. It has the kind of reputation that encourages people to respond to its efforts." The MBC survey included one respondent from each hospital or center. The respondents had a range of responsibilities, including labor-and-delivery nurse, lactation consultant, and department administrator. "I don't think our survey is limited because we had a variety of respondents," Van Liew said. "I think that the variety of respondents strengthens it. We identified people who were either affiliated with MBC or who were identified by their own hospital or center personnel as being knowledgeable about breastfeeding policy at the site. This makes more sense than restricting our survey to a certain profession, because hospitals vary in terms of who makes or advocates for policy and what different positions are called."

Data from 94 hospitals and birth centers showed that Minnesota had not made much progress toward Baby-Friendly designation: only two hospitals or centers reported being actually or almost designated and 16 reported significant progress toward designation. The good news, though, was that representatives from 72% of the hospitals or centers said they were working on at least one step toward Baby-Friendly status.

The 2014 MBC survey included questions about perceived key advocates for Baby-Friendly hospital/center policies and challenges to Baby-Friendly designation. Among the major findings:

- Nurses (especially those with five or more years of professional practice), lactation consultants, and administrators were key initiators of the Baby-Friendly certification process in the 18 centers with either Baby-Friendly designation or significant progress toward designation;
- 85% of all center respondents perceived that cost—either specifically related to lactation consultation or more general costs—was an important barrier;
- More than half of the center respondents perceived that lack of support from key personnel was a significant barrier to becoming Baby-Friendly. Physicians were especially identified as lacking support for Baby-Friendly initiatives; and
- About 50% of the respondents from hospitals/centers that had not made significant progress toward becoming Baby-Friendly identified lack of education about the designation process itself as a barrier.

"I also knew that there were significant disparities in health overall in rural and urban settings, so I decided to examine whether there were differences in infant feeding practices and progress toward Baby-Friendly designation between rural and urban sites," Van Liew said. She found that rural sites were significantly less likely than urban sites to show progress in Baby-Friendly designation or to have infant care practices that supported breastfeeding.

## Translating Survey Data to Action

Van Liew used her survey results to write her MPH capstone paper and she presented her findings at MBC's Perinatal Hospital Leadership Summit in May 2014. She noted that there has only been one other survey

## WHAT IS BABY-FRIENDLY DESIGNATION?

Baby-Friendly designation is awarded in accordance with the Baby-Friendly Hospital Initiative (BFHI). The BFHI is "a global program that was launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding" (**https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative**). Data suggest that women in hospitals and birthing centers that are BFHI-designated have higher rates of breastfeeding initiation and duration than others.

Baby-friendly designation is awarded to birthing facilities that successfully implement the Ten Steps to Successful Breastfeeding. The steps, as described by Baby Friendly USA (**https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps**), are:

"1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast-milk, unless medically indicated.
7. Practice rooming in—allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center."

Baby-friendly designation is a process that involves examining and changing policies and procedures, training staff as change is implemented, and developing auditing processes to ensure that maternity and nursery care are consistent with optimizing breastfeeding initiation and success. The process has been described as the 4-D Pathway that involves **Discovery** (e.g., registering with Baby-Friendly USA, completing a self-appraisal); **Development** (e.g., collecting data on current policies, developing a workplan and training procedures); **Dissemination** (e.g., training staff, collecting data); and **Designation** (e.g., implementing auditing procedures, successfully completing an on-site assessment of Baby-Friendly practices).

like the MBC survey that has described the Minnesota experience: the Newborn Feeding Environment Survey (NFES). The results of that survey were also analyzed by an MCH graduate from the University of Minnesota in 1999, Dr. Joan Dodgson. "Dr. Dodgson's MPH advisor, Wendy Hellerstedt, was my advisor—and her PhD advisor, Laura Duckett, was also on my MPH committee," Van Liew said. "In addition to the wonderful people whom I worked with at MBC, including Dr. Pam Hegge and Linda Dech, it was good to work with people in my academic program who had research expertise and the historical perspective about breastfeeding practices and policies in Minnesota. My mentors and I feel that our findings will be relevant not only regionally, but nationally, because Minnesota's experiences may be similar to those in other states."

*"Our data also help us understand that some informational challenges may be easily addressed."*

Van Liew knows that MBC will use the survey data to address education and opportunity gaps in Baby-Friendly designation in Minnesota. "One of the primary goals of MBC is to support access to comprehensive and culturally appropriate lactation care and services for all women," Van Liew said. "MBC provides evidence-based provider education, patient education materials, and advocacy. The data we gathered help us better understand that rural hospitals may have greater challenges in promoting breastfeeding in birth centers than urban centers. Our data also help us understand that some informational challenges may be easily addressed," she said. "For example, several of our respondents identified cost as a potential barrier to Baby-Friendly designation. We can address this concern as we look at the literature about the cost of Baby-Friendly designation, it seems that, while there are short-term costs, they may not persist. In fact, the start-up costs may eventually be outweighed by long-term benefits and savings. We also found that nurses, administrators, and lactation consultants are important supporters of Baby-Friendly practices and are identified as influential," Van Liew said. "It will be particularly important to continue to tap into their talents and their passion for breastfeeding if we are going to make more progress in Baby-Friendly designation in the future."

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## Consider a Master's in Public Health (MPH) Degree in Maternal and Child Health

*by Shoua Vang*

*Michelle Gin intends to receive her Masters in Public Health (MPH) in Maternal and Child Health (MCH) from the University of Minnesota's School of Public Health in 2015, with a concentration in two areas: Public Health Policy and Health Disparities. She is a full-time student, the National Student Coordinator for Physicians for Social Responsibility (PSR), a Leadership Education in Adolescent Health (LEAH) Fellow with the University of Minnesota Medical School, and a graduate assistant for the School of Public Health's Office of Admissions and Student Resources.*

Gin's passion for public health has given her the opportunity to travel broadly. During her undergraduate education at the University of Iowa, she spent two years abroad studying public health. "I did various work on public health practices in India, studied female genital mutilation in Gambia, and medicinal plants in Costa Rica," she explained. Prior to enrolling in the MPH MCH program in Fall 2013, she worked with a state-wide campaign in Iowa to reduce unintended pregnancies in 18–30-year-old women called, "Avoid the Stork," and she promoted women's empowerment with the Women's Resource and Action Center (**http://wrac.uiowa.edu/**).

"I decided to pursue an MPH because I have a strong passion for public health, especially adolescent health, and I needed to further my education," she said. Gin looked at several domestic and international academic programs and determined that a degree from the University of Minnesota would give her the flexibility to pursue either a domestic or international public health career. "The University of Minnesota is in a great location, the cost of tuition is competitive, and the MCH program here is one of the best in the nation," she explained. Although she was connected with various professors at different universities, she felt a strong connection with a professor at the University of Minnesota, Wendy Hellerstedt, PhD, MPH, who is now her academic advisor. "I've really enjoyed being around like-minded individuals who have similar passions and truly care about public health, as well as having the opportunity to build life-long friendships and professional networks," she said.

*"The University of Minnesota is in a great location, the cost of tuition is competitive, and the MCH program here is one of the best in the nation."*

As an MPH student, Gin believes having experiences outside of the School of Public Health is essential to success, either through non-public health courses, student organizations, or activities. Fortunately, such opportunities are plentiful at the University of Minnesota. She is a member of the School of Public Health's Health Disparities Work Group (**http://www.sphresearch.umn.edu/hdwg/**). She also volunteers for the organization, International Physicians for the Prevention of Nuclear War (IPPNW, **http://ippnw.org**), for which she coordinates conferences around the world about positive dialogue for change around nuclear weapons abolition. "Because of my dedication to Physicians for Social Responsibility and IPPNW, I have had unique opportunities to do public health work internationally, such as attending the Women's Global Health and Human Rights Conference in Tunisia this past spring," she said. In August 2014, Gin plans to lead a group with IPPNW on a 300+ mile bike tour ending at the 21st World Congress in Astana, Kazakhstan. They plan to meet with mayors and other elected officials, peace activists, and fellow students along the way to voice their concerns about nuclear weapons and the importance of nuclear weapons abolition.

Michelle Gin

Field experiences are required of all MPH students and Gin has identified one that links her passion and her training. This summer she is working with Dr. Peter Karamoskos, a nuclear radiologist from Melbourne, Australia, who studies the association of nuclear radiation exposure and maternal and child health. He is mentoring her efforts to review research studies that have assessed health outcomes that may be associated with radiation exposure. This review, she hopes, will summarize the evidence about the risks

of nuclear radiation exposure to MCH populations. "My goal is to develop a training program about how to educate people about maternal and child health outcomes associated with nuclear radiation exposure and present that program in Kazakhstan at the IPPNW World Congress this August," said Gin.

Gin entered the MPH program with a strong interest in adolescent populations and reproductive health. "Unintended pregnancies and adolescent health are very interesting to me, especially among low socioeconomic groups. I figured graduate school would be a time of new education, ideas, and people. By the time I graduate, what I want to do could be very different than what I thought I'd do when I started my training," she said. "And I'm very open to that."

*Shoua Vang is an MPH student in the Maternal and Child Health Program, Division of Epidemiology & Community Health, School of Public Health, University of Minnesota.*

## TOP 10 REASONS TO EARN AN MPH DEGREE IN MATERNAL AND CHILD HEALTH AT THE UNIVERSITY OF MINNESOTA

### Opportunities in the Field of MCH

1. **MCH MPH graduates often work with—or on behalf of—socially and economically vulnerable populations** that include women, children, youth, and family members (broadly defined to include fathers, grandparents, etc.).
2. **MCH is one of the oldest—and one of the most varied—areas in national health promotion and assurance in the US.** In the US there is a national agency dedicated to MCH work, the Maternal and Child Health Bureau, which oversees public health programs that address a wide range of topics, including reproductive and prenatal health care access, newborn screening, family home visiting, care of children with special health care needs, and autism research. All of these initiatives require MCH professionals at national and local levels, see **http://www.hrsa.gov/about/organization/bureaus/mchb/**
3. **MCH MPH graduates develop public health programs and policies** that focus on health promotion, health care equity, disease prevention, and primary care services. Their work is conducted in non-profit organizations, government agencies, universities, school districts, advocacy organizations, health clinics, and research/academic institutions.
4. **Every state—and many cities and counties—have departments specifically dedicated to MCH public health** advocacy, assessment, and program development. In Minnesota, see **http://www.health.state.mn.us/divs/fh/mch/** for a description of the many focal areas in the State's MCH Section.
5. **MCH MPH-level epidemiologists** participate in research teams to conduct needs assessments, evaluate programs, and identify and promote social and environmental conditions that contribute to the health of women, children, youth, and families. MCH professionals with epidemiologic skills are especially in demand in city, county, and state health departments. Because MCH epidemiology training is so important, the Centers for Disease Control and Prevention sponsors MCH epidemiology training and internships. See **http://www.cdc.gov/reproductivehealth/mchepi/index.htm**
6. **MCH professionals are in heavy demand internationally**. Most of the eight United Nations' Millennium Development Goals focus on MCH areas, including eradicating poverty, reducing child mortality, empowering women/promoting gender equity, improving maternal health, and reducing the risk of HIV/AIDS and other diseases that affect vulnerable populations. See **http://www.who.int/topics/millennium_development_goals/en/**
7. **MCH professionals have organizations that help them network and that provide them with opportunities for continuing education**: the Association of Teachers of Maternal and Child Health (**www.atmch.org**) and the Association of Maternal and Child Health Programs (**www.amchp.org**).

### Quality of the University of Minnesota MCH MPH Program

8. **The University of Minnesota has one of the most respected MCH programs in the world.** We have had more than 1000 graduates, many of whom have become leaders in MCH research, program development, and policymaking.
9. **The University of Minnesota's MCH program has about 40 regular or adjunct faculty members**, representing a variety of disciplines (e.g., pediatrics, nursing epidemiology, sociology, public health, psychology, anthropology) and community and academic work settings.
10. **To prepare our students for leadership positions,** they undertake field experiences with MCH leaders to enhance their research, program development, and policy making skills.

## WHAT IS MCH? WE ARE MCH!

Do you ever wonder how to explain the depth and breadth of MCH public health work? Our HRSA training grant colleagues at the University of South Florida/Tampa developed a series of Prezi presentations to address this issue. Each presentation begins by posing the question, "What is MCH?" It then describes MCH in terms of our work with individuals, families, and communities. The Prezi presentations end with brief "stories" that were submitted by our University of Minnesota Center for Leadership Education in MCH, and other HRSA-funded training grant colleagues across the nation, to describe our varied work. There are four Prezi presentations available at the following links. The main one is the longest version; the mini-Prezis can be quickly viewed and each has different stories from the main Prezi. Take a look—you might recognize a story from someone you know!

- "We are MCH" Main Prezi: **http://prezi.com/rz0qkn_wwzvp/we-are-mch/**
- "We are MCH" Mini #1: **http://prezi.com/c7e6u6hpyk2u/we-are-mch-mini-1/**
- "We are MCH" Mini #2: **http://prezi.com/wc9jvevjv3nz/we-are-mch-mini-2/**
- "We are MCH" Mini #3: **http://prezi.com/kyjdfgl9b17o/we-are-mch-mini-3/**

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## Save the Date: Conferences and Events

### SEPTEMBER 9, 2014
**Minnesota Reproductive and Sexual Health Update, University of Minnesota**
Saint Paul, MN
**http://us1.campaign-archive1.com/?u=c9dcf5399d7eac61bc2cbec52&id=d23d2af77b&e=92103bedec**

### SEPTEMBER 10-11, 2014
**ASTHO Annual Meeting 2014**
Santa Ana Pueblo, NM
**http://www.astho.org/Annual-Meeting-2014/**

### SEPTEMBER 17-19, 2014
**2014 Community Health Conference: Public Health on the Horizon**
Brainerd, MN
**http://www.health.state.mn.us/divs/opi/pm/conf/**

### SEPTEMBER 17-19, 2014
**2014 CityMatCH Leadership and MCH Epidemiology Conference**
Phoenix, AZ
**http://www.citymatch.org/conference/citymatch-conference/2014/Home**

### SEPTEMBER 18-20, 2014
**Health Across Borders: Migration, Disease, Medicine, & Public Health in a Global Age (Conference)**
College Park, MD
**http://newamerica.umd.edu/conferences/fall2014/overview.php**

### SEPTEMBER 18-20, 2014
**APHP Reproductive Health 2014 Conference**
Charlotte, NC
**http://www.arhp.org/professional-education/annual-meetings/reproductive-health-2014**

### SEPTEMBER 25, 2014
**Sixth Annual Minnesota Childhood Injury Summit**
Vadnais Heights, MN
**http://www.minnesotasafetycouncil.org/safekids/summit/2014/index.cfm**

### SEPTEMBER 29, 2014*
**11th Annual Women's Health Research Conference: Updates on Women's Cancer Research, University of Minnesota**
Minneapolis, MN
**http://www.epi.umn.edu/mch/events-calendar-new/11th-annual-womens-health-research-conference-updates-on-womens-cancer-research/**

### OCTOBER 16-17, 2014
**2014 Public Health Law Conference**
Atlanta, GA
**http://aslme.org/2014-public-health-law-conference**

### OCTOBER 20, 2014*
**Interdisciplinary Institute on the Reproductive Health of Incarcerated Women in Minnesota**
Saint Paul, MN
**http://z.umn.edu/mchincarceratedwomen**

### OCTOBER 22-24, 2014
**National Forum on Hospitals, Health Systems and Population Health: Partnerships to Build a Culture of Health**
Washington, DC
**http://www.populationhealthandhospitals.com/**

### OCTOBER 23-24, 2014
**2014 Many Faces of Community Health Conference**
Minnetonka, MN
**http://manyfacesconference.org/index.html**

*Sponsored or co-sponsored by the Center for Leadership Education in Maternal and Child Public Health