I recently gave a presentation to an Introduction to Gender and Minority Studies class at Louisiana State University. This was an interesting experience, as most of my talks tend to lean on the technical aspects (meaning GIS) of how to solve the problem of racial disparity in birth outcomes in the city. This audience was nontechnical and more interested in the injustices facing the poor (and more often than not African Americans) in the city. I would not have been comfortable giving this talk a couple of years previously, but 4 years of being attached to the Baton Rouge Healthy Start, writing continual updates and reports, applying for new grants, and attending all the associated meetings (e.g., evaluation meetings, project area committee meetings, Fetal and Infant Mortality Review (FIMR) meetings) have given me a reasonable insight into the causes of the problems as well as the distribution of dots on a map.

One point I discussed caused a certain degree of consternation, as it usually does, but with an unexpected and satisfying outcome. I outlined the commonly considered risks associated with pregnancy, one of which is receiving the first prenatal visit in the second trimester. I explained that this “risk” was partly due to the way the local medical system treated women in poverty. If a woman realizes she is pregnant, and many clinics will want a woman to wait 2 weeks after her missed menstruation for pregnancy verification, probably 6 weeks have passed. At this point she can apply for presumptive eligibility for Medicaid, and
she will receive her temporary card 2 weeks later. Unfortunately, the full Medicaid card will not arrive for 4 weeks after application. Many doctors and providers in Baton Rouge (at time of writing) will not schedule a prenatal visit until this card has arrived. It often takes 4 weeks of waiting time until a free appointment can be found. Therefore, \(6 + 4 + 4 = \) second trimester. Solutions to this problem are being sought, including the electronic automation of Medicaid distribution which, it is hoped, will reduce 4 weeks to a matter of days. *Hopefully this situation will no longer exist by the time this book rolls off the press.*

What made this lecture interesting was when an African American student talked to me afterwards and explained I had just described her situation, and she had as of yet not received a prenatal visit. I gave her the contact information for the Baton Rouge Healthy Start and told her to go and introduce herself. I also asked about her transport situation (which is a huge deterrent for many women). Maybe I am making more of this than I should, but academics, and especially geography academics, are not used to intersecting so dramatically with the real world. It was a nice feeling.

This is an argument I have championed for a long time. At the 2001 meeting of the Association of American Geographers I presented the beginning stages of the Baton Rouge Healthy Start GIS in a session, organized by Dr. Charles Croner from the Centers for Disease Control and Prevention (CDC). This session included several other impressive names from the world of GIS, spatial analysis, and health: Gerrard Rushton, Susan and Grant Thrall, Art Getis, and Peter Rogerson. A major point of my presentation was that the GIS analysis of health data had to have tangible outcomes, the results of which could be applied in the field.

As mentioned in Chapter V, there has been a long-standing debate in academic geography about the sanctity of theoretical research as compared to applied geography, as well as whether GIS is a science or not (Pickles, 1997; Wright, Goodchild, & Proctor, 1997). Again, this book is not the forum to address the issue. We will simply except that geography and GIS have been an integral part of the creation and continuation of the Baton Rouge Healthy Start.

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**Beginnings**

I was in my first year at LSU (early 2000) when a world-renowned epidemiologist asked me to join him at a CityMatCH meeting. CityMatCH is an organization of city and county Maternal Child Health (MCH) programs, the mission of which is to “improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities” (CityMatCH, 2004).