

DataSpeak

July 23, 2008

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Gopal Singh: Good afternoon. Welcome to today's DataSpeak web conference on the status of maternal and child health on the U.S. Mexico border.

My name is Gopal Singh, and I'm the project officer for the Maternal and Child Health Bureau's MCH Information and Resource Center, which is a sponsor of the DataSpeak series. Today we are pleased to present the fourth DataSpeak program for this calendar year.

Archives of the first three DataSpeak programs of 2008, as well as other programs held since 2000, can be found on the MCH IRC Web site at the address on the slide.

Today's program will focus on the current status of the maternal and child health population on the U.S. Mexico border and the MCH survey capabilities.

We have three presenters for this program. The first two will be presenting live and will be available to answer questions at the end of the presentation.

Our third speaker, Dr. Sam Notzon, Director of International Statistics at the National Center of Health Statistics, is unable to join us today due to a problem with his schedule. He has, however, recorded his presentation; and instructions for accessing that recording will be given to you at the end of today's program.

Our first speaker today will be Dr. Jill McDonald, Senior Epidemiologist for the U.S. Mexico Border Region for the National Center for Chronic Disease Prevention and Health Promotions Division of Reproductive Health. She will discuss current maternal and child health issues of concern and current epidemiological capacities in the border regions. She will also present several data projects that she's currently involved with to strengthen current MCH data availability on the border.

Our second presenter will be Brian Castrucci from the Texas Department of State Health Services Division of Family and Community Health Services, Office of Title V and Family Health.

He will discuss fetal and infant mortality in the border region as well as current data on breast feeding and research regarding the effects of hospital policies on breast feeding initiation rate.

Mr. Castrucci will also discuss an epidemiological phenomenon known as the Mexican Paradox, which influences the health of the maternal and child health population in the border region.

Dr. Notzon's recorded presentation will include data from a draft chapter he has produced for the U.S. Mexico Border Health Commission.

He'll provide information from his recent analysis of perinatal data from 44 U.S. counties on or near the U.S. Mexico border. This includes information on the fertility rate, risk factors for pregnant women and birth outcomes.

He will also include some limited information about child health and the Caesarean delivery rate in the area. A link to Sam Notzon's recorded presentation will be provided at the end of the program or, alternatively, you can access it from the MCHIRC Web site at any time.

It is now my pleasure to introduce the Vivian Gabor, the moderator for today's program. Vivian, I will now turn the floor to you.

Vivian Gabor: Thank you, Gopal, and welcome to all of our participants. We are delighted to have everyone with us today.

Before we start our presentations, I have just a few housekeeping items to take care of. For those of you who are logged in via the Internet, you'll be seeing an ongoing slide show through the next hour. At the end of the program, we would greatly appreciate it if you could just take a moment to complete the short feedback form.

We'll provide instructions for doing so at that time. Your phone line will be muted during the presentation. But after we hear all the presentations, we will have a Q&A, question and answer session. You'll have an opportunity to ask questions through the telephone operator who will come on at that time to provide instructions for doing so.

You can also post questions online at any time during the program. If you are logged in via the Internet, you may enter your questions in the question box located on the left side of your screen and hit enter.

If you encounter technical problems during the presentation, please feel free to call the MCH IRC help line. That's at 202 842 2000.

Additional resources on today's topic have been posted on the DataSpeak Web site, including those that our speakers will highlight in their presentations and others that will become... that will be posted later after publication.

I'd like to turn to our first presenter, Dr. Jill McDonald. She'll begin our discussion today.

Good afternoon, Jill, and thank you so much for joining us.

Jill McDonald: Thank you, Vivian, for having me on the program. I'm going to talk today about an initiative of the CDC's MCH Epi program that's focused in the U.S./Mexico border region.

Vivian Gabor: Before we talk about the system, per se, how is the U.S. Mexico border region defined and what are the socio demographic characteristics of this population?

Jill McDonald: Well, my first slide here is a map that explains the border region. It's 2,000 miles long. It involves four U.S. states, six Mexican states.

It consists of an area 100 kilometers to the north and 100 kilometers to the south of the border. It includes 80 municipalities and 44 counties, and it isn't just a political boundary but really a region that's been defined by both countries by national agreement in 1983.

And although it is split down the middle by this international border, it's really not a barrier to travel, either legal or illegal. There are more than a million legal border crossings per day at checkpoints like this one. This is a picture of Juarez, El Paso.

More than 14 million people live in the region. They're pretty much equally divided. Seven million on each side of the border. The population is growing very quickly. It's expected to reach 20 million by 2020. Much of the population, close to 90%, actually resides in 14 pairs of sister cities that straddle the border at various points along those 2,000 miles.

The population was very young, very high fertility. It's mostly Hispanic. And it's characterized by low education, low income and limited access to health services.

Vivian Gabor: What are the MCH concerns in the region?

Jill McDonald: Well, there's a binational organization in the region called the U.S. Mexico Border Health Commission that actually Sam Notzon may be speaking more about in his recorded presentation.

This commission was established in the year 2000, and it was established with the idea of unifying the region, guiding public health decision making, and one of the things they did was identify a shared binational health agenda and priorities. And they call that the Healthy Border 2010 program or agenda.

And among those objectives in Healthy Border 2010, a number of them relate to maternal and child health. They include reducing adolescent pregnancy, infant mortality, mortality from birth defects.

We do see motor vehicle crash mortality in children, increasing levels of prenatal care. Levels of early initiation of prenatal care. Access to healthcare in general. Reducing incidence of HIV/AIDS. Mortality from cervical cancer, diabetes including gestational diabetes. And several other important MCH concerns I listed here in the region include fetal and maternal mortality. Maternal and childhood obesity and very high levels of Caesarean births.

Vivian Gabor: What's the status of MCH's Epi capacity in the region?

Jill McDonald: Well, the capacity is limited. Well, few available health resources in the region. Few epidemiologically trained health department staff. The national and state databases and survey systems are really not designed to represent the border region and population there. Up and down, across the border, data measures and data collection procedures are not standardized. There's generally poor coordination amongst the states and the national jurisdictions. Services and businesses are conducted in two primary languages, English and Spanish. Telephone coverage is incomplete. Formal street addresses are lacking in many residential areas. And especially these last two things really make typical survey data collection techniques used commonly in this country difficult to administer there.

Vivian Gabor: Give us a little background now about the MCH epidemiology program that you work with and its interest in the U.S. Mexico border region.

Jill McDonald: I will do that. But first I should say I work for the Division of Reproductive Health which is within the National Center for Chronic Disease Prevention and Health Promotion at CDC. The Division of Reproductive Health has a long history of conducting family planning and reproductive health surveys in the region going back 30 years or so. And the Maternal and Child Health Epidemiological Program, which is where I am, is part of this division of reproductive health. Here on this slide you can see the mission statement for our program. Basically we build capacity at the state, local, tribal levels to use epidemiologic data for public health action. And the program is now involved in building Epi and data capacity in the border region looking at it almost as if the region were a state.

Vivian Gabor: What are some of the specific capacity building activities in which CDC has been involved in the border region?

Jill McDonald: Well, in late 2002, in collaboration with many partners in the region, the Division of Reproductive Health at CDC launched a four year demonstration project called the Brownsville Matamoros Sister City Project for Women's Health. The purpose of the project was to create a model for binational reproductive health and behavioral surveillance in the region.

The population that was under surveillance for this project was women giving birth in one pair of sister cities or communities. That was Cameron County, where Brownsville is located and Matamoros which is in the state of Tamaulipas. For the sample, we used a stratified systematic clustering sampling approach where the strata with all the hospitals with 100 more births per year and the clusters were selected days within the 2005 survey period.

We sampled about 500 women in each community and conducted postpartum in hospital interviews to collect information about prior pregnancy, pre pregnancy. Prenatal experiences, behavioral lifestyle factors. Contraceptive practices, and health coverage access to care issues. And pretty much used standard questions whenever possible on the questionnaire.

This is a picture of an interviewer conducting an interview at bedside during that demonstration project. The bed happens to be in a hallway because the Brownsville Matamoros sister city project actually coincided with a dengue fever outbreak, and there was no room available for this woman and many others who were giving birth at the time.

Vivian Gabor: Can you tell us about the results from the MSCP that you could share with us today?

Jill McDonald: Yeah, I can. There were really two main conclusions I think that we can draw from the project.

One is that hospital based sampling and postpartum interviews do constitute an effective method for collecting reproductive health surveillance data in this part of the region. The sample covered 98 percent of the births occurred during the study period and 97% of the women sampled actually completed interviews.

And the second conclusion that we've drawn is that the data collected appeared to be useful. Local health institutions have completed analyses on several priority topics. Several of these

have already been accepted for publication. Most of these are going to be presented in the October issue of the online journal Preventing Chronic Disease, and it's going to focus specifically on maternal and child health in the border region. So this theme issue is going to be a good source of more in depth results and information about the project. And also the data are going to be available for public use starting in October through the U.S./Mexico Border Health Association, that organization is actually the owner of the data that's a resource we can put on your Web site later.

And I'm going to start here with giving you a few examples. This is a finding by Ruiz and others from their analysis of healthcare coverage prior to pregnancy. And as you can see, in this table, only 26% of the women residing in Cameron County had coverage before pregnancy, whereas almost three times as many women in Matamoros were covered.

And after adjustment for socioeconomic factors, the difference is even more striking. And, of course, everybody would like to see 100 percent coverage in both communities. And the authors I know are doing more work to characterize the women without prepregnancy coverage. As you can see here, comparing findings across the two communities, does provide additional information that might be helpful in understanding other factors and behavior that we're interested in. For example, why do women cross the border to receive certain kinds of services.

And I'm going to move to another example. This is from an analysis by Castrucci, and you'll hear more about it from Brian later. So I'll be brief here. But they examined the relative odds of having initiated breast feeding at the time of the hospital interview. Both U.S. and Mexico encourage breast feeding among all women who have a live birth. And, yet, these results show pretty clearly that Matamoros women are twice as likely to do so. And also the results have raised questions about breast feeding policies in both countries, how differences in those policies might have contributed to the difference Castrucci and others see here. What are we on the U.S. side of the border able to learn from our Mexican neighbors as a result of this. But I'll leave that because I know you'll hear more about that in a few moments.

And then move to another analysis also by Castrucci and authors. Where they found that Cameron County women who gave birth were almost seven times as likely to have had a screening test for cervical cancer Matamoros women. The difference here is in the other direction. Results also point to differences in screening policies between the two communities, especially with respect to screening during prenatal care, which is much more likely to take place in Cameron County.

Similar results here in an analysis by Goffman and others, looking at HIV screening during pregnancy. You can see that Cameron County women are as almost 12 times as likely as Matamoros women to be tested. Interestingly, the policies around HIV testing in Mexico have changed since these data were collected such that prenatal testing is now recommended. So it makes us think, if the survey were to be repeated this year or in the near future, it would be very neat to see what kind of effects this new policy has had on the likelihood of receiving testing during pregnancy in Matamoros.

In this analysis of adolescent and young adult women giving birth in the region by Galvan Gonzales and others, age specific birth rates were very similar in the two communities, both for adolescents as you see here, but also for women 20 to 24 years old. So the rates are very high and they're very consistent with what we know about adolescent birth rates in U.S. counties along

the border, particularly in Texas. It's an example of a shared problem that the two countries have that could perhaps do well to work collaboratively on.

Here are some additional results from those analyses that also presumably could be useful for planning. Smoking rates in the two communities, for the 14 to 24 year age group were very comparable and very low. 0.4% and 1.1% in Cameron County. And given trends elsewhere, for as smoking goes, we think these numbers are likely to rise and probably should be monitored closely.

In contrast to the smoking rates, the next row down, the drinking rates are two times as high in Cameron County as they were among women in Matamoros. This occurs in spite of a lower drinking age in Matamoros where it's only 18. So these results suggest that there may be some differences in social norms and other factors between the communities that may be operating and worth studying getting to know better.

So I'd say, overall, I'm trying to show you that the BMSP data could provide a number of things, a better understanding of local problems through enabling this direct comparison between the two communities, can suggest by national solutions to shared problems. Can provide evidence that may prompt program and policy changes that affect the region and documentation to support possible reallocation of resources.

Vivian Gabor: Thanks, Jill. Now that the pilot project is completed, how is CDC working to ensure that capacity building activities continue in the region?

Jill McDonald: A large part of the work that the MCHP Epi program does in capacity building is really conducted by a group of people called the MCHP Epi Program assignees. This is a map of how our assignees were distributed currently and in the past. They're MCH epidemiologists for whom CDC provides partial support and they work to build capacity in their assigned state. I'm one of the newest assignees. See the border on the bottom of the map there, in dark green I think it is. And my focus will be to develop further capacity throughout the region.

Vivian Gabor: How will the border assignee, or you, build local capacity in the border region?

Jill McDonald: Well, the centerpiece of our capacity building efforts are these initiatives called Border MACH.

The goal of Border MACH is to develop local capacity to use Epi data to answer questions of important programmatic importance. And the first step was to establish a binational advisory committee which we've done. And we're now in the process of working with City MACH and our governmental partners in the states and also in Mexico Secretariat of Health to develop curriculum for sister city teams of MCH staff related to program staff, and we hope to assist these teams in developing the skills to use existing sources of data that they already have like vital statistic data, pool the data, standardize the data binationally, to the extent that's possible and we hope to be implementing that training in a series of workshops over the next two years.

But beyond Border MACH, we sketched out some long term goals to work toward in the region as well, and I've listed them here on this slide. They include more useful epidemiologic data at the community level, institutional and governmental collaboration, use of data by local public health staff to monitor similarities, differences, trends across and along the border. The development of

a regional MCH identity. And our ultimate goal is increased use of border data to develop and support successful MCH programs and policies throughout the region.

Vivian Gabor: Thanks, Jill, for that excellent presentation on data from the region that you've already collected in the pilot and your future plans for enhancing the capacity of data collection epidemiology on the border.

If our audience wants to contact you regarding the information you presented today or future publications, how can they contact you?

Jill McDonald: I have that on my next slide, thank you. I think it's all there.

Vivian Gabor: Okay. Thanks so much, Jill.

Jill McDonald: Thank you, Vivian.

Vivian Gabor: Now I'd like to turn to our second speaker, Brian Castrucci, from the Texas Department of State Health Services. Good afternoon, Brian.

Brian Castrucci: Good afternoon, Vivian. Thank you for inviting me to this presentation and to share some interesting data from Texas.

Vivian Gabor: Why don't we start your presentation, if we could, by asking you about infant mortality along the U.S./Mexico border. How does it compare to Texas and to the rest of the country?

Brian Castrucci: The U.S./Mexico border region has the lowest infant mortality rate than the United States, the whole and the state of Texas.

Within Texas, we see the same patterns. Here, we see fetal infant mortality rates by geography within Texas. Fetal infant mortality rates are like infant mortality rates except they also include fetal deaths. Like the previous slide, the border region has lower rates of fetal infant mortality, nearly 35% lower compared to urban areas of Texas.

Vivian Gabor: From a programmatic standpoint, what does this tell you, if anything, about how infant mortality should be addressed in the border regions?

Brian Castrucci: It really doesn't tell us much more than the rates are lower in the border region. To determine how to best intervene to lower these rates, we need to look at fetal infant mortality in a different way.

In Texas, we apply the perinatal periods of risk, or PPOR methodology, to the fetal infant mortality rates. PPOR uses fetal death records and link infant birth and death records to categorize these deaths into one of four cells based on weight at birth and age at death. Note that all deaths under 1500 grams are grouped into a cell labeled Maternal Health Prematurity regardless of age of death.

Each of these cells map onto specific points for intervention. For example, the maternal health prematurity cell relates to preconception care. While the infant health cell relates to infant safety and nutrition.

When you look at the PPOR maps in the three specific geographic regions really regardless of the geographic region the maternal health prematurity cell accounts for the majority of fetal infant mortality. This means that most fetal infant deaths weigh less than 1500 grams at birth and underscores the need for increased attention during the preconception period.

These are differences between these maps are found in the infant health cell which is associated with infant safety and nutrition. This may be a result of increased breast feeding prevalence on the border or decreased injuries. While there are differences, when you look at the distribution within each region, you find that the proportions are actually very similar.

In this slide I present the proportion that each PPOR cell is of the total fetal infant mortality rate within the three geographic regions. The distribution is relatively similar. This tells us that while fetal infant mortality rates are lower in the border region, all regions would benefit from interventions promoting preconception health, along with the border and urban and rural areas as well.

Vivian Gabor: How about child mortality? Does the border region of Texas have lower mortality for older children?

Brian Castrucci: Yes, this pattern continues into childhood and into early adulthood. Here, we have the mortality rates in border and nonborder counties for children ages one to 14 years. For these three selected causes of death and for all causes, the border has lower rates.

The disparities between border and nonborder mortality rates are much larger among 15 to 24 year olds. Among this age group, rates for accidents and all cause mortality are each nearly 30% higher in the nonborder area, while suicide and homicide rates in nonborder areas are almost double those of border areas.

Vivian Gabor: Earlier, Jill mentioned breast feeding data that were collected in the BMSCP project. Can you tell us why the breast feeding rate is so important in the border region and remind us what the project found?

Brian Castrucci: The Texas Mexico border has some of the poorest counties in either country. Given the poverty rates, low cost high impact interventions such as breast feeding are extremely important to reduce the burden on an already overburdened healthcare system.

Recent data from the Brownsville Matamoros sister city project, which Jill mentioned earlier, allowed us to compare rates of attempted breast feeding on the U.S./Mexico side of the border. The prevalence of attempted breastfeeding in Matamoros was 81.9 percent, compared to 62.7% in Cameron County, Texas. After adjusting for other factors, the odds of attempted breast feeding for women living in Matamoros were nearly double for those living in Cameron County. This difference is really indicative of the differences in the hospital level breast feeding policies of the two countries.

Vivian Gabor: Can you tell us more about what you know about how these policies differ on each side of the border?

Brian Castrucci: Sure. Unlike the U.S., Mexico has federal regulations that support breast feeding. Mexico's ministry of health clinical practice guidelines support breast feeding initiation

within the first two hours following delivery when conditions permit. Support breast feeding on infant demand and include standards for criteria and procedures that promote and protect exclusive breast feeding.

Another difference between the U.S. and Mexico is the practice of free hospital provided infant formula. Federal regulations in Mexico restrict the distribution of formula in the hospital, restricted distribution or promotion of breast milk substitutes for medical units, and restricted distribution of incentives to healthcare providers from the manufacturers of breast milk substitutes.

Vivian Gabor: What about within Texas? Do you have any data or information on how hospital breast feeding policy on the border compares with the rest of the states?

Brian Castrucci: As part of the WIC Infant Feeding Surveillance Study, which is conducted annually through Texas WIC clinics, and I think is one of the coolest surveillance systems that we've devised on very little money, we actually looked at five pro breast feeding hospital practices.

These were feeding within the first hour after delivery, receiving only breast milk while in the hospital, allowing mother and infant to be in the same room. Not using a pacifier. And providing mothers with breast feeding support numbers.

For all the pacifier use, a lower proportion of women in the border experienced these behaviors compared to women living outside the border. These percentages need to be increased statewide through all geographies. So we clearly need to do significant work to really limit the geographic disparities that we see here.

Another area for improvement in the border and throughout Texas is the proportion of breast feeding women who receive free infant formula from the hospital. More than 85% of breast feeding women in the border and more than 88% of breast feeding women in nonborder areas reported that they received infant formula. Interestingly, 52% of the women in the border region who did not breast feed and who received free formula indicated that they would have attempted to breast feed had they not received this free formula.

Vivian Gabor: Brian, there's significant discussion, moving to a slightly different topic, of the Mexican Paradox. That is, a paradox of differences in health between people living in Mexico and the other side of the border. Are there any data from Texas that can add to that discussion?

Brian Castrucci: Yes. Actually I really appreciate the opportunity to share some analyses that we've conducted to more deeply explore the Mexican Paradox. While newly arrived immigrants often experience low socioeconomic status, lack of education and insurance, inadequate prenatal care and younger maternal age they tend to have better birth outcomes than more cultured counterparts, this phenomenon known as the Mexican Paradox.

The traditional Mexican culture actually acts as protection for newly immigrated women. When they abandon their traditions and become more culterated to the U.S. lifestyle, they tend to inherent some of our culture's worst habits. We wanted to explore this phenomenon in the Texas Mexico border region. This region shares similar cultural influences from both the U.S. and Mexico and, therefore, it experiences less of the trappings of the U.S. lifestyle and allows for continued adherence to more traditional Mexican practices.

In our investigation, we looked at three outcomes: Low birth weight, preterm delivery and prenatal care. First, we looked within the border region comparing U.S. born Hispanic women and Mexican born Hispanic women. Then we looked within the Mexican born Hispanic women and compared rates between geographic region. And I really think we have some interesting results to share.

Within the border region, Mexican born Hispanic women had better birth outcomes and U.S. born Hispanic women. This occurred despite the fact that the Mexican born Hispanic women had significantly lower rates of prenatal care utilization. This demonstrates that the Mexican Paradox can be found along the Texas Mexico border.

While Mexican born Hispanic women had better birth outcomes than U.S. born Hispanic women in the border region, we found that among Mexican born Hispanic women, those living in the border region had the worst outcome compared to Mexican born Hispanic women living in urban and rural areas. It's important to note that prenatal care utilization among the Mexican born Hispanic women in the urban and rural areas were significantly higher than in the border region.

This suggests that while Mexican Paradox may exist, it doesn't necessarily mean that there's not potential for even further improvement in birth outcome. These data also suggest that the Mexican Paradox may have a stronger influence outside of the border area. Further research is needed to explore these nuances among Hispanic women in different Hispanic subgroups.

Vivian Gabor: Do you have any other information on MCH data in border states like Texas that you'd like to share with our audience?

Brian Castrucci: I actually do. While we primarily focused today on the border, I just briefly want to broaden our perspective to that of the border state. Myself growing up in Massachusetts and then working mostly in Philadelphia and New Jersey, working in a border state has some interesting nuances.

Based on the 2000 Census, there are four states in which Hispanic people account for 25% or more of the population: Texas, California, Arizona and New Mexico. Between California and Texas alone, there are 20 million Hispanic people. And this has a significant impact on the interpretation of data for Texas.

So let's take, for example, adolescent birth. While you would never report an unadjusted mortality rate, adolescent birth rates are not routinely adjusted. But maybe they should be. In each and every state in the United States Hispanic adolescents have the highest birth rates. However, the impact of Hispanic adolescents on a statewide rate is dependent on the size of population.

Let's take, for example, Texas, Georgia and Delaware. In aggregate rankings, both states, Georgia and Delaware, have lower adolescent birth rates and better ranking. However, as these data demonstrate, birth rates among Hispanic females in Georgia and Delaware are significantly higher than Texas. However, in both Georgia and Delaware, these rates are applied to a relatively small population compared to Texas.

When adolescent birth rates are stratified by race ethnicity and ranked within the strata a very different picture appears. The need to recognize the role of population dynamics and shaping public health indicators is increased when projected population trends are considered.

Population projections estimate that by 2020 Hispanic adolescent females will account for more than 50% of the 15 to 19 year old female population up from 38% in 2004. This is really one of the interesting epidemiological aspects of working in a border state and a contributor to why Texas is, why it's important to consider these kind of racial and ethnic differences when interpreting Texas data.

This really started to come up when we looked at, again, routinely Texas has one of the highest adolescent birth rates, if not the highest adolescent birth rate, in the country. But Florida probably has the highest mortality rate if it's unadjusted. And this is just something that we need to think about and look at so that when people are comparing states we actually can talk a little more from an informed perspective around how our population dynamics, not necessarily our rates, are really driving some of the rankings that we see.

Vivian Gabor: Thank you, Brian. Thank you so much for your presentation. Interesting information. If anyone in our audience would like to contact you in follow up to your presentation, how may they do so?

Brian Castrucci: This slide has all my contact information. The Texas Department of State Health Services. Vivian can attest, it's really easy to get ahold of me. I welcome anyone to contact me should they have any questions or comments.

Vivian Gabor: Thank you, Brian. Thank you, too, Jill, for all the valuable information that you've provided today. I'd like to remind our audience, again, that there are a variety of resources that our presenters have compiled and will be compiling to put up on our Web site related to this DataSpeak program. It will be on the resource page of the DataSpeak Web site.

Now if you'll see on the screen we're in the question and answer portion of our program. And we are fortunate that both of our presenters were able to remain with us on the line to answer your question.

OPERATOR: (Caller instructions).

Vivian Gabor: While we're waiting for any phone questions to come in, I just wanted to let you know, as you see on the screen, you can also ask a question online. Simply enter your question in the field at the bottom of the box that's called questions and hit enter. While we're waiting for the calls online, we have one question that came in through email, a few questions that came in through email. And Alison Gary can start those questions.

Alison Gary: Our first question is to Brian. What is the source of information comparing the data, comparing the PNC LBW, et cetera, between the border data with urban and rural data?

Brian Castrucci: That's going to be Texas birth record data. We're using the basic kind of La Paz 32 county definition. I mean, there are several definitions of border. The 32 county which actually goes not for the counties that actually just touch Mexico but kind of one or two rows back, is the accepted HRSA definition.

So it's all birth record data.

Alison Gary: We have another question from the same person. Are the rural and urban definitions given within the BMSCP or the figures, are they Texas and Tamulipas data.

Brian Castrucci: The data that I shared around the low birth weight and preterm delivery and prenatal care, that's actually all of Texas. And those definitions are just the standard kind of micro metropolitan areas. And then border. Border is actually not exclusive. You have both rural and urban areas within the border. But the grouping is all of the border counties compared to then all nonborder urban counties and all nonborder rural counties. So that's all Texas data.

Alison Gary: Great. I have another question. Have either of the speakers found differences between legal immigrants and undocumented immigrants?

Jill McDonald: Well, I'll answer with respect to BMSCP. We did not look at that. We did not. That was a sensitive area. We did ask people where they resided and we know which side of the border they gave birth. So there is some cross border activity with respect to that. But we did not... we really did not try to get a self report on that. I think that's something that everybody's interested in, of course, but I think it's going to require maybe a little more thought how we should best go about that.

Brian Castrucci: It's right now like the great unmeasured variable. We all want to know it. But I know with our Texas birth data, the closest we're going to get is going to be foreign born/not foreign born. And foreign born explains a lot of the variance in a lot of our outcomes. But with our programmatic data, often program isn't asking that question. Either they're not allowed by federal funders or they've chosen not to ask that question because it can be a barrier for people accessing service, and we also don't want to create barriers to people accessing the necessary health and welfare services that we offer in the state. However, it is clear we are desperate to know what the answer is.

Vivian Gabor: Operator, any questions that have come in from the phone line? (Caller instructions)

Vivian Gabor: We'll go on with the ones that have come in online.

Alison Gary: What is the role of public health officials from Mexico in increasing surveillance capacity on the border?

Jill McDonald: Let me try, I'll to answer that. The role... well, they have national surveys that are conducted periodically, and also, at least recently, those surveys tend to also collect data that are representative of the state. So they have a survey, for example, very much like the NHIS survey here in this country but they wind up with data that are representative of the country as a whole as well as the states.

As far as the border region itself, that's really the motivation behind BMSCP. There is very little survey activity designed to represent the border on either side, the Mexico side or the U.S. side.

Vivian Gabor: Operator, any questions on the phone?

Operator: We have a question from the line of Paul Julian with New Mexico Department of Health.

Paul Julian: I just want to go back to the discussion on the qualifier that we're hesitant or don't use which is resident status, and I want to hear from the panel what they think the reasons are why we do not try to capture this field.

Jill McDonald: It sounds like Brian tried to start to answer that. I guess that would be great to hear your thoughts on that, too, Paul. I can tell you for BMSCP; it was a decision that was made because the question is so sensitive, because we didn't know yet how to ask it and what kind of an influence that would have on the answers we got, depending on how we asked it. There have been so little work done on it, and that the main purpose of our work was just to see if we could develop a methodology that worked and reach a representative sample of the population. So because that was not the primary priority for us, we did not work with that question. Not that we weren't interested. But it just wasn't a priority and there wasn't a good path cleared for that.

Paul Julian: This goes back to the difficulty in the border region, we have people moving back and forth across the border and they may give false addresses. Like one thing we touched on was whether or not this was real information you would give back to fill in those fields. And the other challenge is, is that we get a number of people coming over from Mexico to access services in the border region. And they might give an address that is within the U.S. but it's just an address they threw out there and then they access their service and go back across the border so we end up with some skewed data.

And I suppose in many ways it's a question of framing this question in terms of the overall immigration reform and whether or not this would compromise a person's situation in terms of being here illegally. But I think it is an important thing to know because it would help us do a much better job on planning and targeting ever diminishing public health resources.

Brian Castrucci: I agree. From a public health department standpoint we want to make sure that people are using our services. And any question that despite its epidemiological importance, and trust me, I want that variable more than anybody just to kind of include in all of our grants and our population dynamics, but I think our biggest concern is always are we creating more barriers to service. And if we actually get someone to access what appears to be a government funded service in the U.S. who maybe isn't here legally, I think asking them their residency status just may create a barrier.

Paul Julian: Okay. Thank you.

Vivian Gabor: Operator, any other questions that may have come in on the phone?

(Caller instructions)

Vivian Gabor: We do have a few more that have come in online. Alison.

Alison Gary: What do we know about prenatal HIV screening and perinatal HIV resources in the U.S./Mexico border region?

Brian Castrucci: I think Jill talked about that a bit when she presented the work of Dr. Ginger Gossman. And Dr. Gossman actually works here at the Department of State Health Services and conducted that analysis. Jill, do you want to talk a little bit about that?

Jill McDonald: I guess I'm just kind of wondering where to start here, what the real... I don't totally understand the intent of the question. I mean it is U.S., it is policy on the U.S. side to offer the test prenatally. It wasn't at the time that the survey was conducted, the same policy did not exist on the Mexican side. Although that's changed now.

The data show that virtually all of the women who were in the sample in Cameron County had received a test during pregnancy showing that the policy is working. I know that Ginger Gossman and her colleagues were also looking at the few women who did not receive the test. I think there were very few and I'm not sure they were able to draw any conclusions about those women. I'm not sure if that's...

Brian Castrucci: On September 15th these data from the Brownsville Matamoros sister city project will be published in Preventing Chronic Disease. The nice thing about Preventing Chronic Disease, is while it's Med Lined and Pub Meded and all that kind of stuff, it's an open access journal. So these articles are going to be available to everybody online. And, if anything, these articles are a testament to the impact of policy on health. Really some of the only differences between the two sides of the border, after adjusting away all the other kind of measurable variables, is the policy of the countries.

Now, I think that's true in the pap paper, the pap smear paper I had written, and the breast feeding paper and even the HIV paper. Ultimately, I think the Brownsville Matamoros sister city project is supposed to be a baseline, a pilot. We hope we can repeat these kind data collections to now see kind of before after the policy change, how is that changed HIV testing during pregnancy in Matamoros.

And, ideally, you expand this kind of data collection to the 14 pairs of sister cities throughout the entire border region and you really have a comprehensive and interesting surveillance system that we can use not only for point in time estimates but changes over time as well.

Jill McDonald: Just picking up a second there on Brian's response. I'm not sure exactly what the intent of that question on HIV prenatal testing was. But I wanted to emphasize that not only will the data, not only will the publications be available in Preventing Chronic Disease. But at that same time the data are going to become available for public use. And it would be fantastic if others involved in this web conference and stakeholders on the border actually think about other important questions that they could analyze with the data. I think that would be a fantastic thing to have developed.

And I think it would all work towards this result that Brian's talking about, that to the extent that the data are useful locally, I think that makes a stronger case for trying to expand this kind of data collection throughout the region.

Alison Gary: I was surprised with such the low use of tobacco with the data along the border. Can you provide information about the age distribution since it was a 14 to 24 range, which is quite large. Can you address the tobacco issue and what you think, why you think that it is really low?

Jill McDonald: That's a great question and kind of a big one. The data... one of the reasons we combine... I'm involved in that analysis so I'm speaking in the first person. We combined the 14 to 24 age group because the numbers were small. We did not oversample adolescents in the BMSCP. Again, I think that could be done in the future, but that wasn't the primary result we

were after there. So the numbers are small. So the age distribution is... the women in Matamoros are somewhat younger. I can't tell you to what extent that contributes to the fact that the results are almost identical.

We were surprised also because that level of smoking is lower than you'd expect from like what we see in Texas PRAMS, or PRAMS among U.S. Hispanics. And even some of the data that's available at the state level in Mexico, which is not exactly the same measure. It's ever smoking, whereas what you saw there in that table, it was essentially current smoking, smoking in the three months before pregnancy.

So there's no direct comparison. But there is the sense that it may be lower than what we see on either side of the border just a little bit further removed. So I can't... it doesn't fit nicely into the aculturation theories as far as I can see and the Hispanic paradox that Brian talked about. It's not a nice, neat fit. But it does, it certainly suggests some kind of cultural factors that I don't think we understand very well.

OPERATOR: We have a question on the phone line from the line of Amethyst Craig with County of San Diego Health. Amethyst Craig, your line is open for the question. Perhaps they're on mute but we have another question from the line of Adrianna Perez from the University of Louisville.

Adrianna Perez: Hi Brian and Jill, I have a question again about the comparison between the BMSCP data and the Texas data. I just wanted to make sure I understand the comparison, and the BMSCP data that it was presented in the slides included only the portion of Cameron. And then it's comparable with the Texas area and the border area or was the BMSCP data compared, which it has Matamoros and Cameron compared with entire Texas excluding the Cameron County.

Brian Castrucci: The data from the Brownsville Matamoros sister city project just compare Matamoros and originally was supposed to be Brownsville but expanded to all of Cameron County. It's really binational opportunity to compare data between the two countries along the border region. I think a lot of what you see in the literature talks about the Texas border. But we rarely have the opportunity to look at comparisons with the other country. The other data that I presented was purely from our Texas birth record and just the Texas data throughout the entire Texas Mexico border rural and urban areas just within Texas.

Jill McDonald: One thing this may be related that I could comment on. Brian, you mentioned the 32 counties and I also gave a definition of the border. Those two definitions are consistent. The La Paz agreement between Mexico and the U.S. in 1983 didn't name counties and municipalities. It just talked about the 100 kilometer stretch north and south. And then people were left with the question of, well, what happens if only a little piece of the county touches and all these other questions. And I think it was through the U.S./Mexico Border Health Commission and other organizations that this definition of 44 counties, 32 of which are in Texas and the 80 municipalities, came into being.

So I don't know if that was part of your question, Adrianna.

Adrianna Perez: No, my main question was I understand that the records from Texas then includes Cameron County records?

Brian Castrucci: They do include Cameron County records.

Adrianna Perez: So there is no clear comparison in the point that this excludes some of the records from that in order to compare really there is a Texas versus Cameron alone. So that was like my thinking process, but I understand what you did now. Thank you very much.

Vivian Gabor: Thank you, everyone. I know there are more questions. There was one more that came online. That is all the time we have for discussion today. If you can think of more questions, though, certainly please submit them to us via email through the end of this week using the email address that's up on the screen mchric@altarum.org. And we'll respond to your question as soon as we can get them to the presenters to respond to you. This program archive with Jill and Brian's presentations as well as you'll hear soon about Sam Notzon, will be available on the DataSpeak Web site in the next few weeks so you can access it at your convenience.

On your screen now is a link to Dr. Sam Notzon's recorded multimedia presentation. This includes data from a draft chapter he has produced for the U.S./Mexico Border Health Commission. You can simply click on the link and his presentation will open up in a new browser window.

And, finally, we remind you before you log out at the end we'd greatly appreciate you taking a moment to provide us with feedback on today's program. You can do so by clicking on the program evaluation link that's on the screen now. The short survey will also open up in the new window.

We'll give you another chance to, if you don't have a chance right now to do that survey, we'll send it to you in the next couple of days. We'll be broadcasting more DataSpeak programs in the coming months as well. Our next program on schedule is for September on surveillance of children's body mass index.

Announcements for that program and future DataSpeak programs will be sent out via email. Or you can periodically check the DataSpeak Web site at www.mchb.hrsa.gov/mchirc/dataspeak. The program for today is now adjourned.