SPIRIT OF 1848: APHA 2009 REPORTBACK (date: November 29, 2009)

TO: EVERYONE ON SPIRIT OF 1848 EMAIL BULLETIN BOARD
FROM: SPIRIT OF 1848 COORDINATING COMMITTEE
RE: REPORTBACK FROM THE 2009 APHA CONFERENCE

Greetings! The Spirit of 1848 Caucus is happy to share our reportback from the 137th annual meeting of the American Public Health Association (November 7-11, 2009, Philadelphia, PA). In this reportback we:

(a) present decisions we made at our business meeting, including initial ideas for the APHA 2010 session; and

(b) give highlights of our APHA 2009 sessions.

We are sending this reportback by email and posting it on our web site. Currently, 2,756 people (slightly down from 2,840 last year) – from both the US and elsewhere in the world – subscribe to our email bulletin board. We expect still more to sign up, given the interest expressed at the APHA meeting. Attendance at our sessions was lower this year than in years past: this year, slightly under 400 persons came to our sessions (not counting those who visited the very crowded student poster session), which is less than the approximately 600 total who attended last year. That said, each of our sessions had very good attendance by APHA standards, noting that for the APHA meetings held in 2006, 2007, and 2008, the average attendance per scientific session ranged between 29-34 persons/session, and our 2009 sessions had attendance ranging from approximately 25 to 175 persons per session.

And:

1) please feel free to email interested colleagues & friends this update/report, which can also be downloaded from our website, along with our mission statement and other information about Spirit of 1848, at: http://www.spiritof1848.org

2) please likewise encourage them to subscribe to our listserve! – directions for how to do so are provided at the end of this email and on our website. If any of the activities and projects we are reporting, either in this reportback or on our listserve, grab you or inspire you -- **JOIN IN!! We work together based on principles of solidarity, volunteering whatever time we can, to move along the work of social justice and public health.**

3) if you have any questions, or would like to help out with organizing our sessions for next year, please contact any of us on the Spirit of 1848 Coordinating Committee (with each committee having 2 to 3 co-chairs, for good company & to move the work along!):

--Nancy Krieger (Chair, Spirit of 1848, & data & integrative & e-networking); email: nkrieger@hsph.harvard.edu
--Catherine Cubbin (Politics of public health data committee); email: ccubbin@austin.utexas.edu
--Vanessa Watts (Politics of public health data committee); email: vanessa.watts@montana.edu
--Anne-Emanuelle Birn (History committee); email: aebirn@utoronto.ca
--Alexandra Minna Stern (History committee); email: amstern@umich.edu
--Luis Avilés (History committee); email: laviles@upm.edu
--Suzanne Christopher (Pedagogy committee); email: suzanne@montana.edu
--Lisa Moore (Pedagogy committee); email: lisadee@sfsu.edu
--Rebekka Lee (student rep for the Student poster session); email: rlee@hsph.harvard.edu
--Jennifer Garcia (student rep for the Student poster session); email: jennifergarcia@ucla.edu
--Pam Waterman (E-networking committee and Spirit of 1848 representative to the APHA Governing Council); email: pwaterma@hsph.harvard.edu

NB: for additional information the Spirit of 1848 and our choice of name, see:

--Coordinating Committee of Spirit of 1848 (Krieger N, Zapata C, Murrain M, Barnett E, Parsons PE, Birn AE). Spirit of 1848: a network linking politics, passion, and public health. Critical Public Health 1998; 8:97-103.

--Krieger N, Birn AE. A vision of social justice as the foundation of public health: commemorating 150 years of the spirit of 1848. Am J Public Health 1998; 88:1603-1606.

Both of these publications are **posted** on our website, at: http://www.spiritof1848.org/

A) SPIRIT OF 1848 BUSINESS MEETING (Tues, Nov 10, 2009, 6:30-8:00 pm)

Attended by: (a) Spirit of 1848 Coordinating Committee members (alphabetical order): Luis Avilés (history), Suzanne Christopher (pedagogy), Catherine Cubbin (data), Jennifer Garcia (student rep), Nancy Krieger (chair & integrative), Rebekka Lee (student rep), Vanessa Watts (data), and Pam Waterman (e-networking and Spirit of 1848 representative to the APHA Governing Council), and (b) additional Spirit of 1848 members: Maria Bacquero, Slande Celeste, Penny Killian, Chandra Ford, Rebecca Hasson, Sean Phelan, Sherry Spence, and Jessica Waggett

Spirit of 1848 Coordinating Committee members who were unable to attend were: Anne-Emanuelle Birn (history), Lisa Moore (pedagogy), and Alexandra Minna Stern (history)

1) We re-affirmed the mission statement of the Spirit of 1848 (available at our website, at: http://www.Spiritof1848.org) which, among other things, describes our subcommittee structure and our history.
-- In brief, we grew out the work in the late 1980s of the National Health Commission of the National Rainbow Coalition, we cohered as the Spirit of 1848 network in 1994 and began organizing APHA sessions as an affiliate group to APHA that year. In 1997 we were approved as an official Caucus of APHA, enabling us to sponsor our own sessions during the annual APHA meetings.
-- We have 4 sub-committees: (a) politics of public health data, (b) progressive pedagogy & curricula, (c) history (with the sub-committee serving as liaison to the Sigerist Circle, an organization of progressive historians of public health & medicine), and (d) e-networking, which handles our listserve and website.
-- To ensure accountability, all projects carried out in the name of the Spirit of 1848 are approved by the Spirit of 1848 Coordinating Committee. The Coordinating Committee communicates regularly (by email) and its chair (and other members, as necessary) deals with all paperwork related to organizing & sponsoring sessions at APHA and maintaining our Caucus status. The subcommittees also communicate regularly by email in relation to their specific projects (e.g., organizing APHA sessions).

2) We reported back on how our various sessions went (see detailed descriptions below), discussing both attendance and content. The estimated attendance for our sessions was as follows: Social history of public health ($n \approx 100$); The politics of public health data ($n \approx 175$); Progressive pedagogy in public health ($n \approx 25$); "integrative session" ($n \approx 95$). As noted above, attendance at these sessions was either lower than – or, in some cases about the same as – their counterparts in previous years (last year history was ≈ 100; data was ≈ 250, pedagogy was ≈ 100, and the integrative session was ≈ 150). Our 2009 attendance figures nevertheless are good by APHA standards, since the average attendance for APHA scientific sessions is around 30 people/session. Our sense was that the sessions by and large went well, with strengths including the diversity of analytic approaches taken and also the diversity of the audience, e.g., many non-historians attended the history session, and many public health colleagues not directly engaged in research addressing Indigenous health attended the integrative session to find out about Indigenous research methodologies and how they may be relevant to their own work.

3) After our Spirit of 1848 business meeting, Pam Waterman represented the Spirit of 1848 at the now annual APHA all-caucus breakfast, held on Wed, November 11, and reported back that:

> The Caucus breakfast was well attended, with representatives from a majority of the Caucuses present.
>
> As part of his welcoming remarks, Dr. Benjamin (the Executive Director of APHA) informed us that next year, APHA is "investing in sections." Instead of each section purchasing an individual booth in the exhibition hall (what is currently done), APHA will be providing a "section pavilion" which will house all of the sections in one place. This will help draw attention to the Sections as well as facilitate recruitment of new members. Naturally the Caucus representatives inquired as to the possibility of a Caucus pavilion, since recruiting new members is a common problem for the Caucuses as well. Not surprisingly, a Caucus pavilion is not on the APHA agenda any time soon. Noting that the original argument for Caucuses was that they would bring in new members, Dr. Benjamin admitted that APHA has made it systematically difficult for the Caucuses to do that, e.g., by not allowing new/current members to chose a Caucus affiliation when registering for the conference nor by aiding any efforts to recruit new members. However, Dr. Benjamin did say that if the Caucuses wanted to work as a group to develop a marketing plan for the Caucuses (that apparently would not include a pavilion), they are welcome to do so and present it to the Board for consideration.

Dr. Benjamin also reported that informal surveys of members have revealed that although a majority of APHA members would like to be more active in the organization, almost all of them have no idea where to begin. The APHA Staff and Executive Board are currently working on a "leadership map" to distribute to students and new members (and old members) to make the leadership path more transparent. They will distribute the map to the Caucus leaders as well.

Because so many Caucuses are struggling or have struggled with the process of becoming incorporated, with each one having to reinvent the wheel each time (the Latino Caucus just achieved incorporation status, and the LGBT Caucus is now requesting guidance from other Caucuses/APHA Staff regarding the process), Dr. Benjamin said that the Executive Board is considering either (a) setting up one umbrella legal structure which would incorporate all of the Caucuses OR (b) setting up a system whereby APHA Staff would supply legal and administrative support to any Caucus interested in becoming incorporated.

Fran Atkinson also pointed out that the Memorandum of Understanding that 16 of the 17 Caucuses have in place with the Executive Board expires next year (3-year) term. She advised all Caucuses members to review the MOU before the mid-year Caucus Conference Call and note any changes we think should be made.

We are also VERY grateful to Pam for representing the Spirit of 1848 at the APHA Governing Council proceedings – the first year the Caucuses have been able to attend (as observers, without a vote). She reported back as follows:

Nine of the 17 Caucuses completed all the steps necessary to earn a non-voting seat on the Governing Council (including the Spirit of 1848). This year, for the first time ever, there were two tables at the back of the Governing Council meeting with placards for representatives from each of the 9 Caucuses. (I note here that the Spirit of 1848 assigned seats are the FARTHEST from the proceedings possible. They are the very last seats at the very last table in the very last row. I did not take it personally :). Barbara Giloth, Speaker, took a moment to acknowledge the presence of the Caucus Representatives at the beginning of the meeting. This was met with a nice round of applause.

Including the Spirit of 1848, there were representatives from 5 of the Caucuses at the opening meeting (Saturday from 3-6). However, for the subsequent meetings (Tuesday 9-12 and 2-5), I was usually the only Caucus representative in attendance.

Other than the welcoming remarks, there was no discussion that arose during the meetings that related to the Caucuses as a whole, or to the Spirit of 1848 in particular.

4) With regard to sessions for next year **(138th annual meeting of APHA, Nov 6-10, Denver, CO, with a theme of *"Social Justice: Public Health Imperative"*)**, we discussed various options for the session content. We tentatively have agreed to the following topics described below, noting that:

(a) the **call for abstracts** will go live on the APHA website (http://www.apha.org/meetings/) on **FRIDAY, DECEMBER 18, 2009.**

(b) **abstracts will be due between FEBRUARY 1-5, 2010.** As soon as we know the date of the abstract deadline assigned to the Spirit of 1848, we will post it on our listserve.

Advancing social justice & public health – and countering co-optation: theme for APHA 2010 Spirit of 1848 sessions:

The theme of the APHA 2010 meeting ("Social Justice: Public Health Imperative") is central to the mission of the Spirit of 1848 – and we believe it imperative that there be a sharp, critical focus on what it means to link issues of social justice and public health. The Spirit of 1848 sessions for 2010 will therefore each emphasize the importance of critical approaches to work on "social justice and public health," noting that as we begin to see the "mainstreaming" of work regarding the "social determinants of health," we are also seeing a dilution of the politics involved. A core concern pertains to how, with "mainstreaming," comes the possibility, if not likelihood, of cooptation. Thus, although it certainly is better to start to have work on the "social determinants of health" move into the mainstream (and potentially encounter backlash) rather than be ignored, we need to think critically about the impact of "mainstreaming" on the ideas, work, and

efforts to rectify health inequities. Every Spirit of 1848 session will accordingly critically engage with mainstreaming & the state of the field, recognizing both positive aspects and potential problems due to cooptation.

History: This session will accept **only solicited abstracts** that critically examine issues of social justice, public health, and both resistance to and cooptation by efforts to minimize the political issues at stake. It will be organized by Spirit of 1848 Coordinating Committee members Anne-Emanuelle Birn (email: aebirn@utoronto.ca), Alexandra Minna Stern (email: amstern@umich.edu), and Luis Avilés (email: laviles@upm.edu).

Data: This session will accept **only solicited abstracts** that critically examine issues of social justice and public health in relation to public health data systems and monitoring of health inequities, including both resistance to and cooptation by efforts to minimize the political issues at stake. It will be organized by Spirit of 1848 Coordinating Committee members Catherine Cubbin (email: ccubbin@austin.utexas.edu), Vanessa Watts (email: vanessa.watts@montana.edu), and Nancy Krieger (email: nkrieger@hsph.harvard.edu).

Pedagogy: This session will have an **open call for abstracts** – and also **solicit abstracts --** that critically examine issues of social justice and public health in relation to both course content and pedagogical approaches, including both resistance to and cooptation by efforts to minimize the political issues at stake. It will be organized by Spirit of 1848 Coordinating Committee members Suzanne Christopher (email: suzanne@montana.edu) and Lisa Moore (email: lisadee@sfsu.edu).

Integrative: This session will accept **only solicited abstracts** and will critically examine issues of social justice, public health, and both resistance to and cooptation by efforts to minimize the political issues at stake, and do so in relation to the 3 foci of our Spirit of 1848 Caucus: the social history of public health, the politics of public health data, and progressive pedagogy for public health. It will be organized Spirit of 1848 Coordinating Committee members Nancy Krieger (email: nkrieger@hsph.harvard.edu), Anne-Emanuelle Birn (email: aebirn@utoronto.ca), and Luis Avilés (email: laviles@upm.edu).

Student poster session: This session will have an **open call for abstracts** for student posters on topics that link issues of social justice and public health. Noting that students often have limited budget for travel, we will reach out especially to students (& faculty) in Denver, CO and nearby cities. If you have any questions about this session, or can help publicize the call for abstracts, please contact Spirit of 1848 Coordinating Committee members Rebekka Lee (email: rlee@hsph.harvard.edu) and Jennifer Garcia (email: jennifergarcia@ucla.edu).

We note that the timeslots for these sessions will be in our usual slots:

Spirit of 1848 session*	Day	Time
History (social/progressive history of public health)	Monday	10:30 to 12 noon
Politics of public health data	Monday	2:30 to 4:00 pm
Integrative session (history, data, pedagogy)	Monday	4:30 to 6:00 pm
Curriculum (progressive pedagogy)	Tuesday	8:30 to 10:00 am
Student poster session: social justice and public health	Tuesday	12:30 to 1:30 pm
Business meeting	Tuesday	6:30 to 8:00 pm
*We are also one of the designated co-sponsors of the P. Ellen memorial session (primary sponsor = Medical Care Section), on the Tuesday, 2:30-4:00 pm. P. Ellen Parsons was one of the original members of the Spirit of 1848 Coordinating Committee, and we help with organizing this session.		

B) HIGHLIGHTS OF SPIRIT OF 1848 SESSIONS (APHA 2009)

As usual, our sessions were well attended, thought provoking, and clearly useful to those who came. In total, we estimate that approximately 340 persons came to our sessions (not counting those who visited the very crowded student poster session), which is less than the approximately 600 total who attended last year. That said, each of our sessions had very good attendance by APHA standards, since attendance ranged from 25 to 130 persons per session, and the average attendance at APHA scientific sessions (based on attendance statistics from 2006-2008) is 29-34 persons/session. Approximately 50 people also attended the P. Ellen Parsons session we co-organized/co-sponsored.

Below is a brief summary of the highlights of each session, in chronological order.

1) SOCIAL HISTORY OF PUBLIC HEALTH

Our engaging session, replete with some controversy, was attended by ≈ 100 people (on the same order as the ≈ 100 in 2008, the ≈ 120 in both 2006 and 2005, and more than ≈ 70 in 2007 and ≈ 45 in 2004).

THE SOCIAL HISTORY AND POLITICS OF WATER AND PUBLIC HEALTH
Mon, Nov 9 ***10:30 AM-12 noon (Session 3162.0) * Phil Conv Center (PCC) Rm 113A**

10:30 AM — Introduction: Social history and politics of water and public health. Anne-Emanuelle Birn, MA, ScD

10:35 AM — Unclogging obstacles to water and sanitation coverage: the promise and perils of comparing Philadelphia's history with the crisis in the developing world. Niva Kramek, MES, and Katryn Bowe, BA

10:55 AM — Building inequality: sewers, civic ideals, and public health in Los Angeles, 1873-1891. David Torres-Rouff, PhD

11:15 AM — Critical reflections: on history, culture and struggles over access to water and sanitation. David S. Barnes, PhD (discussant)

11:30 AM — Question & answer period

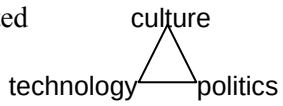
Anne-Emanuelle Birn opened up the session with a powerful overview, one that made clear that issues of water quality and access are political, and not simply technical, problems. Currently, half the world's population lacks piped water and sanitation, and more than 3 million persons each year die due to water contamination (of which 2 million or more are children). How each society addresses issues of water and sanitation is revealing; one telling example shared compared the pre/post-conquest conditions of Tenochititlán/Mexico City, whereby pre-conquest the city's streets and lake were kept clean, with waste managed for agriculture/aquaculture, but post-conquest the Spaniards turned the lake into a cesspool. With the rise of capitalism, the industrial revolution, rapid urbanization, and then imperialism, came new demands on – and new problems with ownership of and access to – clean water and sanitation, with implications for public health and politics overall. In Uruguay, for example, in the late 19th c the British bought the previously publicly administered water system, with reduced access and quality leading to increases in diarrhea; after a century of similar water struggles, in 2004, Uruguay passed the first constitutional amendment anywhere that guarantees water as a public resource necessary for life and a human right, and prohibits private sector involvement in the provision of water.

Niva Kramek and Katryn Bowe then discussed how issues of water access and sanitation ("watsan") played out during the growth of Philadelphia in the 18th and 19th century (which in the early 1800s became the 1st US city to create a public utility for water, complete with centralized waterworks and municipal water fountains) and contrasted this history to the current realities of inadequate access to sanitation and clean water in the world today. Emphasizing the importance of prevention of dirty water, as opposed to the more typical focus on water treatment, they argued that the history of Philadelphia water struggles underscores how the chronic neglect of sanitation (i.e., prevention of pollution of water by feces and by industrial waste) has been a ongoing serious problem, one exacerbated by the fragmentation of efforts, with sanitation belonging to one city department, and water supply to another. Illustrating these points were repeat typhus epidemics in the late 1800s/early 1900s, and decades of political in-fighting over who should bear the cost and reap the profits from municipal sanitation and water supply projects, even as various political leaders did realize that investment in "watsan" was important for economic growth, population growth, and tourism. Turning to "watsan" issues in what they termed the "developing" world, they argued that health concerns have been unable to lead to improvements in access and quality; as an alternative, they controversially suggested the focus should be on both the economic return to investment in

"watsan" (with such investment taking the form of small-scale entrepreneurial projects, e.g., ecosan toilets and biogas digesters) and on the local behaviors that countenance unsanitary conditions (including defecation in open fields).

David Torres-Rouff then presented a richly detailed history of the politics of water and sanitation in Los Angeles, including in relation to race/ethnicity, nationality, immigration, and class. He contrasted: (a) the pre-1848 orientation to water, characterized by the Mexican/Spanish pueblo system, in which water was a common good that flowed in public water canals ("zonas," used both for irrigation and waste removal), its use guaranteed to all individuals, with strong prohibitions against any individual using water in a way that could restrict the access to others, versus (b) the Anglo orientation, brought in by the US conquest and appropriation of northern Mexico in 1848, with the Anglos having sufficient power by 1850 to change profoundly the terms of water use so that it became a commodity that could be bought and sold in a private, pay-for-service system. During the 1860s a variety of private schemes abounded, and in 1873 there was a showdown in which the Anglos installed the first sewer system in Los Angeles – one that extended only into the Anglo parts of Los Angeles and which replaced the "zonas." Excluded from this physical transformation of both water use and space were the Mexican and Chinese neighborhoods of Los Angeles (respectively "Sonoratown" and "Chinatown"), which were not allocated any sewers. Informing the politics at play were the stereotypes of "sanitary, modern, American" versus the "dirty, primitive Mexicans and Chinese" – with the Mexican resistance to private water and sewer systems cast by the Anglos as a matter of "backwardness," as opposed to objections to making a public utility into a private for-profit system. Simultaneously, the Anglo city council set about paving and grading the roads in the Anglo sections of LA, while leaving the streets unpaved and dusty in Sonoratown and Chinatown. Thus, by the 1890s, these different neighborhoods dramatically differed in their cleanliness, the Anglo areas enjoying sewers and paved stress, the Mexican and Chinese areas having open cesspools and sewage running down the dirt streets, with this distinction in infrastructure further reinforcing negative stereotypes of "Mexicans" and "Chinese" as "diseased." The presentation ended with some comments on the politics of water and sewers in contemporary Los Angeles, noting that in 2004 the city agreed to a $2.4 million settlement regarding spilled sewage and a 10 year plan to resolve the problems, including a plan to revive Los Angeles' buried rivers in the spirit of public rights to the value of water, including for gathering spaces and creating community, as well as to replace old failing sewers in the very neighborhoods denied access to adequate infrastructure in the late 1800s and early 1900s. A final comment was that contemporary public health research appears to neglect the issue of broken sewers, despite its relevance to issues of environmental justice and public health.

The discussant, **David Barnes**, reflected on how the politics of sewage and water access reflects an interplay of three mutually constitutive phenomena – technology, culture, and politics – all of which are connected by feedback loops, creating a triangle. Thus, although "technology" is often treated as a "deus ex machina," in fact its use is historically contingent and depends on social mobilization for clean water and sanitation," with "culture" mediating the "demand" side of expectations, values, and mores, and "politics" affecting resource allocation. A key point is that "objective need" is not enough to force change, since the problem of inadequate sanitation and access to clean water is a known health burden and known solutions exist, yet the problem persists.



During the **Q&A period**, two controversies were addressed. The first concerned the contrast between the apparent need for integrated, large-scale projects (as per the 19th and early 20th c construction schemes for sanitation and water pipes) versus some of the recommendations made for "developing" countries to focus on small-scale projects, many of which focus strongly on changing sanitary "behavior" – with the claim made and debated that large scale projects are only feasible if there is strong government capable of enforcing such programs on local areas/neighborhoods. The second pertained to the debatable strategies employed by projects in several countries lacking adequate "watsan" systems (e.g., Ethiopia, India, Indonesia), which, based on the view that a "health message" was insufficiently powerful to mobilize change, are instead now explicitly adopting approaches that rely on stigma, so that individuals and communities who do not use latrines are encouraged to see their sanitary practices as "disgusting" and that they should be ashamed for being "dirty." Although such programs do appear to mobilize some new effort towards adopting latrines, the Q&A discussion underscored how using stigma is "playing with fire," especially with marginalized populations subjected to economic deprivation and lack of meaningful political power, as per the ways the Mexicans and Chinese were wrongly stigmatized in Los Angeles because of the denial of adequate sanitary infrastructure to their neighborhoods.

2) POLITICS OF PUBLIC HEALTH DATA

Our informative and engaging session was attended by ≈ 175 people (fewer than the ≈ 250 in 2008 and the ≈ 220 in 2007 and 2005, but more than the ≈ 140 in 2006).

MACROECONOMICS, POLITICAL SYSTEMS, AND POPULATION HEALTH & HEALTH INEQUITIES
MON, NOV 9 ***2:30 PM-4:00 PM (SESSION 3361.0) * PHIL CONV CENTER (PCC) RM 108B**

2:30 PM — Introduction. Catherine Cubbin, PhD

2:35 PM — Health inequities in global context: evidence from the World Values Survey. Jason Beckfield, PhD & Sigrun Olafsdottir, PhD

2:55 PM — Income support and women's health reform in developing countries: the impact of microfinance. Deborah Viola, PhD

3:15 PM — Public health implications of economic recessions. Jessica M. Robbins PhD

3:35 PM — Discussant. Nancy Krieger, PhD

3:45 PM — Question & answer period

Catherine Cubbin opened up the session, introducing the speakers and also the theme of the session – our need to conduct research on how large-scale societal determinants of health, such as macroeconomics and political systems, affect population health and the magnitude of health inequities.

Jason Beckfield, a political sociologist, presented analyses he conducted with his colleague Sigrun Olfasdottir examining global variation in the magnitude of relative and absolute measures of health inequities, as assessed in relation to income and educational level, in a study based on socioeconomic and self-reported health data obtained from 38 countries included in the 1995 wave of the World Values Survey. Two key aspects of the analyses were: (1) to specify the outcome of interest to be the magnitude of health inequities, as opposed to just average population levels of health, and (2) to model separately the negative gradient typically associated with deprivation and the positive gradient typically associated with affluence. The analyses grouped countries into 4 income levels, and within each of these 4 groupings, there was clear evidence of variation in the magnitude of income- and education-based differentials in self-reported health – both for the negative gradient for deprivation and for the positive gradient for affluence. Of note, in the majority of countries, the negative impact of deprivation was greater than the positive impact of affluence (suggesting a non-linear relationship between income and health) – but in some countries, such as Sweden, the positive impact of affluence exceeded the negative association for deprivation, implying that features of their welfare state mitigated the harmful effects of low-income. Moreover, in low income countries, the negative gradient associated with lower education was smaller than that associated with low income, a finding which underscores the importance of material deprivation; additionally, in most countries the negative effects of low education overall exceeded the positive effects of high education. An overall major finding is that the magnitude of health inequities is variable, not constant. This finding rebuts the economists' conventional argument that "health selection" drives health inequities (if it did, then why would there be so much country-level variation in their magnitude?) – and it likewise challenges the argument that "SES," per se, is a "fundamental cause" of health, with the results instead suggesting that macro political and economic phenomena affect how relative and absolute measures of income and education (i.e., "SES") translate into health status. Additionally, the finding that income inequality does not necessarily have uniformly negative effect on population health challenges conventional wisdom on the uniformly negative impact of income inequality, showing instead there can be a high income benefit that accompanies high income inequality. This finding further suggests work on income inequality and health has been misdirected, in its focus on the relationship between income inequality and overall (average) levels of health; more germane is the relationship between income inequality and the magnitude of health inequities. Better understandings of how the larger political and economic context affects the magnitude of health inequities will, however, require "time travel," i.e., analysis of data extending back several decades, both to capture different periods of political and economic policies and also to take into account the lag time required to address how prior conditions affect current health outcomes.

Deborah Viola, an economist, next linked health with macro- and micro-economic phenomena by, first, recounting how global trade agreements to "open up trade" have typically negatively affected women linked to the crop sector in rural areas of poor countries and, second, sharing results of a study on health impacts of microcredit programs intended to bolster the income of women in such countries. She noted that asking the latter question is contrary to what most

economists focus on, since they tend to see "health" as an "economic input," rather than as an "outcome" affected by economic resources – a perspective that likely underlies the paucity of research on how economic policies shape population health, and especially the health of low income populations. Her particular study was conducted in Bangladesh, a poor country in which 60% of the population is illiterate, and her interest was in ascertaining how women's health and that of their household is affected by augmented income, as such (and not just as a marker for other services that may be provided in conjunction with microfinance initiatives, e.g., provision of contraceptives). Her specific hypotheses were that increased income due to microfinance would: (1) increase the amount spent on needed medicine and doctors' fees; (2) increase food consumption; (3) reduce tobacco consumption; and (4) increase the average duration of breastfeeding. Using data from 87 villages included in surveys conducted by the World Bank in 1991-1992 and 1998-1999, she examined cross-sectional differences in health outcomes for the borrowers vs non-borrowers, and found evidence (in multivariable analyses taking into account illiteracy, gender, and other sociodemographic factors) in support of the first 3 hypotheses. Future analyses will use the panel data to address longitudinal change, community-level variables, and also the number of loans obtained (as opposed to only dichotomizing between borrowers vs non-borrowers). The larger implication is that understanding population health requires considering both macro- and micro-finances, and how economic policies, depending on their content, increase or decrease health inequities.

Jessica Robbins, an epidemiologist in Philadelphia's local city health department, next presented her attempts to find research providing evidence useful to local health planning on the likely health impacts of economic recessions. Particular questions of interest (especially for planning purposes) were whether economic recessions might lead to more utilization of emergency rooms, or to individuals delaying medical care and coming at later stages of illness, or to increases in asthma or heart attacks. She documented that although she did find a number of studies looking at health impacts of economic cycles, recessions, and unemployment, few provided data that could offer guidance to local health planning, especially with regard to prioritizing limited resources. Questions prompted by her review of the literature included: (1) if recessions do lead to increased suicide rates, who is most vulnerable and at risk; (2) if they lead to reduced smoking, what can be done to continue to reduction after the recession ends; and (3) what can be done to mitigate the myriad negative health impacts associated with unemployment and also, as suggested by new research, foreclosures? She encouraged audience members to do the work needed, in line with Spirit of 1848 interests, to show how phenomena such as recessions, and also other economic policies originating outside of public health, impact on population health.

The discussant, **Nancy Krieger**, then reflected, from an ecosocial perspective, on how the presentations drew attention to how macro economic and political phenomena are processes – not things – that become embodied and expressed in levels and distributions of population health, including the magnitude of health inequities. The session's presentations underscored the need to consider societal determinants on health, that is, macro-level political and economic systems, and not only "social determinants" as often measured at the "individual" level (e.g., income, education). They likewise highlighted how attention to issues of level and spatiotemporal scale is vital. For example, the question of how recessions, unemployment, and microfinance affects health needs to be qualified, so as to ask: the health of whom? – individual adults, other adult members of their households, their children, their communities – and at what time point? – over a short or long period of time, and at what point in people's lives? During the Great Depression in the 1930s, for example, economists argued that it clearly had little health impact, since mortality rates remained stable; to rebut this argument, Edgar Sydenstricker, the first statistician employed in the US Public Health Status, established the Ten City study on the health effects of the depression (itself a precursor to the US National Health Interview Survey) so that effects on illness rates, and not just death rates, could be examined – and he found strong evidence of acute effects on morbidity. The cross-national variation observed the World Survey study on the magnitude of health inequities further point to the possibilities of important and informative heterogeneities in their likely system-level political and economic determinants – and ditto the need to consider how global context affects regional and local patterns. In other words, interpreting results in light of the possibilities of the cumulative interplay of exposure, susceptibility and resistance, at multiple levels (from individual to national), and in historical context, is necessary for good science. A final point made evident by all three presentations is that the reason to study the topics addressed is because the outcomes are mutable, not inevitable, and can be modified by informed action. Hence the importance of considering links between public health, social movements, and social change, since they typically are key to understanding and altering the patterns of health and health inequities discussed in the panel presentations.

During the **Q&A**, one set of questions focused on criticisms of microfinance programs, noting that results have generally been more beneficial in Asian and Latin American as compared to African countries, and also that these programs are premised on the view that poverty results from inadequate access to market and to functioning capitalist economies,

thereby not addressing how capitalism inevitably produces poverty (both absolute and relative) for the many and wealth for the few. Another set of questions addressed the problems local health departments face in implementing programs in times of severe budget cuts, with one suggestion being that in such times it may be worth pursuing intersectoral strategies, across government agencies, to pool limited resources to address more effectively and simultaneously diverse "non-health" factors (e.g., in education, housing, health) that shape population health and the magnitude of health inequities.

3) INTEGRATIVE

This session offered all involved the opportunity to focus on the relevance of social justice to the conduct of good science, by considering the insights of Indigenous methodologies as applied to public health research, data, and pedagogy. It was attended by ≈ 95 persons, most of whom were new to Indigenous frameworks relevant to public health work.

INDIGENOUS METHODOLOGIES IN PUBLIC HEALTH RESEARCH: AN ISSUE OF SOCIAL JUSTICE AND GOOD SCIENCE
MON, NOV 9 ***4:30 PM-6:00 PM (SESSION 3438.0) * PHIL CONV CENTER (PCC) AUDITORIUM**

4:30 PM — Introduction: Nancy Krieger, PhD

4:35 PM — Legacy of conventional research with Indigenous communities and its relevance to current public health research. Suzanne Christopher, PhD & Vanessa Watts, DSc

4:50 PM — The politics and purposes of Indigenous public health data. Bonnie Duran, DrPH

5:05 PM — Teaching Indigenous research methodologies. Felicia S. Hodge, DrPH

5:20 PM — Graduate student researchers in Aboriginal health & Indigenous methodologies. Katherine Minich, MHSc & Krista Maxwell, MA, PhD (C)

5:35 PM — Discussant: Native American pedagogy & health. Brenda Seals, PhD, MPH

5:45 PM — Question & answer period

Nancy Krieger opened up the session, introducing the speakers and also the theme of the session. She noted the origins of the session lay in conversations initiated by one of the panelists, Vanessa Watts, when she was working on her dissertation while also the student representative on our Spirit of 1848 Coordinating Committee. When talking about her research, Vanessa brought up some of the difficulties she was encountering, being split between the worlds of conventional public health ways of knowing and approaches to generating and scientific knowledge, versus those of the Indigenous methodologies she and her study participants considered more relevant and valid. Because these questions of ways of knowing are core to the conduct of scientific research and raise truly profound intellectual questions with which we all must grapple – no matter the specific focus of our research – we accordingly encouraged Vanessa to develop a Spirit of 1848 integrative session to explore the relevance of Indigenous methodologies to public health research, so as to push all of us forward in our thinking, whether we work directly or not on issues relevant to Indigenous health.

Suzanne Christopher and Vanessa Watts (Crow/Blackfeet from Montana) first jointly presented on the historical context and current actualities of research "on" versus with Indigenous peoples in the US. Recounting the long legacy of violations of Indigenous peoples and distortions of knowledge about them, including most recently by public health "helicopter research" and "drive by research," Suzanne provided the basis for historical distrust of "research" conducted "on" (as opposed to with and by) Indigenous communities – and at the same time argued that the need for appropriate research to inform efforts to improve Indigenous health was well-understood and appreciated; as stated by one American Indian woman she spoke with, "we have been researched to death and now want to be researched back to life." Vanessa next reviewed key rights relevant to the conduct of research involving Indigenous populations. Especially important is the UN Declaration on the Rights of Indigenous Peoples, ratified only in September 2007 (after 20 years of discussion), and with the only 4 votes against it being from countries with considerable Indigenous populations, i.e., Canada, the US, New Zealand, and Australia – noting further than in April 2009 Australia approved the declaration and in July 2009 New Zealand said it would do the same (but has not formally done so yet). Key concepts that public health researchers need to understand, especially in relation to research methodologies, include "self-determination" and "intellectual property," which together raise profound issues regarding the generation, use, and dissemination of public health knowledge. Both also discussed how Indigenous approaches to knowledge, including an emphasis on storytelling, stand in stark contrast to conventional reductionist "Western" approaches and instead emphasize that understanding relationships, in context, is key to developing trustworthy knowledge.

Bonnie Duran (Opelousas/Coushatta) then presented on the genealogy and use of public health data in relation to Indigenous health, tracing its journey from being "about" versus "from" Indian Country. She reviewed its use initially to oppress and subjugate Native peoples, citing as examples research from the 1880s and 1890s that distorted and castigated American Indians' health and healing practices and which also argued that "Indians" inevitably were a "dying race." Drawing on Foucault's ideas of "biopower," she then discussed more contemporary examples of how knowledge enforcing "regulation of the body" has been used by dominant researchers to decide who and what should be studied and to perpetuate the status of Indigenous peoples as passive "subjects." Arguing against the practice of "subjugated knowledge," she offered as an alternative the perspective that good science requires social justice and gave as examples recent work pertaining to histories written by and research controlled by Indigenous peoples. She also invited **Dr. Francis C. (Sam) Notzon**, the Director of the International Statistics Program at the US National Center for Health Statistics to discuss briefly their new work on improving public health data on Indigenous health. One new important resource he flagged is the Native Health Database, housed at the University of New Mexico, which includes not only health data but also data on major legal and historical events relevant to Indigenous health status; the database is available at: http://hsc.unm.edu/library/nhd

Felicia Schanche Hodge (Wailaki Indian tribe from Northern California) then expanded on the theme of contrasting "Western" versus Indigenous paradigms for knowledge, in relation to public health research, practice, and teaching. Rejecting the colonialist assumptions behind the ideas of "discovery" and the claim that "most values and meanings are similar," a key question to ask always is "whose interest is being served?" and whether the research is being done "on" versus "with" Indigenous peoples. Core to Indigenous paradigms is the view that all knowledge is relational, shared with all creation, and cannot be privately owned or discovered. Research consequently becomes a way of discovering the richness and depth of the world, premised on the belief that there are multiple approaches and interpretations relevant to research, and that it is key to know who is asking the questions, of and about whom. This precept holds whether one is using quantitative or qualitative methods – including the method of story telling, whose utility as a culturally appropriate and rich methodology she illustrated by providing examples of knowledge obtained with this method that otherwise were not addressed by conventional interview approaches.

Katherine Minich (Inuk from Nunavut Territory) and **Krista Maxwell**, building on their own experience as public health graduate students, then discussed the results of focus groups they led concerned with the experiences of Indigenous and non-Indigenous public health graduate students seeking to do work with Indigenous frameworks and methodologies. All expressed frustration with the lack of appropriate mentorship and the obstacles they confronted in doing the work, with one student observing it was "easier to do work in Africa" – and another reporting on the outright racism expressed by some faculty, e.g., one professor asking "how is using traditional knowledge different from reading a horoscope in a newspaper?" With regard to implementing Indigenous research methodologies, the Indigenous students emphasized the importance of spiritual preparation, building relationships, and the importance of having grown up as a "traditional person," and the non-Indigenous students spoke to the necessity of practicing de-colonizing research, of finding Indigenous mentors, and of approaching the work with a deep sense of humility. Suggestions to make Indigenous health research methodologies more accessible to students included strengthening interdisciplinary links, addressing the racism in academia, and, for the Indigenous students, grappling with dynamics of doing research in one's own community, while for the non-Indigenous students, coming to terms with having a settler identity.

The discussant, **Brenda Seals** (Eastern Band Cherokee), reflected on how the issues discussed were both of vital importance to Indigenous communities and also much more widely applicable. Many individuals, not just Indigenous peoples, want to tell their stories to understand their health, and many confront the difficulty of fitting the round circle of knowledge into what are often the square pegs of conventional scientific approaches to obtaining knowledge. Examples of problematic research include restricting study of American Indian health to surveys on alcohol, as if it were the only issue, or combining data across the extremely diverse 500+ federally recognized tribes, as if there were a single summary measure of "Indian health." At the same time, the need for trustworthy research and knowledge, including for interventions and programs, is acknowledged. To do this work well, Brenda concluded, means the researcher must see her/himself in terms of the 7 generations – both as the last of these generations, benefiting from the knowledge that has come before, and also as the beginning of the next 7 generations, in terms of one's obligations to the future.

During the **Q&A**, one set of questions focused on the lack of – and questions about – mechanisms to enforce the conduct of appropriate and ethical research with Indigenous peoples, with the need for such mechanisms and enforcement highlighted by several examples shared about contemporary scientific misconduct (e.g., one non-Indigenous researcher

who stole blood samples from one group of American Indians who had not consented to her analyzing them, and yet who was able to publish results in mainstream journals and be accorded scientific prestige). Another question concerned similarities and differences of Indigenous frameworks and "western-origin" but non-Indigenous critiques of the dominant reductionist biomedical paradigm. The overall session ended by emphasizing the importance of respect, dignity, and social justice for the conduct of valid science.

4) PROGRESSIVE PEDAGOGY

This session on links between pedagogy and community-based participatory approaches was attended by ≈ 25 people (a smaller than usual pedagogy session, noting that in 2008, ≈ 100 attended, in 2007, ≈ 250 attended, and in 2006 ≈ 50 attended). We are unclear on the reasons for low attendance, noting that some of our prior sessions that also focused on CBPR in relation to pedagogy did draw more of an audience.

COMMUNITY PERSPECTIVES ON COMMUNITY-BASED PROGRESSIVE PEDAGOGY
TUES, NOV 10 * 8:30 AM-10:00 AM (SESSION 4068.0)*** PHIL CONV CENTER (PCC) RM 113A**

8:30 AM — Introduction. Suzanne Christopher, PhD & Lisa Dorothy Moore, DrPH

8:35 AM — "Will they really use our work?" The importance of University/Community Partnerships in creating relevant Service learning assignments. Jean M. Breny Bontempi & Chris Cole

9:00 AM — Community-based participatory research as a lens for reconceptualizing service learning: diverse urban students bridging campus and community. Ester R. Shapiro, PhD & Michelle Rogers, BA, Asi Yahola Somburu, BA, Genita Johnson, MD, MPH, Brian K. Gibbs, MPA, PhD, Naomi Bitow, MPH, Roland Smart, BA, K.T. Craddock, EdM, PhD, V. Kumarpeli, MB, BS, MSc, MD, S. Walker, BA, Felton Earls, MD

9:25 AM — Question & answer period

Suzanne Christopher opened up the session, introducing the speakers and also the genesis of the session – which is that having previously included some courses that emphasized the importance of community-based service and learning, we thought it would be useful to get community perspectives on this approach to pedagogy.

Jean M. Breny Bontempi described the partnership between her academic institution (South Connecticut State University) and AIDS Project New Haven in a course focused on community-based service learning. Opportunities included the chance for students to work on projects that get used by the community and to learn critical skills regarding collaboration and group dynamics; challenges included the difficulties of conducting such a class in a student body that is largely part-time/commuter students and the attendant difficulties of work schedules, commuter schedules, and family responsibilities. One solution to these problems was to have students divide up into workgroups that matched with both their academic interests (in relation to skills they already had and new skills they wanted to learn) and their time constraints. One workgroup accordingly focused on administrative/management aspects of the project, another on secondary data analysis (including literature reviews), and the third on primary data collection (e.g., conducting a client and staff satisfaction/needs survey, on-site observation, and a client focus group). The University's IRB approved the work of the class, conditional on informed consent being obtained from all participants and also prohibiting the publication of any content data on the project's findings (although discussion of the process of the class can be shared). Staff from AIDS Project New Haven were actively involved in designing the project goals (including methods used), provided advice throughout the project, and at the end came to the final class in which students presented their findings and recommendations – and then took this information back to their board, thereby initiating some potentially useful changes in their practices. Positive aspects for the community agency of being involved in the class included: (1) getting fresh views on their work from an "outsider" perspective; (2) receiving the product of quality focused work provided as a free service; (3) the reward of introducing developing professionals to service work; (4) attracting subsequent interns and volunteers from students who took the course; and (5) strengthening the agency's ties to the University. The two major challenges concerned: (1) ensuring client confidentiality, and (2) allocating the staff resources to provide adequate supervision of the students. The overall sense was that the benefits far exceeded the challenges for all concerned.

Ester Shapiro next presented on models, methods, and challenges in service learning, drawing on experiences from what had started out as a joint collaboration between two institutions, but was now a course based only at her institution (since the relevant unit at the other institution no longer existed, following the departure of its head for another position). Noting that most service-based learning has been premised on the assumption that it is for white middle-class students who have

not experienced poverty or social exclusion so that they can benefit from learning about conditions in marginalized communities, she countered that the urban commuter students who take her course are in fact from the very communities targeted for being served by the service-based courses. Consequently, course objectives need to address pathways by which these urban commuter lower income students can convert their community-based knowledge into professional pathways for personal and community development. The approach of community-based participatory research, as used in the course, offers one bridge for helping students see the relevance of research to further these twin goals, and also for understanding how research can be a tool for accountability. The theme of the importance of learning in order to "give back" was then emphasized by Special, one of the graduate students who took the course and who now is mentoring undergraduates to get them involved in community-based research that can address community needs.

During the **Q&A**, one set of questions focused on the difficulty of addressing curriculum content versus getting the actual work done; one solution discussed was using classroom time (and also "laboratory time") for both teaching content AND holding the discussions needed to move the project along. Another set of questions focused on issues of students' diverse skill levels (ranging from practically illiterate to very skilled students) and time demands (given jobs, commuting, and families), with discussion emphasizing the importance of the course for putting these challenges in context and also the necessity of structuring the course so that students can participate at (and extend) their relevant skill levels, and work collaboratively in teams, with opportunities provided for them to mentor each other (as opposed to viewing all mentoring as solely the faculty member's job). An alternative suggestion, based on approaches currently used in New Zealand, is to recruit students from relevant community services (e.g., Maori health providers) that see the value of research and data and who are eager to have members of their staff brought into the University to learn helpful skills, which they can then bring back to their organizations. The overall emphasis in the discussion was on the need for inclusive methods, drawing on what the students, academic institutions, and community groups can each best offer.

5) STUDENT POSTER SESSION

Our 8th **"STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH"** had 9 posters accepted (of which 1 had to withdraw). Throughout the hour for this session there was a constant flow of people coming to see the posters, giving the student presenters many opportunities to discuss their work. The eight posters displayed were as follows:

STUDENT POSTER SESSION: SOCIAL JUSTICE & PUBLIC HEALTH

TUES, NOV 10 * 12:30 -1:30 PM (SESSION 4162.0)*** PHIL CONV CNTR (PCC) HALL A/B**

Board 1 — Evaluating the progress made towards universal health care for Philadelphians six year after a successful ballot referendum. *J.R. Pahys*

Board 2 — Infrastructure, women's time allocation, and economic development: a multidisciplinary theoretical model. *P.R. Agénor,* ***M. Agénor, MPH***

Board 3 — Public health and people with disabilities: where are we and where do we need to go? *D.E. Nary, MA, C. Gonda, BGS*

Board 4 — Issues in assessment of "race" among Latinos: implications for public health *V.C. Allen, BA;* *C. Lachance, MPH, B.Rios-Ellis, PhD, MS, K. Kaphingst, ScD*

Board 5 — Reducing disparities in emergency preparedness and response for people with disabilities. *C. Gonda, BG*

Board 6 — Formulating an evaluation and data-collection plan for the Baltimore Cardiovascular Health Disparities Initiative. *S. Murthy, MPH, MD candidate,* *S. Cosgrove, MHA, C. Fichtenberg, PhD*

Board 7 — Walksore.com: a new methodology to explore associations between neighborhood resources, race, and health. *M. Brewster,* *D. Hurtado, S. Olson, J. Yen*

Board 8 —Individual and neighborhood level predictors of fear: an examination of the effects of the experience of violence and social capital at both the individual and neighborhood level. *E. Richardson, MS*

Suggesting our session is meeting its objective in helping bring forward the next generation for the ongoing work linking social justice and public health, the poster session represented the first time most of the students had shared their results at a scientific conference and for many it was also their first time attending an American Public Health Association annual meeting. They really appreciated the opportunity to gain the experience of presenting their work and meeting so many different people in so many diverse aspects of public health, and likewise felt affirmed in their focus on issues of social justice and public health.

6) Other:

We co-sponsored & helped organize the **P. Ellen Parsons Memorial Session, on "Health Reform 2009: How did we Do?"** The primary sponsor, as usual, was the Medical Care Section (via Ellen Shaffer); other co-sponsors were the Women's Caucus and the Socialist Caucus. It was attended by ≈ 50 people (down from the ≈ 100 people in 2008 and ≈ 75 people in 2007, but the year before, but higher than the ≈ 35 in 2006).
-- Ellen Shaffer, based at EQUAL (Center for Health Analysis) opened the session by reviewing the long and troubled history of efforts to get health care reform in the United States, discussed the current politics of health care reform in the US (including the major obstacles that conservatives don't really need to have a "better" idea – they can just say "no," with their scare tactics routinely echoed in the corporate media), and then reviewed the features of the bill just passed by the House (HR 3962), and emphasized the need to keep the pressure on to keep the public option alive, to contain the "teabaggers," overturn the anti-abortion Stupak amendment, and permit states the option for single-payer.
-- Ollie Fein, the president of the Physicians for a National Health Program (see: http://www.pnhp.org), reviewed the interconnected problems of uninsurance, underinsurance, and exploding health care costs in the current US health care situation, argued that the legislation being proposed in Congress was effectively a bail-out for private health insurance and would do nothing to control costs while leaving many still uninsured and underinsured, and proposed continuing to advocate for single-payer bills also now on the Congressional agenda (HR676 and S703/HR1200), stating that without such an approach, the expected cost of health care premiums in 2025 will be equal to the average US household income.
-- Elmer Freeman, Executive Director of CCHERS, a consortium of community health centers in Boston, then spoke from the perspective of safety net providers. Noting the problems caused by lack of incentives for physicians to become primary care providers, he argued that he agrees single-payer is the ideal approach, but that it is likely not attainable right now, and the pressure must be kept on for a public option. A key concern is not to have the national plan emulate the "health care reform" enacted in Massachusetts, which has not contained cost and has just meant more money for the insurance companies, including at the expense of the "uncompensated care pool" that used to help with costs of indigent care at such major hospitals as Mass General and the Cambridge Health Alliance.
-- Cindy Pearson, Executive Director of the National Women's Health Project, then discussed the "Raising Women's Voices" project her organization had formed 3 years ago in conjunction with other groups concerned about issues of reproductive health in relation to health care reform. Until last Friday, they thought it had been an effective project, one that built ties with allies wanting single-payer, who emphasized public health and primary care, who recognized the importance of addressing race and class issues in the delivery of health care and the need to support community health centers, and also that listened to women's voices in the health process and argued that abortion cannot be segregated from other aspects of women's health care. Yet, with passage of the Stupak amendment last Friday, which Pelosi acceded to after her meeting with the Bishops and thinking the Democrats would lose the votes without accepting this "compromise," she and others in the "Raising Women's Voices" projects are now rethinking strategies to get this amendment overturned, with possibilities including civil disobedience (per the origins of the National Women's Health Network in the early 1970s, including a protest held in the US Senate) and also increased efforts at mobilization.
-- During the **Q&A**, one tension that surfaced was between those who cannot in good conscience support the current legislation (for falling short of being single-payer, let alone the new anti-abortion amendment) and those who hold that work needs to be done to make the present bills as good as they possibly can be, despite their problems. It was pointed out that it took 35 years from enactment of the National Health Service in the UK to their issuance of the Black Report, which documented that universal health care was not by itself sufficient to end class disparities in health, suggesting that societies need to learn from the limitations and strengths of the legislation they pass. Two additional suggestions were to increase use of shame as a tactic against the insurance industries and also to identify members of Congress willing to speak to the issue of abortion access based on personal experience (for themselves individually or of family members), with it being noted that the genesis of most of the Institutes in the National Institutes of Health lie in members of Congress being motivated by family members suffering from the diseases in question.

Finally, the Spirit of 1848 co-sponsored the Occupational Health and Safety health activist dance on the Tuesday night of APHA.

And we had our usual brightly colored poster visibly posted in all relevant spots! ....

Onwards! ....
Spirit of 1848 Coordinating Committee

SPIRIT OF 1848 MISSION STATEMENT

November 2002

The Spirit of 1848:
A Network linking Politics, Passion, and Public Health

Purpose and Structure

The Spirit of 1848 is a network of people concerned about social inequalities in health. Our purpose is to spur new connections among the many of us involved in different areas of public health, who are working on diverse public health issues (whether as researchers, practitioners, teachers, activists, or all of the above), and live scattered across diverse regions of the United States and other countries. In doing so, we hope to help counter the fragmentation that many of us face: within and between disciplines, within and between work on particular diseases or health problems, and within and between different organizations geared to specific issues or social groups. By making connections, we can overcome some of the isolation that we feel and find others with whom we can develop our thoughts, strategize, and enhance efforts to eliminate social inequalities in health.

Our common focus is that we are all working, in one way or another, to understand and change how social divisions based on social class, race/ethnicity, gender, sexual identity, and age affect the public's health. As an activist and scholarly network, we have established four committees to conduct our work:

1) Public Health Data: this committee will focus on how and why we measure and study social inequalities in health, and develop projects to influence the collection of data in US vital statistics, health surveys, and disease registries.

2) Curriculum: this committee will focus on how public health and other health professionals and students are trained, and will gather and share information about (and possibly develop) courses and materials to spur critical thinking about social inequalities in health, in their present and historical context.

3) E-Networking: this committee will focus on networking and communication within the Spirit of 1848, using e-mail, web page, newsletters, and occasional mailings; it also coordinates the newly established student poster session.

4) History: this committee is in liaison with the Sigerist Circle, an already established organization of public health and medical historians who use critical theory (Marxian, feminist, post-colonial, and otherwise) to illuminate the history of public health and how we have arrived where we are today; its presence in the Spirit of 1848 will help to ensure that our network's projects are grounded in this sense of history, complexity, and context.

Work among these committees will be coordinated by our Coordinating Committee, which consists of a chair/co-chairs and the chairs/co-chairs of each of the four sub-committees. To ensure accountability, all public activities sponsored by the Spirit of 1848 (e.g., public statements, mailings, sessions at conferences, other public actions) will be organized by these committees and approved by the Coordinating Committee (which will communicate on at least a monthly basis). Annual meetings of the network (so that we can actually see each other and talk together) will take place at the yearly American Public Health Association meetings. Finally, please note that we are NOT a dues-paying membership organization. Instead, we are an activist, volunteer network: you become part of the Spirit of 1848 by working on one of our projects, through one of our committees--and we invite you to join in!

Community email addresses:

Post message:	**spiritof1848@yahoogroups.com**
Subscribe:	**spiritof1848-subscribe@yahoogroups.com**
Unsubscribe:	**spiritof1848-unsubscribe@yahoogroups.com**
List owner:	**spiritof1848-owner@yahoogroups.com**
Web page:	**www.Spiritof1848.org**

First prepared: Fall 1994; revised: November 2000, November 2001, November 2002

NOTABLE EVENTS IN AND AROUND 1848

1840-1847: Louis Rene Villermé publishes the first major study of workers' health in France, A Description of the Physical and Moral State of Workers Employed in Cotton, Linen, and Silk Mills **(1840)** and Flora Tristan, based in France, publishes her London Journal: A Survey of London Life in the 1830s **(1840)**, a pathbreaking account of the extreme poverty and poor health of its working classes; in England, Edwin Chadwick publishes General Report on Sanitary Conditions of the Laboring Population in Great Britain **(1842)**; first child labor laws in the Britain and the United States **(1842)**; end of the Second Seminole War **(1842)**; prison reform movement in the United States initiated by Dorothea Dix **(1843)**; Frederick Engels publishes The Condition of the Working Class in England **(1844)**; John Griscom publishes The Sanitary Condition of the Laboring Population of New York with Suggestions for Its Improvement **(1845)**; Irish famine **(1845-1848)**; start of US-Mexican war **(1846)**; Frederick Douglass founds The North Star, an anti-slavery newspaper **(1847)**; Southwood Smith publishes An Address to the Working Classes of the United Kingdom on their Duty in the Present State of the Sanitary Question **(1847)**

1848: World-wide cholera epidemic

Uprisings in Berlin, Paris, Vienna, Sicily, Milan, Naples, Parma, Rome, Warsaw, Prague, Budapest, and Dakar; start of Second Sikh war against British in India

In the midst of the 1848 revolution in Germany, Rudolf Virchow founds the medical journal Medical Reform (Medicinische Reform), and publishes his classic "Report on the Typhus Epidemic in Upper Silesia," in which he concludes that preserving health and preventing disease requires "full and unlimited democracy"

Revolution in France, abdication of Louis Philippe, worker uprising in Paris, and founding of The Second Republic, which creates a public health advisory committee attached to the Ministry of Agriculture and Commerce and establishes network of local public health councils

First Public Health Act in Britain, which creates a General Board of Health, empowered to establish local boards of health to deal with the water supply, sewerage, cemeteries, and control of "offensive trades," and also to conduct surveys of sanitary conditions

The newly formed American Medical Association sets up a Public Hygiene Committee to address public health issues

First Women's Rights Convention in the United States, at Seneca Falls

Henry Thoreau publishes Civil Disobedience, to protest paying taxes to support the United State's war against Mexico

Karl Marx and Frederick Engels publish The Communist Manifesto

1849-1854: Elizabeth Blackwell sets up the New York Dispensary for Poor Women and Children **(1849)**; John Snow publishes On the Mode of Communication of Cholera **(1849)**; Lemuel Shattuck publishes Report of the Sanitary Commission of Massachusetts **(1850)**; founding of the London Epidemiological Society **(1850)**; Indian Wars in the southwest and far west **(1849-1892)**; Compromise of **1850** retains slavery in the United States and Fugitive Slave Act passed; Harriet Beecher Stowe publishes Uncle Tom's Cabin **(1852)**; Sojourner Truth delivers her "Ain't I a Woman" speech at the Fourth Seneca Fall convention **(1853)**; John Snow removes the handle of the Broad Street Pump to stop the cholera epidemic in London **(1854)**