

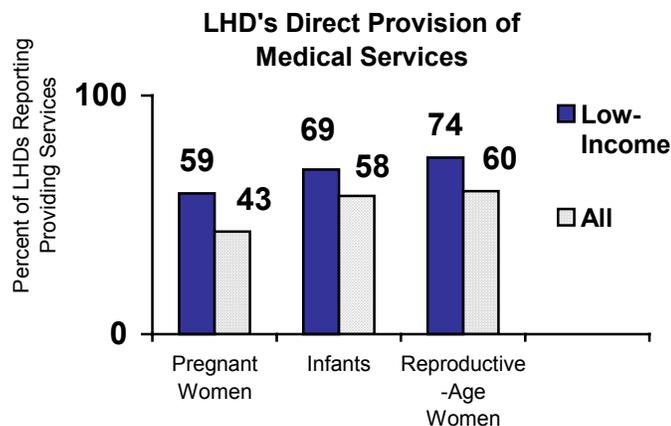
The Roles Local Health Departments Undertake in Serving Non-Pregnant Women of Reproductive Age

Under Title V of the Social Security Act, Maternal and Child Health populations traditionally include pregnant women and their infants. However, in recent years, the definition of MCH populations being served has been expanding in recognition of the importance of the health of women in their own right, as well as the importance of women's preconceptional and interconceptional health with regard to the health of any children they may bear. To this end, many local health departments (LHDs) throughout the United States are continuing, expanding, and/or initiating activities and programs that include non-pregnant women of reproductive age (hereafter referred to as reproductive-age women) as part of the MCH population they serve.

The data presented below provide a description of activities in which LHDs engage on behalf of reproductive-age women. The data are based on the reports of 193 respondents about their respective LHD's activities from 1996-99. The respondents were selected from LHDs in metropolitan areas and counties in 48 states. Please refer to the accompanying brief entitled "The Roles Local Health Departments Play in the Organization and Provision of Perinatal Services" for more detailed methodological and respondent information.

Provision, Coordination, and Assurance of Access to Services

About half of the LHDs reported directly providing medical services to all pregnant women (43%) and infants (58%), and they reported doing so as well for reproductive-age women (60%). Services were reported to be delivered more frequently to low-income reproductive-age women (74%) than to all women regardless of income (60%). Medical services were more frequently reported to be delivered in LHDs in the Southeast (92% for low-income women and 72% for all women) than other areas of the country (65% low-income women and 55% all women).



LHDs pursue private providers' involvement in service delivery as well. Close to one-third of LHDs initiated efforts to increase private provider participation in delivering services to reproductive-age women (28% for uninsured or publicly insured women and 31% for all women), and one-third reported facilitating private providers' contracting with public programs for this population. One-fifth of LHD respondents reported contracting with private providers to provide wrap-around services for reproductive-age women.

Forty-five percent of LHDs reported undertaking activities to enhance providers' ability to screen for eligibility of reproductive-age women for Medicaid or other public services. Examples include simplified application forms (35%), or placing LHD staff at hospitals, clinics, or family planning enrollment sites (27%). LHDs organized on a regional or district basis were least likely to place staff in other sites (8%), while those in large metropolitan areas were most likely (38%) to do so.

Collaborations and Advocacy

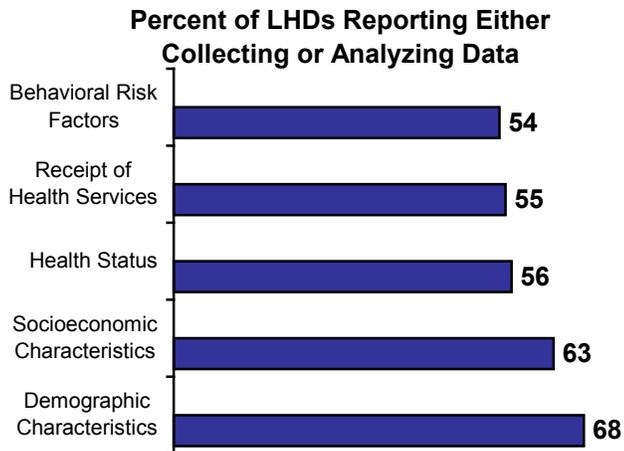
LHDs have the opportunity to collaborate with many different individuals and organizations in the community. In that regard, 58% of LHDs reported presenting information to local political leaders and 50% developed or are disseminating reports on health needs of reproductive-age women. Slightly less than two-thirds of LHDs (62%) reported participating in one or more coalitions addressing the health concerns of reproductive-age women; three-quarters of those LHDs (72%) reported staffing the coalition. Another 12% of LHD respondents reported that a coalition that discussed health issues related to reproductive-age women existed in their community, but that they were not participants.

Over half (54%) of LHD respondents reported participating in, collaborating with, or providing expertise to other public or private initiatives or programs specific to reproductive-age women. About one-fifth (22%) reported convening meetings of local providers to enhance identification of high-risk women. Forty-one percent of LHD respondents reported participating in activities to educate providers about health care for reproductive-age women.

Local media were sent materials or news releases on topics related to the health of reproductive-age women as reported by 63% of LHDs, and 71% of LHDs reported undertaking educational activities on health information and resources specific to reproductive-age women directed toward local consumers.

Data Use

About two-thirds of LHD respondents reported collecting data on the health of reproductive-age women (67%) and 61% separately reported analyzing such data. Over half (57%) reported both collecting and analyzing the data, covering topics that included the women's demographic or socioeconomic characteristics, behavioral risk factors, health status, and receipt of health services. Half (54%) of LHD respondents reported conducting focus groups, community forums, or key informant surveys, utilizing a client database for services (51%), or compiling data for needs assessments for this population (50%).



Quality Assurance, Monitoring, & Accountability

Twenty-two percent of LHD respondents reported participating in the development of population-based standards of care for reproductive-age women. About half of the LHDs (53%) involved elected officials, consumers, providers, and/or agency heads in developing plans related to the health needs of reproductive-age women. Nearly half (46%) reported having

produced a plan to systematically address priority health problems and needs for reproductive-age women. Eighty-nine percent of those that did produce such a plan disseminated it. LHDs in the least populated areas or in areas where they were organized on a regional basis were less likely to involve elected officials (76%) than other areas (94%). They also were less likely to disseminate a report about the plan (73% versus 97%). About half of the LHD respondents (47%) reported disseminating reports updating their progress in meeting local health goals for reproductive-age women.

To a lesser degree than other activities, LHDs reported initiating or promoting regulations and policies that promote the health of reproductive-age women at the local (19%) or state (32%) level. Slightly over a third provided legislative or regulatory bodies with expertise or consultation on this population at either the local (37%) or state (36%) levels.

Interactions with MCOs

About 22% of LHD respondents reported contracting with one or more managed care organizations (MCOs) to serve reproductive-age women. LHD respondents reported that the LHD (22%) or another agency in the community (4%) developed guidelines for contracts with MCOs concerning care for reproductive-age women; the guidelines more frequently were written for women with publicly-funded health insurance (96%) as opposed to all women (45%). When the sample was restricted only to LHDs in areas with some MCO-related activity, 38% of the respondents reported that guidelines were developed related to the care of reproductive-age women. LHDs in Western Mountain/Plains states were less likely to report the development of guidelines (26%) than those in other areas (41%).

Of the 81 LHDs reporting that they or another community agency obtained data about MCOs, forty percent monitored the care provided to reproductive-age women, and one-third monitored their health outcomes.

Comments

A recent study by CityMatCH looked at some issues similar to the information we present above. They reported activities related to women's health based on data from 78 CityMatCH members. While most data are not directly comparable with those reported herein, the CityMatCH findings suggest greater activity related to community needs assessments (81% versus 46%) and possibly provision of some services. These differences could be due to the inclusion in our study of counties as well as metropolitan areas.

The percentage of LHDs involved in activities with respect to reproductive-age women is lower overall than we found for pregnant women and infants. This is not surprising as the two latter groups are traditional MCH populations. Despite these differences, the level of activities is substantial across the spectrum of LHD functions on behalf of reproductive-age women, and is likely an increasing trend.



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