SPIRIT OF 1848: APHA 2011 REPORTBACK (FINAL: November 13, 2011)

TO: EVERYONE ON SPIRIT OF 1848 EMAIL BULLETIN BOARD
FROM: SPIRIT OF 1848 COORDINATING COMMITTEE
RE: REPORTBACK FROM THE 2010 APHA CONFERENCE

Greetings! The Spirit of 1848 Caucus is happy to share our reportback from the 139th annual meeting of the American Public Health Association (October 29-November 2, 2011, in Washington, DC). In this reportback we:

(a) present decisions we made at our business meeting, including initial ideas for the APHA 2011 session; and

(b) give highlights of our APHA 2011 sessions.

We are sending this reportback by email and posting it on our web site. As of November 1, 2011, 3,125 people subscribe to our email bulletin board (up from 2,926 last year), from both the US and elsewhere in the world. We expect still more to sign up, given the interest expressed at the APHA meeting. Attendance at our sessions was very good this year: 650 persons came to our sessions (not counting those who visited the very crowded student poster session or the sessions that we co-sponsored), on par with or better than prior years (in 2010, 675 attended our sessions, as did 400 in 2009 and 600 in 2008). Moreover, our sessions, as usual, had very good attendance by APHA standards, noting that average attendance for APHA sessions is 30 persons/session, and our 2011 attendance ranged from 70 to 240 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 Simonds (Politics of public health data committee); email: vanessa-simonds@uiowa.edu
--Anne-Emanuelle Birn (History committee); email: aebirn@utoronto.ca
--Luis Avilés (History committee); email: luis.aviles3@upr.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 1, 2011, 6:30-8:00 pm)

Attended by: (a) Spirit of 1848 Coordinating Committee members (alphabetical order): Suzanne Christopher (pedagogy), Nancy Krieger (chair & integrative), Rebekka Lee (student poster), Vanessa Simonds (data), and Pam Waterman (e-networking and Spirit of 1848 representative to the APHA Governing Council), and (b) additional Spirit of 1848 members (alphabetical order): Maria Pia Chaporro, Elizabeth Fore, Mary Mbaba, Chris Morrssink, Sarah Ramirez, Tabashir Sadegh-Nobari, and Mary Wang.

Spirit of 1848 Coordinating Committee members who were unable to attend (but provided input in advance) were: Luis Avilés (history), Anne-Emanuelle Birn (history), Catherine Cubbin (data), Jennifer Garcia (student poster), and Lisa Moore (pedagogy).

Note: as of this 2011 APHA meeting, Alexandra Stern stepped down from co-chairing the 1848 history subcommittee, after 3 years of service – and we thank her for & greatly appreciate all her contributions!

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 shared our delight that the outgoing President of APHA, Linda Rae Murray, who has attended many of our sessions over the years, publicly said in her powerful Presidential Address in the opening session (on Sun, Oct 30), that we, the Spirit of 1848, are her "favorite" caucus! – which was an unexpected and wonderful shout-out, not only about our Caucus, but for all that we stand for, in & outside of APHA.

3) We flagged that discussions are underway to see if it would be feasible, institutionally, as well as useful, substantively, to figure out some sort of affiliation between the People's Health Movement and the Spirit of 1848 Caucus specifically, and also PHM and APHA more broadly; to learn more about the People's Health Movement, whose objective #1 is "To promote the Health for All goal through an equitable, participatory and inter-sectoral movement and as a Rights Issue": and to sign onto The People's Charter for Health, see: http://www.phmovement.org/

4) We were glad to learn that the APHA governing council passed, on Nov 1, 2011 with 74% approval, a resolution supporting the Occupy Wall St movement (which the Spirit of 1848 had supported) – see details below, in item #7, re Spirit of 1848 & the APHA Governing Council sessions .

5) We reported back on how our various sessions went (see detailed descriptions below), discussing both attendance and content. The estimated attendance for our sessions (n ≈ 650 total) was as follows: social history of public health (n ≈ 70); the politics of public health data (n ≈ 200); progressive pedagogy in public health (n ≈ 140); "integrative" session (n ≈ 240). As noted above, attendance at these sessions was on par with previous years (last year history was ≈ 130; data was ≈ 120, pedagogy was ≈ 150, and the integrative session was ≈ 275). Indicating how APHA members do find our sessions useful, we note that 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 engagement of the audience in the Q&A.

6) We discussed ways to better highlight the existence of the Spirit of 1848 and its listserve. Plans include:
(a) setting up a static facebook page that directs folk to both our website and our listserve;
(b) more prominently featuring the listserve on our Spirit of 1848 website; and
(c) expanding the listserve reminder to encourage listserve subscribers to promote the Spirit of 1848 listserve via their facebook pages and via twitter, and also to invite people who receive messages forwarded from the Spirit of 1848 listserve to subscribe directly to the listserve.

7) The next morning, 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 2, and reported back that:

> Alan Baker, the interim executive director of APHA, greeted the caucus representatives, present from almost every caucus, and briefly reviewed changes in the APHA membership structure (also touched upon at the Governing Council meeting on Saturday) that are being considered as a means of growing the steadily declining membership, as well as increasing revenue. He also noted that APHA has received a $1 million grant from the Kellogg Foundation for infrastructure, technical, and leadership development that will help support, and possibly expand, APHA staff. Barb Levin, of the Inter-sectional Council -- the APHA committee that comprises section chairs, chair-elects, and immediate past chairs -- also addressed the group to explain the ISC's function within APHA.
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> The main order of business at the breakfast, however, was a brief review of the proceedings from the Caucus Retreat held this past August, and a vote whether or not to form a 'Caucus Collaborative', which would be a committee composed of 1 representative from each caucus. Although we are not quite sure how it will work, the group voted quickly and unanimously to form the Collaborative. An email will be sent to each of the caucus leaders requesting that s/he identify her/his caucus' designated representative.
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> An unexpected highlight of the breakfast this year was a visit from President Linda Rae Murray, who said that her "favorite part of APHA is the Caucuses", but made a point to note that she was NOT speaking on behalf of APHA ☺. She reminded us that we are supposed to be the "trouble-makers", and as such, she urged us to continue to work to bring to the table the pieces of public health that the typical APHA members might not notice, and to continue to change the face of APHA, and by doing so, change the face of public health.

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

> Representatives from 4 of the 18 APHA caucuses, including the Spirit of 1848, attended the Governing Council sessions, with the Community-Based Public Health Caucus often seating 3 representatives at a time. There was no business that arose during the meetings that pertained to the caucuses in general, or the Spirit of 1848 in particular. As the Spirit of 1848 representative, I was moved to speak in favor of a measure that was introduced to urge APHA to issue a statement in support of the Occupy Wall Street Movement. Discussion was cut off, however, before I and the other Caucus representatives from the Women's Caucus and the Community-Based Public Health Caucus could speak.
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> The motion was passed with 74% of the votes in favor. The final text follows:
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> The Occupy Wall Street movement is now active in more than 1,000 cities in the US and has related protests around the world. APHA supports its call for greater social equality, social justice reducing income inequality, and its demand that corporate crime be investigated and prosecuted. APHA will identify opportunities to build on the energy and enthusiasm of the global Occupy movement and its synergies with public health.

8) With regard to sessions for next year **(140th annual meeting of APHA, Oct 27-31, 2012, in San Francisco, CA, with a theme of *"Prevention and Wellness Across the Lifespan"*)**, 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 16, 2011.**

(b) **abstracts will be due between FEBRUARY 6-10, 2012.** As soon as we know the date of the abstract deadline assigned to the Spirit of 1848, we will post it on our listserve.

(c) as an overall framework for our sessions, we agreed to put analysis of health, prevention, and wellness across the lifespan in larger societal context, paying heed to level & spatiotemporal scale (i.e., lifespan of individuals, of neighborhoods & communities, and of historical generations at the national and global level). Moreover, in addition to our usual focus on ensuring speaker diversity in relation to race/ethnicity & gender, we also plan to include speakers ranging from the rising generation of youth, with their often wonderfully audacious impatience to create a better world, to our elders who are rich with experience, knowing we can learn much from both.

History: This session will accept **only solicited abstracts** that critically examine the history of activism around social welfare and social protection (i.e., promoting societal health & preventing health inequities, from "womb to tomb"), and will focus on activists engaged in both the US and abroad. It will be organized by Spirit of 1848 Coordinating Committee members Anne-Emanuelle Birn (email: aebirn@utoronto.ca) and Luis Avilés (email: luis.aviles3@upr.edu), along with Sarah Ramirez (email: sramirez@stanford.edu).

Data: This session will have an **open call for abstracts – and also solicit abstracts** -- that critically examine, conceptually & empirically, the new emphasis on "lifecourse" in social epidemiology. We are seeking presentations that: (a) critically explore concerns about the increasingly depoliticized, individualistic, and ahistorical approach to "lifecourse" appearing in biomedical research and its overwhelming emphasis on early life (including prenatal) exposures and "maternal effects," an orientation that downplays not only resilience/plasticity but also the importance of addressing gender relations and the social as well as biological relevance of fathers/partners, and also adolescent & adult experiences (noting that myriad studies demonstrate the importance of addressing cumulative disadvantage) and/or (b) focus on analyzing changing magnitudes of health inequities over time, whether within or between countries or regions, in relationship to historical generation & societal context, including for specific age-groups. This session will be organized by Spirit of 1848 Coordinating Committee members Catherine Cubbin (email: ccubbin@austin.utexas.edu), Nancy Krieger (email: nkrieger@hsph.harvard.edu), and Vanessa Simonds (email: vanessa-simonds@uiowa.edu)

Pedagogy: This session will have an **open call for abstracts** – and also **solicit abstracts** -- that critically examines teaching, both in and outside of traditional academic settings, that includes a focus on social justice & public health in relation to different age groups and/or is geared towards either younger students (e.g., in high school) or to elders in our communities. It will be organized by Spirit of 1848 Coordinating Committee members Lisa Moore (email: lisadee@sfsu.edu) and Suzanne Christopher (email: suzanne@montana.edu).

Integrative: This session will accept **only solicited abstracts** and will critically examine issues of social justice & public health across the lifespan and will 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 by Spirit of 1848 Coordinating Committee members Nancy Krieger (email: nkrieger@hsph.harvard.edu), Anne-Emanuelle Birn (email: aebirn@utoronto.ca), and Luis Avilés (email: luis.aviles3@upr.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, including but not limited to work with a critical lens on issues of societal health, prevention, and wellness across the lifespan. Noting that students often have limited budget for travel, we will reach out especially to students in the San Francisco Bay area. 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); also helping to organize this session will be Tabashir Sadegh-Nobari (email: tabashir@ucla.edu).

We note that the day & time of these sessions will be in our usual time slots:

Spirit of 1848 session* -- name, day, and time (listed in chronological order)
-- 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 2010)

As usual, our sessions were lively, well attended, and thought provoking. We estimate that approximately 650 persons came to our sessions (not counting either those who visited the very crowded student poster session or who attended the sessions that we co-sponsored); this total attendance was on par with prior years -- in 2010, it was 675; in 2009, it was 400; and in 2008, it was 600. Also as per usual, our sessions had very good attendance by APHA standards: average attendance for APHA sessions is 30 persons/session, and our 2011 attendance ranged from 70 to 240 persons per session. Additionally, approximately 140 persons attended the session "In Honor of Jack Geiger" that we co-sponsored and about 15 attended the P Ellen Parsons memorial session that we likewise co-sponsored.

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

1) SOCIAL HISTORY OF PUBLIC HEALTH

This session was attended by ≈ 70 people (attendance in 2010: ≈ 130 people; in 2008 & 2009, ≈ 100).

CRITICAL HISTORIES OF COMMUNITY HEALTH CENTERS
MON, OCT 31 ***10:30 AM-12 NOON (SESSION 3177.0) * WASH CONV CTR (WCC) RM 101**
10:30 AM — Moderator. Sarah Ramirez
10:35 AM — Serving an Expanding Community: How a free HIV clinic Transformed into a full Community Health Center. P. Justin Goforth
10:55 AM — A Matter of Principle: Community Health Centers and Health Care as a Right. Fitzhugh Mullan
11:15 AM — Young Lords and the Struggle for Racial Justice and Public Health in New York. Johanna Fernandez
11:35 AM — Question & answer period

Sarah Ramirez opened up the session, asking all present to think critically about the histories of community health centers in relation to struggles for social justice & public health, including the salience of this history for today.

P. Justin Goforth then discussed what he termed the 4 decades of LGBT (lesbian, gay, bisexual, transgender) health in the US, spanning "from church basements to medical homes," drawing on his experience as long-standing staff member & nurse at the Whitman-Walker clinic in Washington, DC, combined with his decades of involvement as an AIDS activist and out gay man living with HIV/AIDS (active in ACT UP and Queer Nation and who, among other things, in the 1980s, in one action, was part of putting a large condom on the home of Jesse Helms …). The first decade, spanning from the mid-1960s through 1970s, was, in his words, "pre-LGBT health care." It encompassed the pivotal event of the 1969 Stonewall Rebellion, when people who identified as LGBT (in contemporary terms) fought back against police harassment, and also when gay men began publicly and collectively challenging their inequitable treatment in mainstream health facilities, e.g., by forming, in several cities, the first gay men's VD (venereal disease, as it was termed then) clinics, typically in church basements (as was the case for Whitman-Walker, which also had its roots in the Washington Free Clinic). The second decade, of the 1980s, was marked by the emergence of HIV/AIDS in 1981, the formation of ACT UP and Queer Nation to fight for better treatment and prevention, and to shift the struggle to the rights of LGBT, not only about health care but more generally. During this second decade, Whitman Walker obtained its first funds for AIDS education and evaluation, as well as for housing, and also established the first dental services for people living with HIV/AIDS, who at this time were still predominantly gay, white, and non-impoverished men. The third decade, during the 1990s, saw the shift brought about by the first treatments for AIDS, starting with AZT in 1989, thereby starting the transformation of AIDS into a "manageable" chronic disease. During this decade, activism led to passage of the Ryan White CARE act, enabling expansion of services – albeit efforts to further prevention via needle exchange were stymied by Congress. In the 4th decade, the 2000s, HIV/AIDS in the US – and Washington, DC – clearly shifted to becoming a disease primarily of people of color living in poverty, funds for health care and social services became more scarce, and for the 1st time ever, in 2005, Whitman Walker missed paying a payroll and had to lay off staff. These changes led to it deciding, in the late 2000s, to become a full-fledged community health center, providing not only equitable health care for whomever walked in, but also one that began to bill for some services (e.g., pharmacy) in order to use the funds generated to pay for other services; completing the circle, it also took back under its roof the Washington Free Clinic from which it had been born.

Fitz Mullan next discussed the relationship between the community health centers (CHCs) and the National Health Service Corps (NHSC, founded in 1972, which enabled newly trained physicians to have the cost of their medical education covered in return for providing services, post-graduation, to medically underserved populations, and for which he served as director during the 1970s). He noted that before 1965, there had been little direct federal involvement in the

provision of health care; that changed after 1965, however, with the decision of the Office for Economic Opportunity (OEO), established as part of the War on Poverty and in response to the Civil Rights Movement, to fund CHCs and to do so directly, by-passing the states, because many states could not be trusted to spend funds as intended, i.e., on medical care for people of color. Two key principles pertained to community control of CHCs and also health care as a right, with CHCs demonstrating this was a right that could be fulfilled; also key was the federal provision that CHCs could "build capacity" – literally, in terms of "brick & mortar," by building health centers where none existed, above and beyond the hiring of health care personnel. Subsequent attempts to impose state control of CHCs (e.g., by putting their funds into block grants administered by states) were successfully blocked by CHC advocates; even so, federal funding has declined, as a proportion of CHC budgets, from 100% in the early days to about 20% now, with replacement funds largely coming from Medicaid and Medicare. Although Nixon succeeded in abolishing the OEO, he was forced to keep the CHCs, which were transferred to the Dept of Health Education and Welfare (HEW), now termed the Dept of Health and Human Services (DHHS); the Carter administration subsequently supported both the formation of the National Association of CHC as an advocacy group and established the first formal links between the CHCs and the NHSC, in which newly trained physicians paid back the cost of their medical education by working as CHC employees. During the Reagan administration, funds for NHSC were cut, but these physicians could – as "private practitioners" – be hired as CHC staff; by the 1990s, CHCs had found ways to obtain funding via Medicaid and Medicare – and in the 2000s, CHCs have become a key way of covering the medically uninsured, despite the challenges imposed in this era of economic austerity. In summary, CHCs have made enormous gains over the past 50 years, but many challenges remain – not the least of which include "capacity crunch," limited ability to train the medical workforce, and where CHC fit into health care reform.

Johanna Fernandez then presented her analysis of the activism of the Young Lords in the 1960s and 1970s and its impact on public discourse and policy and practices re medical care and public health. She framed her research with the larger question of: why was health so important to the Civil Rights Movement? One answer arising from her investigation is that the same structural and economic forces that gave rise to this movement also generated the health inequities that it addressed. She noted that the Young Lords – who were active mainly in NYC and Chicago and were modeled after the Black Panthers – represented the 1st generation of Puerto Ricans born after the big post-WWII migration to the mainland. This generation had seen their parents receive degrading and inadequate medical care in the US, and were further radicalized by the other movements of the 1960s against the war and for civil rights. Many of their concrete campaigns accordingly had health content, whether about the inequitable functioning of hospitals, inadequate garbage collection, the need for testing for lead poisoning, or providing free breakfasts to children. Also key was the de-industrialization of urban economies, leading to a shift from blue collar to service jobs, which had lower wages, a decline in the tax base for municipal services, a rise in permanent unemployment among working age young adults, and programs of "urban renewal," leading to gentrification and displacement of the urban poor. These conjoined phenomena resulted in higher morbidity and concomitantly both increased demands on inequitable health systems and instigated a rise in activism with health-related demands. Specific actions and programs of the Young Lords accordingly focused on inadequate medical care and also lead poisoning, with tactics such as occupations of community spaces and hospitals leading to both increased media coverage and a changing of the public discourse about social responsibility for redressing societal inequities, including in relation to health and health care. Parallels to the ways in which current Occupy Wall St movements are changing the public discussion, via dissent in the streets, were raised as well.

During the **Q&A period**, comments focused on the critical need to: (1) retain a critical analysis of government interventions, including those of the Office of Economic Opportunity (whose mandate was to promote "maximum feasible participation" at the community level), recognizing that part of the impulse to fund these efforts was to defuse social strife and rebellion; and (2) regain a critical history of community health centers, including for their staffs, who so often do not know the histories of struggle that led to their formation.

2) POLITICS OF PUBLIC HEALTH DATA

Our session was attended by ≈ 200 (attendance in 2010: ≈ 120; in 2009: ≈ 175; in 2008: ≈ 250).

DISCRIMINATION, HEALTH, AND THE POLITICS OF PUBLIC HEALTH DATA: NEW EVIDENCE, BROAD PERSPECTIVES
MON, OCT 31 ***2:30 PM-4:00 PM (SESSION 3378.0) * WASH CONV CTR (WCC) RM 101**
2:30 PM — Introduction. Vanessa Simonds
2:35 PM — Racial Discrimination and Health: *My Body, My Story* – as told by explicit and implicit measures of exposure, in context. Nancy Krieger
2:55 PM — "My Heart Has Been Strengthened by Having to Go Take This Journey": Embodiment of Historical Trauma and Micro-Aggression Distress among American Indians and Alaska Natives. Karina L. Walters
3:15 PM — Structural Racism and the Architecture of Health. Makani Themba-Nixon
3:35 PM — Question & answer period

Vanessa Simonds opened up the session, introducing both the speakers and the session's theme – the need for critical analysis of how racial discrimination, at different levels and over different time periods, can harm health.

Nancy Krieger presented results from the *My Body, My Story* study, whose participants were recruited from Boston community health centers between August 2008 and December 2010, i.e., during the current period of economic crises. Premised on the ecosocial theory of disease distribution and its concern with embodying inequality, a central point of the presentation was that research on racial discrimination and health (and health inequities more broadly) must "directly grapple with issues of power and inequity, and how both not only drive the phenomena we seek to study, but also affect the measurement of exposure and its effects." Noting that the study on which the APHA presentation was based has just been accepted by PLoS ONE (an open-access journal), below we provide the study abstract; as soon as the article is published (on Nov 18, 2011), it can be accessed at no cost at: http://dx.plos.org/10.1371/journal.pone.0027636 Additionally, a list of useful references pertaining to the study framework, hypotheses, methods, and findings, is available at the APHA website; see: http://apha.confex.com/apha/139am/webprogram/Session31523.html

Krieger N, Waterman PD, Kosheleva A, Chen JT, Carney DR, Smith KW, Bennett GG, Williams DR, Freeman E, Russell B, Thornhill G, Mikolowsky K, Rifkin R, Samuel L. Exposing racial discrimination: implicit & explicit measures–the *My Body, My Story* study of 1005 US-born black & white community health center members. *PLoS ONE* (in press).

Background: To date, research on racial discrimination and health typically has employed explicit self-report measures, despite their potentially being affected by what people are able and willing to say. We accordingly employed an Implicit Association Test (IAT) for racial discrimination, first developed and used in two recent published studies, and measured associations of the explicit and implicit discrimination measures with: each other; socioeconomic and psychosocial variables; and smoking.

Methodology/Principal Findings: Among the 504 black and 501 white US-born participants, age 35-64, randomly recruited in 2008-2010 from 4 community health centers in Boston, MA, black participants were over 1.5 times more likely ($p < 0.05$) to be worse off economically (e.g. for poverty and low education) and have higher social desirability scores (43.8 vs. 28.2); their explicit discrimination exposure was also 2.5 to 3.7 times higher ($p < 0.05$) depending on measure used, with over 60% reporting exposure in 3 or more domains and within the last year. Higher IAT scores for target vs. perpetrator of discrimination occurred for the black versus white participants: for "black person vs. white person": 0.26 vs. 0.13; and for "me vs. them": 0.24 vs. 0.19. In both groups, only low non-significant correlations existed between the implicit and explicit discrimination measures; social desirability was significantly associated with the explicit but not implicit measures. Although neither the explicit nor implicit discrimination measures were associated with odds of being a current smoker, the excess risk for black participants (controlling for age and gender) rose in models that also controlled for the racial discrimination and psychosocial variables; additional control for socioeconomic position sharply reduced and rendered the association null.

Conclusions: Implicit and explicit measures of racial discrimination are not equivalent and both warrant use in research on racial discrimination and health, along with data on socioeconomic position and social desirability.

Karina Walters, from the Choctaw Nation (Oklahoma), focused on historical trauma and microaggressions that produce discrimination distress, and presented evidence of their adverse impact on health, even taking into account other forms of trauma. The data she presented was from the *Honor Project*, a national 6-site study "dedicated to testing an 'Indigenist' Stress-Coping Model of the relationships among trauma, coping, and health in urban gay, lesbian, bi-sexual, transgender, and Two-Spirit Native Americans and Alaska Natives" (see: http://www.iwri.org/honorproj/index.html). Noting that debate exists over the conceptualization and measurement of historical trauma, Walters argued that historical trauma is distinct from "intergenerational trauma," whereby the latter can refer to intergenerational consequences of traumatic events that are not themselves intentionally directed at a particular social group (e.g., a hurricane), whereas the former refers specifically to genocidal or ethnocidal events (usually repeated and compounding) that are perpetrated against a group of people – and their environment – who share a group identity and who are selected for traumatic treatment on account of their culture, lifeways or identity as a people, resulting in collective trauma that disrupts communities over generations, as has occurred for Indigenous Peoples. She then summarized evidence regarding US policies and events that have created historical trauma for American Indians/Alaska Natives, thereby disrupting people's ability to fulfill their original instructions, relational ways of being, and spatial obligations and relationships, and instead creating and enforcing systems of dependence on the colonial nation state. Also germane are microaggressions, including microinsults, microinvalidations, and microassaults; these insults occur chronically and induce stress, including by forcing the recipient of such behaviors to have to decide the intention of the perpetrator (i.e., racially biased versus rude to everyone). Walters likewise argued that analysis of the relationships and conditions that enable people to survive and resist their harmful effects is also essential. She then showed several results based on the 447 participants in the Honor Project, who were enrolled via respondent-driven sampling in different cities (with random sampling within identified networks, and oversampling for younger and transgender participants, as well as those with low identities as either LGBT and/or American Indian/Alaska Native) and who overall had high rates of unemployment and impoverishment. Within this group, even after controlling for military service, physical and sexual assaults, and current experiences of racial discrimination, Walters found that historical trauma, including direct assaults on ancestors and also loss of land, increased risk of poor physical and mental health, with direct attacks elevating risk of post-traumatic distress syndrome (PTSD) and indirect attacks increasing risk of depression.

Makani Themba-Nixon then introduced her discussion of structural racism and the architecture of health by recounting her mother's recent experiences, as a black woman, with stroke recovery at a well-known hospital in (liberal) Berkeley, CA – whereby initially the only support provided was for physical, but not cognitive, therapy. It was only when Themba-Nixon and her siblings made clear that their mother was a professor at Berkeley did the hospital staff suddenly say "we have to change treatment plan." This moment, like every other moment, argued Themba-Nixon, was "centuries in the making," such that understanding racist events requires analyzing the interaction, the current context, the history, "knowledge," and beliefs undergirding this context, and the inequitable power relations that are at the foundation of structural racism. Drawing on Gramsci, she argued that analyses must pay attention to the superstructures of meaning, to understand the forms of hegemony that explain control without force and why people do not rebel, because they are trained to operate within these structured relationships. To confront and change the architecture of racism and health, Themba-Nixon underscored the importance of asking "what might transformation look like?" in relation to: genuine democracy; global citizenship & solidarity; schools and other institutions of learning that advanced "justice" values; a mass media/culture that served as a source of progressive/transformative ideas; institutions that provide "truth" and meaning premised on radical ethics and values; and a public sector that truly is public and has real meaning, relevance, and engagement. Also important is re-evaluating evaluation methods to enable measurement of change and progress in context, so as to determine what constitutes valid and viable benchmarks of success. These could include: building power and agency; expanding networks; changing conditions (beyond health indicators, e.g., changing the social determinants of health); shifting the policy discourse (as Occupy Wall St is now doing); shifting the public discussion (ditto); increasing equitable distribution of resources. Addressing any of these issues requires understanding power and how it work. As an example, Themba-Nixon asked why it was that none of the great ideas advanced by progressives in public health became part of the national conversation about health care reform – and what might be alternative ways to disseminate these ideas outside of mainstream restricted media. She further argued that many of our communities want to be "stimulated" (i.e., receive economic stimulus funds), but it is difficult the track the money (especially at the level of local government); what forms of accountability are required? Only by asking these kinds of questions, premised on an alternative collective vision, will transformation be possible.

During the **Q&A**, comments focused on: (1) the need to analyze race/ethnicity and class in conjunction (including economic divisions among populations of color), including in studies of racial discrimination; (2) how we can analyze and measure power relations at multiple levels; (3) the impact of racial inequity on the conduct of science (e.g., questions asked and not asked; data collected and not collected); (4) how to avoid placing people in solely a "victim" mindset and consider also, in context, methods of coping and collective resistance and interventions (e.g., rewalk the Trail of Tears premised on a health promotion model that emphasizes the importance of reconnecting to a vision); (5) how to better link public health interventions with community organizing to alter power relations and distribution of resources; and (6) the need to transform the myriad structures and superstructures that perpetuate racism, not just "out there" but with accountability within public health for those aspects embedded in mainstream approaches to conceptualizing and doing scientific research and public health interventions and evaluations.

3) INTEGRATIVE

This session was attended by ≈ 240 persons (attendance in 2010: ≈ 275; in 2009: ≈ 90; in 2008: ≈ 150). It is called the "integrative" session because its different speakers address the 3 foci of the Spirit of 1848: social history of public health, the politics of public health data, and progressive pedagogy.

POWER, POLITICS, AND HEALTHY COMMUNITIES IN SOCIETAL & ECOLOGIC CONTEXT: FROM HISTORY AND EVIDENCE TO TRANSFORMATIVE KNOWLEDGE FOR ACTION
MON, OCT 31 ***4:30 PM-6:00 PM (SESSION 3455.0) * WASH CONV CTR (WCC) SALON I**
4:30 PM — Introduction. Nancy Krieger
4:35 PM — Impact of Corporations on Community Health: Disease Promotion and Its Remedies. Nicholas Freudenberg.
4:55 PM — Growing Smarter: Achieving Health and Sustainable Communities Through Environmental Justice. Robert Bullard
5:15 PM — Taking Action to Build Health Equity. Barbara Ferrer
5:35 PM — Question & answer period

Nancy Krieger opened up the session, pointing to the contrast between the universally professed desire for "healthy communities" and the obvious fact of gross inequities in the health of communities, both within & across the US, and within and across countries worldwide. Hence this session: to expose how adverse community conditions, created by unjust economic systems, deprivation, and discrimination, are the unsurprising outcome of politics and policies intended

to preserve the privilege and priorities of those with power – and to discuss ways of explicitly challenging and changing these conditions so as to improve population health and eliminate health inequities.

Nick Freudenberg opened up by saying he had spoken at Occupy Wall St (in NYC) last week and encouraged those in the audience to use their method of indicating if they did or didn't like points being stated, by respectively putting up their hands and wiggling their fingers or else indicating "thumbs down." He then developed his argument that corporate practices and behaviors, along with their products, are an intermediate-level social determinant of health and are a timely target for public health activism and policy change, especially given the recent sharp rise of corporate influence. The 6 "disease promotion" industries he focused on were: alcohol, automobile, firearms, food & beverage, pharmaceuticals, and tobacco. Countering what he termed the dominant emphasis on genomic medicine and "lifestyle" explanations of disease, Freudenberg called for scrutiny and exposure of the following corporate practices and their adverse impact on population health overall as well as their contribution to health inequities: lobbying, campaign contributions, philanthropy, and sponsored research (intended to obscure the harms caused by their products). For example, McDonald's spent $12 million in the last decade on lobbying, and in 2007 the Chief of the US Supreme Court, Justice John Roberts, gave a tour of the Supreme Court to the Snack Food Association. He then described two examples of public health campaigns designed to counter corporate practices: (1) Legacy's "Truth Campaign," which engaged young people to oppose smoking on the grounds that the tobacco companies were trying to dupe them; and (2) Corporate Accountability International's current campaign to "Retire Ronald McDonald," given his direct appeal to children as a deliberate way of circumventing parents' views; this is the same group that first called for getting rid of "Joe Camel." Freudenberg proposed that such anti-corporate campaigns can unify the 99% against the narrow interests of the 1% (many wiggling fingers in the air …). Examples he suggested for such anti-corporate campaigns could be: (1) enacting consumer right-to-know laws and company's duty-to-disclose laws; (2) strengthening protection of children and other vulnerable groups from predatory advertising and pricing; and (3) challenging the expanding protection of corporate speech and reduction of liability, by increasing accountability for costs of otherwise externalized harm. He closed by emphasizing the window of opportunity created by the existence of four movements that share the goal of curbing harmful corporate practices: Occupy Wall St, the food justice movement, the movement for health care reform, and the movement organizing around global warming.

Robert Bullard then discussed how calls for a "green economy" and "smart growth" – to create livable communities and sustainable communities – must be reframed to include the need to grow fairer, engaging with issues of environmental justice, regional equity, and what he termed the "legacy issues" arising from past and present histories of racial and economic injustice. Depicting what he termed "geographies of vulnerability," Bullard contrasted the touted lists of "best places," "healthiest places," and "greenest places" to live with those that show the flip side – with data showing that 7 of the 10 unhealthiest places to live are in the US south, home to a stroke belt, asthma belt, poverty belt, obesity belt, etc. Declaring that no one wants to live in a "worst place," he described how residents are "fighting like hell to flip the coin." And, at the neighborhood level, Bullard presented maps showing "food deserts" – i.e., what used to be called places, as described by one resident, "that don't have a grocery store" – with a belt likewise extending from the US south through Appalachia of places with high concentrations of residents who do not own a car and do not have a supermarket within 1 mile of where they live. What is needed, Bullard argued, however, is not more cars, but more investment in public transportation, and more improvements to the built environment to make communities "walkable" (e.g., make sure streets have sidewalks). Consequently, work to "green America," which Bullard stated would produce jobs, would also produce the most public health good if tied to work furthering environmental justice and regional equity.

Barbara Ferrer unfortunately wasn't able to join the panel, due to unexpected illness, but we were fortunate to have her Boston Public Health Commission (BPHC) staff member **Daisy De La Rosa**, who was attending APHA, step in and present the talk instead. The presentation first reviewed evidence persistent racial/ethnic health inequities in Boston, overall and as linked to residential segregation and manifested in neighborhood inequities in foreclosure rates, lead poisoning, asthma rates, homicides, obesity, lack of access to parks and to bike trails, etc. Next, the BPHC's model of social determinants of health was shown, emphasizing the ways in which racism structures the adverse conditions that produce and exacerbate health inequities. Based on this model, BPHC began a process 6 years ago to address racial/ethnic health inequities via work in the communities along with improved data gathering and both policy and system change. Starting with holding themselves accountable, within the BPHC 1100 employees received professional education to move forward the process of making the BPHC become an anti-racist institution; internal policies were changed that perpetuated inequities; and specific targets were set to reduce not only the rates of low birth weight, obesity and asthma but also to reduce racial/ethnic differences in these outcomes. A second key component of their strategy was to build community capacity. Specific steps taken were to: (1) invest $10 million in 75 community and health institutions, including job development to increase youth employment and leadership; (2) the "What is Your Health Code" campaign to raise

awareness in neighborhoods about the links between health and place, including the need for action at the community level (i.e., challenging the dominant view of health as a due to individual "lifestyle"); and (3) a violence intervention and prevention initiative located in 5 micro-neighborhoods focused on improving the built environment, challenging social norms, and connecting people to services. Additionally, at the level of policy and advocacy, the BPHC spurred work across all city departments to improve paid sick leave; it enacted a ban on sugar sweetened beverages on city property; and it decreased the number of dumpster storage lots in neighborhoods and improved zoning for land use. A key aspect of the work was to change how people think about health inequities and the questions asked, shifting from *conventional questions* to *health equity questions*. Examples included: (1) instead of asking "how can we promote healthy behavior?," ask: "How can we to target dangerous conditions and reorganize land use and transportation policies to ensure healthy spaces and places?"; (2) instead of asking "How can we reduce disparities in the distribution of disease and illness?," ask "How can we eliminate inequities in the distribution of resources and power that shape health outcomes?"; (3) instead of asking "What social programs and services are needed to address health disparities?," ask: "What types of institutional and social changes are necessary to tackle health inequities?"; and (4) instead of asking "How can individuals protect themselves against health disparities," ask: "What kinds of community organizing and alliance building are necessary to protect communities?" As part of this work, the BPHC has found it necessary to oppose racial discrimination in all settings and to focus on policies good for health, not just health policies.

In the **Q&A** period, discussion focused on: (1) the need to hold corporations accountable for their practices vis a vis production (e.g., wages and labor practices, international trade agreements, pollution, etc.) and not just for the impact of consumption of their products (e.g., food needs to be healthy not just in terms of its nutrient value but also with regard to the conditions in which it is produced, including the wages, salaries, and occupational safety and health of the workers involved, and the impacts of this production on the ecosystem); (2) the need to overcome the bias against use of public transportation as if only for "losers" (which is not how it is viewed in many European countries); (3) the need to be explicit about why bad conditions cluster in the US South, re political geography and the legacies of slavery, residential apartheid, and Jim Crow; (4) the need to move beyond the "evil average" and focus squarely on health inequities, since many of the "best places" to live also encompass marked inequities (as shown by the data on Boston); (5) the need to be explicit in countering the political institutionalization of greed, as per the neoliberal financial and deregulatory policies imposed since the 1980s; and (5) the utility of drawing on international human rights conventions and treaties, such as the International Convention on the Elimination of All Forms of Racial Discrimination, adopted by the General Assembly of the United Nations in 1965 and which the US signed in 1966 and ratified in 1994.

4) PROGRESSIVE PEDAGOGY

This session on links between pedagogy and capacity building to promote health equity was attended by ≈ 140 people (attendance in 2010: ≈ 150; in 2009: ≈ 25; in 2008: ≈ 100).

A SOCIAL JUSTICE PERSPECTIVE ON TEACHING AND CAPACITY BUILDING TO PROMOTE THE HEALTH OF COMMUNITIES
TUES, NOV 1 * 8:30 AM-10:00 AM (SESSION 4073.0)*** WASH CONV CTR (WCC) RM 101**
8:30 AM — Introduction. Cheryl Merzel
8:35 AM — THRIVE: A Toolkit for Community-Led Initiatives to Address Health Equity. Xavier Morales, Rachel Davis, Melissa Cannon
8:55 AM — From Building Capacity to Building Power: Lessons for Public Health Pedagogy. Makani Themba-Nixon**, Cheryl Grills**
9:15 AM — Paradox of Public Health and Social Justice: Being a Professional in the Social Change Process. David Chavis
9:35 AM — Question & answer period

Cheryl Merzel opened the session, noting its focus was on progressive pedagogy as carried out in community-based organizing and interventions (as opposed to "classroom" learning), with these efforts premised on seeking to build equitable relationships and promote health equity.

Xavier Morales, an urban planner who started out in environmental justice work and then found his niche in public health organizing, then discussed the THRIVE project, housed in the Prevention Institute. Initially funded for 2002-2004 by the Office of Minority Health, THRIVE is a "toolkit for community-led initiatives to address health equity," that was renewed in 2010 to support the training of trainers in 20 sites over the next 5 years. According to Morales, THRIVE's approach is to focus on resilience, not risk, in part by developing community-level measures of resilience that can be assessed. The first step is to instigate community assessments and discuss what is found; the second is to prioritize initiatives to promote a healthy community. A key component involves transforming how community members view the sources of and

solutions to health issues in their community, by shifting to from individual-level to community-level thinking and action. Morales then described how, in one site, THRIVE focused on training youth, who then organized to launch a teen center and also a county-wide mentoring program; other sites launched farmers' markets in neighborhoods lacking supermarkets, and conducted health impacts of urban planning initiatives. All sites sponsored community forums, as part of a process of strengthening residents' capacity to give voice to their concerns and language to express these concerns to local government, thereby holding government more accountable.

Cheryl Grills next described the work she is doing, working with the Praxis technical assistance team, to lead evaluation of the RWJ-funded project "*Communities Creating Healthy Environments (C-CHE): Improving Access to Healthy Foods and Safe Places to Play in Communities of Color*." This initiative began in 2008 with 10 sites and has since expanded to another 12 sites (i.e., 22 in total). As stated by Grills, their purpose is to shift from building capacity to building power. Objectives of C-CHE pertain to addressing such root causes of health inequities as land use policies, predatory marketing, and underfunded public infrastructure, whereby the process is conceptualized as challenging inequity so as to produce structural change whose impact results in food and recreational equity. The evaluation, in turn, is a dynamic process that both theorizes and operationalizes benchmarks of success in relation to base building, community leader development, and policy change – and, in doing so, not only generates information useful to those doing the organizing but is also addressing a major gap in the social science literature that Grills and her colleagues identified: the lack of tools to assess community organizing. Core components of the evaluation, premised on a social justice lens and involving both relationship building and ethnographic thick description, include a power analysis, a policy plan, and a communication plan. Noting that skill development applies as much to the evaluators as it does to the community participants, Grills described how the commitment to listening made clear that, in the case of one group, requesting written reports was inappropriate and inefficient. Instead, it was far better for the group to videotape its events and do "6 o'clock news" style interviewers of those engaged; these tapes were then sent to the evaluation team, thereby ensuring the events and views were documented (with the C-CHE team additionally transcribing the recorded interviews and conversations). Other guiding principles include: (1) people of color lead the work; (2) relationships are being built for the long-term, with an aim of creating a nationally linked movement, (3) experience as well as expertise is valued; and (4) initiatives should be intergenerational and work across race/ethnicity/class/age/native status. One example discussed concerned how one community decided to prioritize a focus on addressing structural barriers to breastfeeding, as informed by social justice and reproductive rights analyses; one action step was to challenge the promotion of breast formula by pharmaceutical companies by successfully changing local hospital policies to make them breast feeding baby friendly.

David Chavis then discussed four paradoxes that he has struggled with and that repeatedly emerge when professionals engage in social justice work and community organizing, including in public health. The kind of "glass ceiling" such professionals hit, he said, gains new names in new cycles of analysis, but the basic problems endure. He identified these 4 paradoxes as follows, illustrating each with common scenarios. First, Paradox 1: what happens when professionals promote social change & social justice from risk-adverse institutions?, and in turn raising the question: are health professionals expecting marginalized communities to make changes that we cannot ourselves make in our own institutions? Second, Paradox 2: many community residents know the problems they encounter, but rarely have access to the knowledge and literature on what does and doesn't work to solve complex public health and other problems, yet many professionals act as if they should downplay the expertise they have rather than share it in partnership to the communities. Third, Paradox 3: the greatest changes have come about through conflict and shifts in power, yet "conflict" is not seen as part of what professionals do. And fourth, Paradox 4: major structural determinants of health inequities lie outside the health system or responsibilities of public health agencies. Accordingly, for organizing work about social justice and health to be more effective, Chavis argued that public health professionals have to learn how to use power and conflict for progressive change and form true partnerships with communities, using our skills and knowledge. We likewise need to do a better job of better preparing young professionals, i.e., by teaching them that organizing is not a "technique" but rather a process of engaged social change. He concluded by saying that the renowned Highlander Research and Education Center, which played a pivotal role in training civil rights activists, taught coal workers math and reading by having them learn how to review management's finance books; they did not dummy anything down but instead built skills necessary for confronting power.

During the **Q&A** period, comments addressed: (1) how evaluation needs to be fluid, not prescriptive, so that it can provide iterative feedback to improve the work, as opposed to be graded against static standards; (2) how to handle IRB involvement, with responses noting that evaluation work as such is exempted from IRB review, but that if IRB review is needed, it is better to work with federally-approved community IRBs as compared to university-based IRBs (and many communities are starting to set up such IRBs); (3) issues of movement building, and whether what's most feasible is to

start with small goals, to build relationships, then take it up to regional equity movements, and from there to national – but this depends on issues and context (as per the fast-moving morphing of the Occupy movement(s) now emerging); (4) the importance of securing funds to support this kind of organizing (e.g., the $15 million for the C-CHE project), with foundations and agencies needing to understand that for the work to be effective, it has to be open to the kinds of issues addressed in the session; and (5) whether the organizing efforts take the steps to raise consciousness about the historical and social context in which work in the US is carried out, including in relation to policies & programs created in other countries that have more progressive governments – with one response discussing how work with agencies focused on children in foster care in LA was transformed by teaching the social workers about the history of inequitable federal, state, and local policies, as well as the history of slavery and disrupted families – and the reminder that we are only one generation out from enaction of the civil rights acts of the mid-1960s; this new knowledge led to staff in these agencies gaining new insights into not only the disempowerment of the people with whom they worked but also for themselves, in their agencies, and in turn inspired new organizing efforts by the staff to realize their power as staff in the system and to start making major changes in agency policy and practices, bolstered by their power in numbers.

5) STUDENT POSTER SESSION

Our 10th **"STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH"** had 8 posters accepted (listed below; presenters' names in **bold font**). 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.

STUDENT POSTER SESSION: SOCIAL JUSTICE & PUBLIC HEALTH

Board 1 — Society, Justice, and Health: A Student-Initiated Course. Wellington Davies, Amethy Aguiree, Jean Bae, Katie-Sue Derejko

Board 2 – Healthy Habitats and Gentrification in New York City (1990 to present). Jocelyn Apicello

Board 3 – Access to Ambulatory Care According to Type of Health Insurance and Income in Chile, 2009. Maria Martinez-Gutierrez

Board 4 – Healthy Communities Begin with Inclusion. Anjali Truitt, Megan Morris

Board 5 – Privileged Discourses of Asthma Management Disparities. Robin Evans-Agnes

Board 6 – Human Trafficking and Health: Setting a New Public Health Agenda through a Gender Analysis. Natalia Linos

Board 7 – Understanding Neighborhood Contexts of the Obesity and Diabetes Epidemic in the Los Angeles Area. Stephanie Hsieh

Board 8 – Incarceration as a Social Determinant of Health: A Conceptual Framework for Considering the Health of Minority Communities in the United States. Zinzi Bailey

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:

a) "In Honor Jack Geiger"

This session, attended by over 150 people, honored Dr. Jack H. Geiger, who among other things in the mid-1960s initiated the community health center model in the US, serving as the co-director and then director of the first urban and first rural health centers in the US, at Columbia Point, Boston, and Mound Bayou, Mississippi. A lifelong activist, in 1943 he was a founding member of one of the first chapters of the Congress of Racial Equality (CORE) in 1943; he also was a founding member of such key organizations linking social justice and public health as: the Medical Committee for Human Rights (MCHR), in the 1960s; Physicians for Social Responsibility, also in the 1960s, and Physicians for Human Rights (PHR) in the 1980s. The event opened by showing the 22-minute video "Out in the Rural: A Health Center in Mississippi," filmed in 1969-1970, which showed the people engaged in establishing one of the early US health centers, including its development of a farm cooperative; the video can be seen at: http://www.socialmedicine.org/2008/06/04/community-health/out-in-the-rural-a-health-center-in-mississippi-with-jack-geiger/ (and also at: http://vimeo.com/9307557). Numerous friends and colleagues then told both very funny stories about various moments with Jack and his inspired work fighting for social justice, health equity, and peace, after which Jack, true to form, demanded time for rebuttal! – and then reflected on the work he has done, with so many others, to create a decent, equitable, safe, just, and peaceful world – and concluded by saying that, as he turns 86, "I ain't done yet!"

The event was sponsored by Medical Care, Public Health Education and Health Promotion, International Health, the Peace Caucus, the Socialist Caucus, the Spirit of 1848 Caucus, Vietnam Caucus, the American Indian, Alaska Native and Native Hawaiian Caucus, the Society for Public Health Education (SOPHE), and the National Association of Community Health Centers (NACHC).

b) P Ellen Parsons Memorial Session: ***"Can public health prevail on Medicare, social programs, and reproductive rights: P. Ellen Parsons Memorial Session"***
As usual, we also co-sponsored & helped organize the **P. Ellen Parsons Memorial Session, on** "***Health Reform, Progressives, and Women";*** also as usual, the primary sponsor was the Medical Care Section (via Ellen Shaffer) and the two other co-sponsors were the Women's Caucus and the Socialist Caucus. It was attended by ≈ 15 people, fewer than in prior years (in 2010: ≈ 90; in 2009: ≈ 50; in 2008: ≈ 100). The two speakers were: (a) Cathy Hurwit, a policy expert now working as Chief of Staff for US Congressional Representative Jan Schakowsky, and (b) Louise Melling, Director of the ACLU Reproductive Freedom Project. Both reviewed major legislative threats to, respectively, social protection and women's reproductive rights and health; both emphasized the critical importance of progressives remaining engaged with the electoral system; and both discussed the urgency of – and obstacles to – getting people "out in the streets" to demand better and more just policies. Pros and cons of the "Occupy Wall St" approach were discussed with those attending, as were strategies to counter the demobilizing shame that: (1) hinders people from saying "abortion" out loud, let alone defend abortion rights, and (2) results from people feeling their financial troubles are their own fault, rather than a consequence of systematically unfair political and economic policies designed for and by the powerful to preserve their privilege.

c) We also co-sponsored two sessions on *"Health Equity 2020"* and *"Implementing Health Equity 2020"*; the questions to the panelists that we contributed to the sessions (as part of our co-sponsorship) were, respectively:

-- for "*Health Equity 2020*":

The notion that government plays an important role -- via enacting & enforcing regulations based on legitimate scientific evidence and through the work of state & local public health agencies -- in improving population health and eliminating health inequities is common sense in public health -- but is anathema to the anti-regulatory political and corporate interest groups funding political organizations, which, despite being cast as "anti-government," in fact just want the sort of government that supports their interests, even if they are antithetical to public health). We've just seen the present administration cave-in on the ozone regulations, claimed to be a "job killer" by its opponents -- as if real deaths due to cardiovascular and respiratory diseases don't count; similarly, in the name of austerity, albeit at a time of almost unrivaled concentrations of wealth among the most affluent, we're seeing drastic cuts in social programs essential for redressing health inequities. Given this political context, how confrontational are you willing to have public health be to take a leading role in standing up for public health and social justice?

-- for "*Implementing Health Equity 2020*":

Cultural competence is a topic that came up in a number of your presentations. All too often, it is premised on an assumption that the health provider simply needs to correct her/his own ignorance about other "cultures." Rarely if ever does it entail having the health provider think critically about her/his own culture, let alone the many racial biases that exist in mainstream culture or about the power that the health professional brings to the patient/provider interaction. In New Zealand, there's a different term -- "cultural safety" -- that does address these issues. And so: can you clarify what the term "cultural competence" means to you? To what degree do you think a more critical approach to "cultural competence" could help to address the health inequities we currently observe in the US? And how could it get successfully implemented on the ground?

Finally, the Spirit of 1848 co-sponsored the 1st ever Praxis Project "World Party" on the Sunday night of APHA and the Occupational Health and Safety health activist dance on the Tuesday night of APHA.

And, as usual, 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**

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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)**