Undoing Institutional Racism: Defining Terms; Moving Forward

Improvements in the overall health and well-being of urban women, children and families will not be fully achievable without a sustained organizational and personal commitment to undoing racism in all its manifestations. Several years ago, in response to research suggesting that racism and discrimination negatively impact health in at least three critical areas: health status, access to health care and quality of health services, CityMatCH embarked on a journey to build member knowledge and capacity in this area. (See page four)

In 2005, the Board of Directors established an Undoing Racism (UR) workgroup to develop effective and appropriate strategies to address racism. Since members understandably brought overlapping and sometimes conflicting perceptions of racism, a key step in the process has been assuring that relevant definitions used by CityMatCH are explicit and unambiguous.

Said Zenobia Harris, UR Workgroup Co-chair, “In order to identify racism when we see or feel it, to perceive its manifestations, to address, overcome and finally conquer it, we must first know what it is. We need to know how racism functions in our work and our world and to understand the complex effects racism has on day-to-day life.”

To achieve common understanding, the workgroup reviewed and amended existing definitions, drafted and discussed “new” ones and worked with the Board of Directors to achieve consensus.

The CityMatCH Undoing Racism workgroup now offers the following common terms for our readers. They will provide a framework as you read through this issue of CityLights and can be used more broadly as a tool for understanding racism’s effect in your jurisdictions:

1. Race: is a social rather than a biological construct, based on geography, ethnicity and ancestry; a specious classification of human beings created to assign worth and social status using white as the model of humanity for the purposes of establishing and maintaining privilege and power.

2. Prejudice: A negative or hostile attitude toward a person or group without relevant experience or knowledge and often based on negative stereotypes; a predisposition to take an intellectual position relative to a given phenomenon irrespective of the nature or amount of relevant objective information. In practice, prejudice is the result of “prejudgment” and can lead to discrimination, as this attitude denies a person’s individuality.

3. Racism = Race prejudice plus power.

4. Racism and discrimination are social constructs of attitudes, beliefs, behaviors and practices. Racism is maintained by not understanding white privilege and internalized racial superiority. Discrimination is the differential and/or unfair treatment of individuals on the basis of race and is the most commonly understood and accepted manifestation of racism.

Camara Jones* further expanded the concept of racism into a three-level framework, which CityMatCH supports:

• Internalized racism: acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth;

• Personally-mediated racism: prejudice and discrimination by individuals towards others; and,

• Institutional racism: differential access to the goods, services, and opportunities of society by race.

The People’s Institute for Survival & Beyond* definition added a fourth level:

• Cultural racism: that which determines what personal/group qualities and characteristics are valued and devalued.

* See page eight for source material.
Unraveling our Challenge: Undoing Racism
by Vicki Alexander, MD, MPH, Co-Chair, CityMatCH Undoing Racism Workgroup

Understanding the historical context of racism helps us to desire, navigate and achieve change; it may help us get unstuck. Earlier this year, CityMatCH Board and staff participated in a training facilitated by the People’s Institute for Survival and Beyond. (See http://www.pisab.org/) The result? A renewed commitment to educate, train and build the capacity of members to undo institutional racism. The recognition that undoing institutional racism is essential if we are to address entrenched health inequities. A better understanding of history, white privilege, and how racism creates stress that can contribute to a negative biological cascade.

As a white person, I realized I had been taught about racism as something which puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage.

— Peggy McIntosh, 1988
Reducing Racial Disparities in Birth Outcomes: An Overview of Research
by Carol Gilbert, M.S., CityMatCH Health Data Analyst

The 2002 increase in the U.S. infant mortality rate signaled that the nation’s previously decreasing infant mortality rate had reached a plateau. The 2003 rate was 6.9, the same as the 2001 rate. However, even while the mortality rate was decreasing, the disparity in black-white rates remained constant. In particular, the infant mortality rate among African Americans is consistently two to three times that for whites. One of the Healthy People 2010 Goals is to eliminate health disparities, specifically including the racial disparity in infant mortality. If the 2003 black infant mortality rate (14.0) had been reduced to that of the white population (.57), nearly 5,000 deaths would have been avoided.

Researchers suggest that the persistence of racial disparities in infant mortality despite decreases in absolute infant mortality, implies a separate set of factors is affecting African American infant mortality in addition to those that affect all infants. Racial disparities arise due to differences in prevalence of risk factors (exposure) and differences in the effect of exposure to the risk factor. Evidence suggests that causes are complex and many risk factors must be addressed. Interactions between two or more factors (effect modification) may also help explain disparities. For example, smoking may have a greater effect on pregnancy outcomes among African American women.

The following paragraphs offer a review of selected past and current scientific efforts to identify the causes of racial disparities in birth outcomes. Differences in socioeconomic status (SES) are hypothesized to be a major cause of racial health disparities, but studies that control for SES have still found racial disparities. Some have even found that high SES African-American babies may have higher infant mortality than low SES Caucasian babies. Access to care has also been investigated as a possible explanation for racial disparities in birth outcomes, but disparities have been shown to persist despite access to a high level of infant perinatal care. Studies have also found that premature mortality rates remain high when prenatal care is provided, and since much of the racial disparity in mortality can be attributed to prematurity and low birthweight, the potential effect of prenatal care on racial disparities is limited. Research and practice are beginning to focus on preventing early births by addressing maternal health prior to conception — including access to quality health care for women who are not pregnant.

Recently, researchers have been investigating effects of stress and infection during pregnancy. These show some promise as factors that may explain racial disparities. In particular, some researchers have been studying the effect of the mothers’ experience of racism on birth outcomes. Researchers are beginning to study intergenerational effects. Since the experiences of the mother as a fetus can affect the development of her reproductive organs, factors affecting the health of a grandmother before her daughter’s birth can influence the survival of her grandchildren. Researchers are beginning to study intergenerational effects, finding that experiences of the mother as a fetus can affect her reproductive capability as an adult. This means that socioeconomic status of grandparents at the time of their daughter’s birth may affect the survival of their grandchildren. For this and other reasons, some researchers conceptualize preterm birth as a “common, complex disorder” similar to cardiovascular disease, which results from a complex interaction of inherited, environmental and behavioral factors.

Though factors affecting poor birth outcomes among African Americans are still being discovered, studied and debated, the practicing community of public health workers, medical providers, and policymakers must continue to develop interventions to improve birth outcomes. Paula Braveman recommends that the public health community engage in “bold experiments with plausible interventions.” Science has found effective strategies to address other complex common disorders, and similar multi-faceted strategies are likely to prove necessary in the fight against racial disparities in birth outcomes.

Endnotes:
3 Wise PH. The anatomy of a disparity in infant mortality. Annual Review of Public Health, 2003 24:341-62 (Figure 2, page 349)
7 RashVA, Andrews HF, Garfinkel RB. The contribution of maternal age to racial disparity in birthweight: a multilevel perspective. AJPHE November 2001, Vol 91, No. 11 | 1815-1824
14 Lu MC, Haffo N. Racial and ethnic disparities in birth outcomes: a life-course perspective. MCHJ Vol 7 No.1, March 2003
17 http://www.mchb.hrsa.gov/mchirc/data-speak/events/may_06/materials/Braveman.ppt, closing slide

CityMatCH is committed to reducing/eliminating disparities in infant mortality. For more information, see CityLights, “Seeing It Through: Preventing Fetal and Infant Deaths,” Volume 14, No. 3-4, Winter 2005-Spring 2006, available on the web at citymatch.org.
Health effects related to the impact of racism are increasingly documented in scientific literature. Several years ago, in response to member input, the CityMatCH Board identified elimination of health disparities as a strategic priority. The quest to translate data into action around this complex socio-political issue led CityMatCH to launch efforts to address health disparities and to “undo racism.”

In 2000, CityMatCH partnered with NACCHO to query the largest 200 cities and metropolitan areas in the U.S. on several MCH issues, targeting specific questions about racial and ethnic disparities in health. An overwhelming majority responded that reducing disparities was of high priority, but just 39 percent reported adequate preparation to address them. Fewer still were addressing social and institutional issues related to housing and poverty.

CityMatCH members asked for assistance with developing efforts to “undo” racism and reducing its effects upon the health of the populations they serve.

In September 2002, the CityMatCH conference featured the ground-breaking Boston Public Health Commission’s strategies to undo institutional racism. Capacity-building articles in CityLights quickly followed, adding to the knowledge base.

Members urged the Board to convene taskforce: a group of selected Board members, staff, and representatives from partner organizations and funders to develop a blueprint of proposed action. During the 2003 conference, this group looked at ways to build member capacity to address institutional racism. With generous support of the W.K. Kellogg Foundation, a rapid membership query was conducted in January 2004, and responses were analyzed regarding perceptions of racism at work within local institutions.

“Undoing Racism in Public Health: A Blueprint for Action in Urban MCH,” was published and disseminated in late 2004, leveraging information acquired in the survey with a literature review and a proposed plan. CityMatCH responded quickly to this Blueprint by developing conference plenaries, workshops and skills-building sessions, by publishing capacity-building articles in CityLights and by providing dedicated topical space in the electronic newsletter, NewsBriefs. (See www.citymatch.org)

In the Summer of 2005, the Blueprint plan gathered momentum when a subset of the Board formed the Undoing Racism workgroup (See page one) to provide leadership and oversight for CityMatCH.

Modeling institutional and personal change, Board and staff have participated in trainings by the National Coalition Building Institute, and the Center for Human Diversity at the University of Nebraska Medical Center. Board and staff gathered for a weekend-long intensive training experience facilitated by the People’s Institute for Survival and Beyond in February 2006. Walking through this training together assured the development of a shared knowledge base regarding the historical context of white privilege, the impact of racism on everyday life in the United States, and the need for community empowerment and engagement to create lasting change.

Sustained engagement of the Board and staff is required for next steps, as is securing additional funding for member training collaboratives and capacity-building tools. Undoing racism is of utmost importance to the membership; CityMatCH is steadfast in assuring opportunities for good health and health outcomes are equally available to all.

For more information, contact: Mark Law, M.S, Coordinator, Membership Services, by phone at: 402-561-7500 or via E-Mail at: mlaw@unmc.edu

AMCHP Explores Infant Mortality and Perinatal Disparities

CityMatCH and the Association of Maternal and Child Health Programs (AMCHP) share a long history of successful collaborations and partnership. Though our memberships represent different levels -- local and state -- of policy and practice, disparities in health and infant mortality are areas of common concern. In 2004, AMCHP launched the State Infant Mortality (SIM) Initiative with the Centers for Disease Control and Prevention and support from the March of Dimes. The initiative helps state public health agencies address their increasing, stagnant or high infant mortality rates. Teams from Delaware, Hawaii, Missouri, North Carolina and Louisiana have explored solutions to this problem with national experts, such as Greg Alexander from the University of Alabama-Birmingham School of Public Health, Michael Lu from the University of California, Los Angeles School of Public Health and William Sappenfield from the Florida Department of Health.

In November 2005, AMCHP conducted a survey of the state teams to determine their progress, challenges and next steps to combat rising infant mortality rates. Eight-nine percent of the teams rated their impact on the state’s strategy to reduce infant mortality rates as medium to high. The survey also collected information on state achievements in reducing infant deaths. Among their varied accomplishments, states created an infant mortality taskforce, successfully established new positions for MCH epidemiology, provided input into their governor’s infant mortality reduction plan, and collected and analyzed new data.

The SIM Initiative is currently designing a toolkit to help state public health agencies. At the 2006 AMCHP Annual Conference, Justine Desmarais, AMCHP Women’s Health Program Director, William Sappenfield, Loretta Fuddy, Chief of Family Health Services in Hawaii, and Linda Sanders, Section Administrator for Healthy Families and Youth in Missouri, presented an overview of the toolkit and lessons learned by SIM Initiative participants. A webinar of that session, "Investigating Troubling Trends: The State Infant Mortality Initiative," is available online (see below).

For additional information, we offer the following selected resources highlighting AMCHP state-level activities to address perinatal disparities:

- The SIM Website (www.amchp.org/simi/)
Taking it On: Undoing Institutional Racism in Seattle-King County

Kathy Carson, CityMatCH Board of Directors and Administrator for Parent-Child Health Public Health — Seattle and King County (WA), recently shared her perspective on efforts to address institutional racism in public health in her community. Highlights of her comments follow.

For the past several years, Seattle has been actively learning about undoing institutional racism. Efforts were initiated within the city’s Human Services Department, (See inset boxes) thanks to the vision and persuasiveness of a dynamic African-American woman employed in that department. The People’s Institute for Survival and Beyond* was brought in to train public employees and people in the community, and over time local trainers were developed and the People’s Institute Northwest was formed.

Public Health — Seattle and King County became involved in this process initially after several public health staff participated in a training experience. Their experience stimulated and encouraged a greater response. Carson described the evolution of her personal experience in the process this way, "I had an opportunity to attend a CDC meeting on race and preterm delivery, which put all the pieces together for me about chronic stress of racism and poverty being the root cause of virtually all risk factors for poor birth outcomes and disparities across the lifespan.” They reviewed Seattle’s Perinatal Periods of Risk analysis in conjunction with this new information about chronic stress and submitted it to the Infant Mortality Prevention Network of community outreach agencies. In turn, this Network joined with public health staff to take the information to dialogue groups in the African-American and Native American communities.

Within public health, Seattle has been working on multiple fronts one of those is education and training. The health department is actively working to train more people, particularly those in management and leadership positions. Key members of the Diversity Management Committee have participated fully in Undoing Institutional Racism (UIR) training. They recognized that this training is much different than training in cultural competence.

With the full support of the committee, multiple sites have sponsored viewings of Camara Jones, “The Gardener’s Tale,” and the PBS special on race. Many employees have received UIR training.

What has been the result of all of this effort? Notable direct impacts have been an increased ability to say and to confront the ‘r’ word and to actively participate in discussions about how racism impacts the workplace and public health services clients. Information about the impact of the chronic stress of racism and poverty on health outcomes has been shared with staff across multiple programs. Carson reports that, "reinforcing the message and amending practices by incorporating stress reduction techniques and additional supports into every client interaction is an ongoing course of action.”

Internal policies will need to be examined, especially in contracting and human resources. As part of a county system, they hope to join with UIR groups in other county departments to consider these issues and to examine their own practices.

Funding is a real concern for any public health activity. This training has been accomplished by using funding allocated by the department to the Diversity Management Committee and joining it with other training dollars that were budgeted in sites and programs. As can be typical, a primary obstacle has been persuading senior management to devote precious time for personal training. Helping the Diversity Management Committee to recognize key differences between UIR and cultural competence training was another stumbling block. For some, it was hard to accept that training experiences must go much deeper than cultural competence.

A major learning from UIR has been the power analysis, taught by the People’s Institute. At this point, the Seattle King County Department of Public Health has many people trained in this technique, however translating that understanding into action has been an elusive goal. Several questions remain, “What policies should we look at that make us ‘a foot of oppression’ in our community? What is our vision of an anti-racist organization?” Another key lesson learned is coming to an honest understanding of how public health can function as one of the ‘feet of oppression’ a term used by the People’s Institute to describe systems and organizations that can hold people back.

Carson said, “We want to figure out how to change that power relationship by involving our clients and the community in decisions that affect them, but we have a long way to go in that effort.”

Though the work is admittedly just beginning, Seattle’s experience may serve as a catalyst for other urban health departments beginning the serious work of undoing institutional racism.

For more information about efforts in Seattle, please contact:
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Fax: 206-296-4679
E-Mail: kathy.carson@metrokc.gov

* For more information regarding the People’s Institute, please contact: The People’s Institute for Survival & Beyond, New Orleans (LA)
Phone: 504-527-5193
Fax: 504-528-7125
Web site: http://www.pisab.org/

City of Seattle Human Services Department’s UIR Principles
Racism is unacceptable in any form. The City of Seattle Human Services Department (HSD) will strive to develop and utilize anti-racist policies and procedures. To undo racism, these guiding principles must be followed by all staff. To help guide us, we have formulated the following Principles:

1) Accountability to and among community, program participants, contractors consultants, service providers, and businesses), and department staff.
2) Community Leadership in all program development, implementation and evaluation, and in setting department policy.
3) Support for community organizing efforts.
4) HSD management will provide information to and involve staff and advisory groups such as the Undoing Institutionalized Racism group in policy development and decision-making processes.
5) Ongoing analysis of HSD practices (planning, implementation and maintenance) regarding undoing systemic racism efforts within all department programs.
6) Cross-divisional networking and resource sharing to better support communities.

Source: http://www.ci.seattle.wa.us/humanservices/UIR/default.htm

What is "UIR"?
UIR is a multi-racial group that seeks to undo racism by identifying and addressing institutional practices and policies which afford privilege to whites over people of color. We are government employees tackling racism in our own institution. Our work together requires an open analysis of practices, personnel, policy, program, planning and implementation within our institutions to illuminate and eliminate systemic racism. Source: see above box.
Addressing Disparities in Premature Birth in the Wake of the 2005 Gulf Coast Hurricanes

Ligia Ayala, MSW, LCSW, Associate Director of Program Services, March of Dimes Louisiana Chapter

In the United States, prematurity is the leading cause of neonatal mortality and second leading cause of infant mortality. In Louisiana, the preterm rate in 2002 was 15.1%; higher than the national average of 12.1%. For African American mothers in New Orleans, the rate was 21.8%. That same year in Louisiana, 1 in 28 infants was born to a woman receiving late or no prenatal care. African American mothers had the highest rates of late or no prenatal care.

On August 29, 2005, Hurricane Katrina devastated the Gulf Coast. The days that followed would reveal Katrina as the most severe natural disaster to impact an entire metropolitan area. Twenty-five days later, Louisiana was hit with the ferocity of Hurricane Rita. In the wake of these hurricanes, already grave statistics on preterm birth in Louisiana are expected to worsen, due to reduced access to prenatal care and increased stress levels for pregnant mothers and families.

The immediate needs of pregnant women and infants were the initial focus of the March of Dimes (MOD) hurricane response. Traditional disaster relief organizations quickly mobilized to assist the most impacted, but the particular needs of pregnant women and infants were not being met. The March of Dimes, the local health departments and other local organizations came together to plan and respond to maternal and child health needs in affected areas.

Starting in the Baton Rouge shelters, moving to temporary housing, and working closely with New Orleans providers as services were restored, March of Dimes staff have gone to where the women are, providing education, resources and supplies. While distributing supplies of formula, maternity clothes, and diapers, the March of Dimes was looking ahead to the potentially bleak long-term impact these disasters could have on preterm birth and other pregnancy outcomes in Louisiana.

Clearly, addressing racial disparities in prenatal care and preterm birth in the context of a long term hurricane response would offer new challenges and opportunities. Funding was secured from the Department of Health and Human Services and the Office of Minority Health to implement a three-pronged approach to reach the most vulnerable pregnant women and infants with education and services.

Two months following Katrina, agencies serving the interests of pregnant women and infants remained focused primarily on crisis intervention and meeting immediate needs. Helping to meet those immediate needs enabled MOD to implement the three-pronged approach. This approach included prenatal health education, provision of prenatal care, and support to families with babies in the neonatal intensive care unit (NICU). Collaborations with the state health department, community based shelters, hospitals, and faith based organizations were essential to these efforts. The initiative reached over 1,000 pregnant women in the first three months following the hurricanes. Educational materials were provided to evacuated families with infants in NICUs throughout the state. At six months, health educators established scheduled educational workshops for pregnant women in community settings. Seventy-eight percent of the participants have been African American women ranging from age fifteen to thirty-four.

The introduction of a new model of prenatal care through CenteringPregnancy® offered another opportunity for collaboration with health care providers and state health departments. In this model, pregnant women receive prenatal care, education and peer support in a group setting with women at a similar stage in their pregnancies. Evaluation of the model in other sites has shown a positive impact on patient satisfaction and birth outcomes. The March of Dimes hosted training for providers interested in this model; sites will implement starting in July. It is anticipated that sites will serve the most at-risk populations, particularly African American and Latino women — from and in New Orleans. This model has been well-received by the Louisiana Office of Public Health and the Fetal and Infant Mortality Reviews (FIMR) throughout the state.

Another key element in providing disaster relief is flexibility and adaptability. Organizations need to be involved in the community to identify where need is greatest at any given time. Willingness and ability to change plans as populations shift has been critical during the initial crisis and project implementation. In some cases, the crisis brought opportunities for innovation and new partnerships. It also brought opportunities for individuals to give their time and money and to donate items of assistance. Channeling these efforts requires organizations be poised to take advantage of gifts while assuring donated items are appropriate and useful.

Traditional communication mechanisms were chaotic, intermittent and even suspended for periods of time following the hurricanes. Gathering basic information on the numbers and location of displaced pregnant women and infants necessary to plan and implement services was difficult. Ordinary means of getting information to people in need — the internet, television, radio, and mail — were unreliable. Organizations must think creatively and purposefully to find those in need and provide services. As with any effort focused on addressing disparities in health, success has been found by reaching women where they are and meeting their priority needs. Pre-existing networks of community partners can facilitate collaboration and information-sharing, which are vital to this effort.

For more information, contact: Ligia Ayala, Associate Director of Program Services, March of Dimes, Louisiana Chapter
Phone: 225-295-0655
Fax: 225-295-0677
E-mail: LAyala@marchofdimes.com

Prematurity -- A Leading Cause of Newborn Death

The National March of Dimes Birth Defects Foundation is a voluntary health agency whose mission is to improve the health of babies by preventing birth defects and infant mortality. Founded in 1938, the March of Dimes funds programs of research, community services, education, and advocacy to save babies. Over the years, CityMatCH and MOD have partnered on a numerous activities and MOD continues to be a strong supporter of CityMatCH-led activities.

For more information, visit the March of Dimes Web site at marchofdimes.com or the Spanish Web site at nacersano.org.
CityMatCH Annual Board Elections Underway

Nomintions for election to the Board of Directors of CityMatCH closed on May 17, 2006, and a strong slate of candidates is currently being voted on by the membership. Service on the Board offers a unique cluster of opportunities to enhance personal and professional leadership skills and the chance to play an active role in shaping CityMatCH policy and practice. Members who are chosen to serve in this capacity are privy to a virtual “network” of upper level MCH peers and professionals.

What makes a great Board member? CityMatCH sees four qualities in particular that set potential Board members apart from the general pool of qualified member representatives. They include the following:

- Vision for the future of urban MCH
- Passion for protecting the health of women, children, & families
- Business acumen to help implement our strategic plan
- Creativity to shape cutting edge products and services

For more information on who the current members and Board are, visit the website at www.citymatch.org

Categories for Board/Nominating Committee Eligibility

1) Regional Representative Eligibility: Nominees must be the designated MCH representative from a CityMatCH member health department within the region for which a vacancy exists. The current Regional Representatives whose terms expired this year were: Marilyn Seabrooks—North East, Ann Salyer-Caldwell—South Central, and Kathy Carson—West. Those regions are comprised of the following states:


South Central: Arizona, New Mexico, Kansas, Oklahoma, Texas, Missouri, Arkansas, Louisiana

West: Hawaii, California, Nevada, Utah, Washington, Oregon, Idaho, Montana, Alaska

2) At-Large Representative Eligibility: Designated MCH representatives from all CityMatCH member health departments are eligible for election to the At-Large seat on the Board of Directors. The current At-Large Representative whose term expires this year is Kimberlee Wyche-Etheridge.

3) Nominating Committee Eligibility: The Nominating Committee is also elected by the full membership of the organization. One new member is elected each year to serve a three year term. The Nominating Committee assists the Central Office with the annual Board of Directors election process and the senior elected member of the Nominating Committee serves as the chairperson. Two spots on the Nominating Committee are up for election.

Elections are taking place during the month of June, 2006 and new members to the board will assume office on August 19, 2006.

If you have questions, you may contact any current Board Member (a complete roster can be found on the CityMatCH website) or Mark Law, Coordinator of Membership Services, at 402-561-7500 or visit the website at www.citymatch.org

Request for Applications: Your Opportunity to Participate in the Revised CityMatCH DaTA Institute

The successful CityMatCH Urban MCH DaTA Institute is changing!

Beginning with the upcoming 2006-2007 teams, the Institute will shift away from a year-long format to a stream-lined nine-month training opportunity.

Since 1997, CityMatCH has invited interested urban MCH practitioners to come together, forming local teams for training in leadership and data use skills, scientific thinking, data methods, planning, evaluation, political strategy development and more. The essential skills participants learn will be directly applied to a project of importance in their local communities throughout the nine-month DaTA Institute.

Applications for the 2006-2007 DaTA Institute will be available online on July 1 and are due September 1, 2006. Once teams have been reviewed and accepted, Institute activities will begin this October and will conclude in 2007 during the annual CityMatCH Annual Urban MCH Leadership Conference.

If you would like to learn more about what the revised DaTA Institute can offer your local community, consider participating in one or both of the following informative opportunities:

1) Informational conference call, July 20, 2006 at 1:00 pm Central.

2) On-site meeting at the CityMatCH Conference, August 21 in Providence (RI). (See page eight for additional information about the conference, or visit the website at www.citymatch.org)

To learn more or to participate on the call or meeting, contact Kathleen (Kock) Brandert at 402-561-7500, or via email at kkockt@unmc.edu. Other questions about the Institute? Visit the CityMatCH website for details.
Providence to Host CityMatCH Annual Urban MCH Leadership Conference


This year’s conference will feature a variety of plenary and skills-building sessions addressing such timely issues as Health Disparities, Community-Based Early Childhood Interventions, Preconception Health and Health Care, Infant Morbidity and Mortality, Obesity, Nutrition and Physical Activity, Teen Pregnancy Prevention, Environmental Health and Integrated Data Analysis.

You will hear from outstanding national speakers, including Jane Elliott, internationally known teacher, lecturer, diversity trainer, and recipient of the National Mental Health Association Award for Excellence in Education, and Dr. Gail Christopher, Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC.

Don’t miss this exciting opportunity to network, gain new skills and be inspired! Register today at www.citymatch.org.

Page One — Selected Resources from the Consensus Definitions:
The Anti-Defamation League. See: <www.adl.org/children_holocaust/more_resources.asp>
The People’s Institute for Survival and Beyond, New Orleans, LA, Diana Dunn, Program Director, <www.pisasb.org>.

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