★★★★★★ THE SPIRIT OF 1848: APHA 2015 REPORTBACK ★★★★★★

TO: **EVERYONE ON SPIRIT OF 1848 EMAIL BULLETIN BOARD**
FROM: **SPIRIT OF 1848 COORDINATING COMMITTEE**
RE: **REPORTBACK FROM THE 2015 APHA CONFERENCE (ver: 11/12/15)**

The Spirit of 1848

Greetings! The Spirit of 1848 Caucus is happy to share our reportback from the 143rd annual meeting of the American Public Health Association (October 31-November 4, 2015, in Chicago, IL). In this reportback we:

(a) present decisions we made at our business meeting, including initial ideas for the APHA 2016 sessions; and

(b) give highlights of our APHA 2015 sessions

And: as usual, we are sending this reportback by email and posting it on our web site. As of November 3, 2015, we are happy to say that 3,287 people (in US & around the world) subscribe to our email bulletin board (which, however, is slightly down from 3,458 at this time last year). Additionally, as of the end of September 2015, fully 224 individuals affirmed they consider themselves to be members of the Spirit of 1848, either via: (a) updating their membership profile in the APHA database, and/or (b) responding to our survey on our Spirit of 1848 listserve asking people who are active members of APHA to submit their name and APHA membership number.

NOTE: the number of Spirit of 1848 members REALLY MATTERS, given new membership rules that will go into effect in 2016 when we and the other APHA Caucuses undergo the APHA caucus recertification process – meaning: this is a time when it COUNTS to be COUNTED!

Accordingly, we STRONGLY REQUEST that all of you reading this report **please take a moment to do BOTH of the 2 following tasks**:

(a) go to our Spirit of 1848 website and fill out the 2-second survey to provide your name & APHA membership number (if you didn't do so this past September 2015; we will also be sending out another request next fall, so that we can also include all new listserve members who join our listserve in the coming year)**;** the URL is:

https://harvard.az1.qualtrics.com/jfe/form/SV_86XQ5KQvFCgCpFP

(& for more explanation about why we need this information, see: http://spiritof1848.org/listserv.htm)

(b) update your APHA membership profile to flag your membership in the Spirit of 1848 Caucus; the steps are:

1) login in at: http://apha.org/
2) click on the bottom part of where your name shows up, which will reveal the "menu" for options
3) click on "update profile"
4) click on the tab for "communities"
5) scroll down to "caucuses," go to "Spirit of 1848," and choose the option for "current participant"!
     (note: selecting a Caucus affiliation does NOT count against the choice of 2 Section affiliations)

As for attendance: in total, we estimate ~ 395 persons came to our sessions (not counting those who visited the very popular student poster session or the session on transgender health & health equity that we co-sponsored or the 3 wonderful radical history tours we co-sponsored with the Praxis Project!), which is on par with the 390 who came in 2014, the 380 who came in 2013 and the 400 in 2009, albeit fewer than the 470 in 2012, the 650 in 2011, and the 675 in 2010. That said, our sessions as usual had very good attendance by APHA standards, which typically have ~30 persons/session, and our 2015 attendance ranged from 60 to 150 persons per session for our 4 oral sessions. Additionally, 13 people attended our business/labor meeting (12 in person, one by phone)!

And also:

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 about our work, please contact any of us on the Spirit of 1848 Coordinating Committee:

   -- Nancy Krieger (Chair, Spirit of 1848, & data & integrative & e-networking); email: nkrieger@hsph.harvard.edu

   -- Anne-Emanuelle Birn (History committee); email: aebirn@utoronto.ca

   -- Luis Avilés (History committee); email: luis.aviles3@upr.edu

   -- Marian Moser Jones (History committee); email: moserj@umd.edu

   -- Jake Coffey (History committee); email: JCoffey@uams.edu

   -- Catherine Cubbin (Politics of public health data committee); email: ccubbin@austin.utexas.edu

   -- Zinzi Bailey (Politics of public health data committee); email: zinzib@gmail.com

   -- Lisa Moore (Pedagogy committee); email: lisadee@sfsu.edu

   -- Rebekka Lee (Pedagogy committee and Spirit of 1848 representative to the APHA Governing Council and APHA Caucus Collaborative); email: rlee@hsph.harvard.edu

   -- Vanessa Simonds (Pedagogy committee); email: vanessa.simonds@montana.edu

   -- Tabashir Sadegh-Nobari (student rep for the Student poster session); email: tabashir@ucla.edu

   -- Nylca Muñoz (student rep for the Student poster session); email: nylca.munoz@upr.edu

   -- Pam Waterman (E-networking committee); 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 note re APHA next year: it will be in **Denver, CO (Oct 29-Nov 2, 2016)**, with the designated theme: "***Building the Healthiest Nation: Ensuring the Right to Health.***"

Attended by: (a) <u>Spirit of 1848 Coordinating Committee members</u> (alphabetical order; n = 5): Zinzi Bailey (data), Nancy Krieger (chair & integrative & data & e-networking), Rebekka Lee (pedagogy & Spirit of 1848 representative to the APHA Governing Council and APHA Caucus Collaborative), Nylca Muñoz (student poster), plus Catherine Cubbin (data; by phone); and (b) <u>additional Spirit of 1848 members</u> (alphabetical order; n = 8): Juan F Correa, Craig Dearfield, Olivia Desormeaux, Wesley Epplin, Alicia Olave-Pichon, Heather Orom, Jennifer Tsai, and Laura Ucik. In total, 13 people participated in the meeting (12 in person, 1 by phone) and we had a very good discussion!

> NB: Spirit of 1848 Coordinating Committee members who were unable to attend were (n=9): Luis Avilés (history), Anne-Emanuelle Birn (history), Jake Coffey (history), Allegra Gordon (student poster), Marian Moser Jones (history), Lisa Moore (pedagogy), Tabashir Sadegh-Nobari (student poster), Vanessa Simonds (pedagogy), and Pam Waterman (e-networking), all of whom provided input previously either at the Spirit of 1848 Coordinating Committee on the Sunday morning of APHA or else via email.

1) **Spirit of 1848 mission**. We re-affirmed the mission statement of the Spirit of 1848 (included at the end of this reportback and also available at our website, at: http://www.Spiritof1848.org) which, among other things, describes our purpose, 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.
-- We also have an official representative to the APHA Caucus Collaborative and to the APHA Governing Council.
-- 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).

> note: our newest additions to the Spirit of 1848 sub-committees are: Craig Dearfield (data), Wesley Epplin (pedagogy), Jennifer Tsai (pedagogy), and Alicia Olave-Pichon (student poster)

2) **Spirit of 1848 listserve**. We noted that our listserve membership currently equals 3,287 people (slightly down from 3,458 at this time last year) and also that our static facebook page is still working as intended – via directing people (who do "like us" ☺!!) to our website!

3) **Spirit of 1848 Sessions**. 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 ≈ 395 total), was as follows (in chronological order): social history of public health (n ≈ 60); the politics of public health data (n ≈ 85); progressive pedagogy in public health (n ≈ 100); "integrative" session (n ≈ 150), and the student poster session attracted a lively crowd throughout its entire hour of display. Additionally, ≈ 100 attended the APHA session we co-organized with the LGBT Caucus, and the radical history tours we co-sponsored were well-attended, with anywhere from 30 to 40 people attending each of the 4 tours (approx. 140 in total). With regard to our 4 Spirit of 1848 oral sessions, the attendance data are, as noted above, on par with 2009 and 2014, but lower than for 2010, 2011, and 2012 – and this is in a context of it being increasingly difficult for people to get funding to come to the APHA meeting (& likely especially those of us who work on issues of social justice & public health). That said, attendance at our scientific sessions remains far higher than the average attendance of 30 people/session for APHA scientific sessions.

Throughout, our sessions underscored the need for critical thinking about the links between social justice & public health, including also the need to be self-critical *about the complex realities vs. rhetoric regarding both "health in all policies" and "health equity in all policies"!* – and ask whether perhaps the focus should be on "**EQUITY IN ALL POLICIES**."

4) **APHA Caucuses & Governing Council.** Rebekka Lee served as our representative to the APHA Caucus Collaborative and at the APHA meeting represented us at both the APHA Governing Council (where we and the other Caucuses now can speak from the floor, but do not have a vote) and the annual APHA all-caucus breakfast, held on Wed, November 4. She has reported back to us as follows:

-- APHA CAUCUS RECERTIFICATION PROCESS

This year has been busy dealing with issues pertaining to revisions to the APHA Caucus certification – and, troublingly, decertification – process. The background to these discussions is the declining membership base of APHA, hence shrinking dues, and a small number of staff to handle the Caucuses as well as the other APHA entities, i.e.., Section, SPIGS, and Forums, plus also the state Affiliates. We are proud to say our Spirit of 1848 Caucus played a constructive role in regard to numerous issues discussed this past year, including: maintaining Caucus self-determination regarding forms of internal governance; having Caucuses be required to turn over only the names of their APHA dues-paying members (and not also the names of the rest of their members); making deadlines for the certification documents be more reasonable (i.e., not have materials due on Dec 31!), etc. One key new criterion is that Caucuses will need to have at least 25 APHA dues-paying members – and we are happy to report we easily meet this goal (as of Sept 30, 2015, we had 224 dues-paying members of APHA declare they are also members of the Spirit of 1848, via their APHA membership profile and/or the Spirit of 1848 survey we sent out over our listserve).

NOTE: because the recertification process will go into effect in the coming year, we are giving you this heads-up now that we will need to do another check-in, around this time next year, as to how many Spirit of 1848 Caucus members concurrently are dues-paying APHA members.

-- GOVERNING COUNCIL

At the Governing Council session, consideration of the Caucus role in Governing Council was named as one of the five top priorities for 2015-2016. Additionally, Thomas Quade (Health Administration) was elected as President-Elect of APHA, and the current President now becomes Camara Jones (who has for a long time focused on racial/ethnic health disparities and who is known by a number of us on the Spirit of 1848 Coordinating Committee). The three new executive board members elected to the Governing Council include Benjamin Hernandez (Health Administration), Mark Aaron Guest (Aging and Public Health), and Elena Ong (Asian Pacific Islander Caucus for Public Health, former Caucus Collaborative Chair).

(Note: As usual, the Spirit of 1848 was not involved with any of the APHA candidate elections or policy resolutions because our policy is not to become involved with either APHA elections or resolutions. This is because, given our reliance on volunteered time, we prioritize our mission of spurring connections to advance work linking social justice and public health, as opposed to focusing on APHA internal policies and politics.)

-- reportback on CAUCUS BREAKFAST (attended by 15 of the 18 APHA caucuses)

The 15 Caucuses in attendance at all or part of the breakfast were (in alphabetical order): Academic Public Health American Indian, Alaska Native and Native Hawaiian, Asian Pacific Islander Caucus for Public Health, Black Caucus of Health Workers, Caucus on Homelessness, Caucus on Public Health and the Faith Community, Caucus on Refugee and Immigrant Health, Community-Based Public Health Caucus, Family Violence Prevention Caucus, Lesbian, Gay, Bisexual and Transgender Caucus of Public Health Professionals, Men's Health Caucus, Peace Caucus, Socialist Caucus, Spirit of 1848 Caucus, Women's Caucus.

The meeting agenda included a presentation from the Health Informatics Information Technology section, an update from Fran Atkinson (Deputy Director of Member Services) on the 2016 Memorandum of Understanding, discussion of *"Generation Public Health"* led by Susan Polan from Public Affairs and Advocacy (this is the emphasis of APHA on "creating the healthiest nation in a generation"), and a presentation from Tia Taylor from the Center of Public Health Policy on the Equal Opportunity Committee and Racism and Health series. The Surgeon General, Vivek Murthy, also attended the meeting for about 15 minutes. He gave a brief introduction explaining his interest in grassroots community engagement brought him to the Caucus Collaborative meeting and focused primarily on listening to the concerns of the Caucus Collaborative members. Topics discussed with the Surgeon General included violence, youth engagement, and elder abuse and suicide in the Native American community.

During the meeting, there was also much discussion about the new proposed APHA Caucus policy (see text re Caucus recertification above). Representing the Spirit of 1848, Rebekka raised concerns about adding transparency on how the policy would be implemented and how the process of discontinuation would occur. There was also much talk about using the Caucuses as a means of recruiting APHA members and a continued split on if and how we would want to have votes in the Governing Council.

At the end of the meeting, the outgoing APHA Caucus Collaborative chair, Selina Smith, from the Black Caucus of Health Workers, turned the role of chair over to Perfecto Munoz from the Latino Caucus (who was absent from the meeting due to medical reasons). Ben King of the Caucus on Homelessness was voted chair elect.

6) **APHA 2016**. With regard to our Spirit of 1848 sessions for next year (**144th annual meeting of APHA, October 29-November 2, 2016, in Denver, CO, whose theme is *"Building the Healthiest Nation: Ensuring the Right to Health"*)** we decided to embrace the theme in our sessions, but with a change: **we will focus on social justice, thriving & sustainable societies, global solidarity, and the human rights required to achieve health – and health equity.** We are keen to address these themes jointly from a local & global perspective, taking into account issues of power, place, sovereignty, and self-determination.

    -- To note: we are exploring possibilities for having papers presented in our Spirit of 1848 sessions published in the *American Journal of Public Health.*

Thus, our provisional plans are as follows (listing sessions chronologically by when they occur at the meeting), with details to be clarified when the APHA call for abstracts goes live on <mark>Monday, December 19, 2015</mark>. All CONTRIBUTED (i.e., unsolicited) abstracts will be due during **the week of February 22, 2016**. Additionally, all solicited (invited) abstracts are due on April 19, 2016.

▪ <u>**Social history of public health:**</u> This session will explore case examples, grounded (literally) in the history of Colorado and the US "West," grounded in recognition of the histories of the US as a colonial-settler society and slave republic, that illuminate how the health of communities, and the extent of health inequities, is situated in the land and water, not solely people's bodies. At issue are links between health equity, the right to health, discrimination, participation, and fights for sovereignty, citizenship, suffrage, better working and living conditions, and political power.
    -- The intent is to use local examples to build awareness of where we are and to strengthen solidarity, by making links not only between us today and those who have come before us, but also between the local examples and similar struggles that diverse peoples have engaged in elsewhere in the world.
    -- Also to be analyzed is the question of who defines the "nations" that can uphold – or violate – rights, and the role of state power in strengthening versus undermining communities' health (e.g., the roles of sovereignty and self-determination for American Indian nations, and of democratic governance to strengthen human rights, on the one hand, versus use of state-sponsored violence that strips away rights, as per the genocidal use of the US military against American Indian nations and the lethal use of state and local law enforcement agents against striking coal miners, as per the Ludlow massacre on April 20, 1914).
    -- We accordingly will solicit abstracts from speakers who can address issues of the right to health, health equity, and the creation – and destruction – of equitable and sustainable societies in relation to the struggles of diverse groups who have lived in the area, including: Indigenous nations; Mexican Americans/Chicanos/Latinos; and workers (including from these groups) who were employed in mining and also in other occupations.
Note: all abstracts for this session will be **SOLICITED.**

▪ <u>**Politics of public health data:**</u> This session will have an **OPEN CALL** for abstracts that employ various kinds of social, economic, health, and policy data (whether quantitative or qualitative) to analyze human rights relevant to health equity in relation to the following issues:
    (a) who counts when it comes to defining rights and to deciding whose lives count, in relation to what health outcomes;
    (b) decriminalization and population health (e.g., in relation to substance use, sex work, sexuality, and decarceration);
    (c) the use of state power to advance or to undermine health equity (e.g., examples of struggles to articulate and win rights that lead to improvements in overall rates of population health outcomes and reductions in health inequities, on the one hand, and, on the other, analyses of police brutality and military violence and efforts to document their toll); and

(d) explicit use of a health and human right framework to guide empirical population health research and to interpret empirical findings, whether in research, programs, or policies.

In all cases, presentations can focus on one or several locales (e.g., country/countries; region/regions; city/cities; neighborhood/neighborhoods) or, alternatively, they can be at the global level.

-- Note: presentations for this session will be primarily drawn from abstracts submitted in response to the **OPEN CALL** for abstracts, supplemented by solicited abstracts as warranted.

■ **Progressive pedagogy:** This session will have an **OPEN CALL** for abstracts regarding courses and training programs focused on links between human rights, population health, and health equity. We welcome presentations about any such courses and training programs that variously seek to include (separately or jointly): students (high school; undergraduates; graduate); community activists, community organizations, and community members; government employees (whether in public health agencies, other state agencies, or in the legislative or executive branches of government); or other groups. Examples of topics can include (but are not restricted to):

(a) specific courses or full-fledged training programs that provide critical instruction about links between health and human rights at the global, national, and/or local levels, and consider controversies in the field (e.g., between uses of "human rights" from "above," to advance imperial agendas, versus uses of human rights from "below," to advance equity, including health equity);

(b) specific courses and/or educational training programs – both already existing and in the process of being created – that are premised on anti-racist principles and address racism in public health, medical, or other health professional curricula, along with consideration of obstacles confronted when attempting to create or institutionally embed such courses and programs;

(c) specific courses and/or educational training programs – both already existing and in the process of being created – that address human rights and health equity in relation to gender, sexual and reproductive rights and reproductive justice, nationality and immigrant rights, environmental justice and climate justice, Indigenous rights, and any and all other human rights included in the scope of political, economic, social, cultural, and civil rights, along with consideration of obstacles confronted when attempting to create or institutionally embed such courses and programs;

(d) discussions and debates over what sorts of materials should be presented, how, to different types of participants, including, in academia, not only students in schools of public health, and other health professions (e.g., nursing, medicine) but also students in schools & programs focused on law, policy, government, economics, sociology, urban planning, etc., and also, outside of academia, in government agencies, civil society organizations, etc.

-- Note: presentations for this session will be primarily drawn from abstracts submitted in response to the **OPEN CALL** for abstracts, supplemented by solicited abstracts as warranted.

■ **Integrative:** As usual, this session will include 3 presentations that together address the specified topic (the right to health and health equity) in relation to the 3 foci of the Spirit of 1848 caucus: (1) the social history of public health; (2) the politics of public health data; and (3) progressive pedagogy. All abstracts for this session will be **SOLICITED**.

■ **Student poster session: social justice & public health**

--This session will as usual have an ***OPEN CALL* for submissions** by students (undergraduate and graduate) that are focused on work linking issues of social justice and public health, with a particular emphasis on work pertaining to *human rights and health*. The call will be very inclusive, and be directed to not only students in schools of public health and other health professions (e.g., nursing, medicine) but also to students in schools & programs focused on law, policy, government, economics, sociology, urban planning, etc. Moreover, given that the call will be open to students who may not have any experience submitting abstracts for a public health conference (e.g., undergraduates, and also students in disciplines outside of public health), our call will point the students to examples of abstracts selected in prior years for the student poster session (see, for 2015: http://spiritof1848.org/apha%202015.html, and, for 2014, see: http://spiritof1848.org/apha%202014.html). We additionally plan to pair any undergraduates who have an abstract accepted with a student poster session committee member, since the undergraduate student may need help (technically, as well as conceptually) with regard to preparing a poster!

Lastly, to address the on-going problem of student uncertainty about funding, which has led to accepted student posters being withdrawn, this year we will adopt a new approach: (1) we will accept 10 posters (the limit for any poster session); and (2) we will set up a waitlist of up to 5 additional posters (ranked in order of preference) and notify these additional 5 persons that they are on the waitlist and will be contacted in case one of the students for the top 10 ranked posters needs to withdraw. Moreover, because the withdrawal notification may be as late as August/September, we'll ask if the people

selected for the waitlist if these terms are ok – and, if not, we will remove that person from the waitlist and replace with the next highest ranked person for the waitlist.

-- Note: presentations for this session will be drawn from abstracts submitted in response to the **OPEN CALL** for abstracts.

f) Radical History Tour: Wesley Epplin, who led the organizing of the Chicago radical history tours, has agreed to do some preliminary investigation as to whether there are options for such tours in Denver. If you have any leads, or would like to help out with organizing the radical history tours, please contact Wesley (email: WEpplin@hmprg.org).

Finally, please note that the **timeline for abstract submission to APHA 2016** is as follows:

(a) the **call for abstracts** will go live on the APHA website (http://www.apha.org/meetings/) on ==**MONDAY, DECEMBER 19, 2015.**==

(b) **abstracts (unsolicited) will be due between** ==FEBRUARY 22-26, 2016.== As soon as we know the date of the abstract deadline assigned to the Spirit of 1848, we will post it on our listserve. **Solicited abstracts** will be due on April 11, 2016.

The contacts for our sessions are:

History: Spirit of 1848 Coordinating Committee members Anne-Emanuelle Birn (email: aebirn@utoronto.ca), Luis Avilés (email: luis.aviles3@upr.edu), Marian Moser Jones (email: moserj@umd.edu), and Jake Coffey (email: JCoffey@uams.edu)

Data: Spirit of 1848 Coordinating Committee members Catherine Cubbin (email: ccubbin@austin.utexas.edu), Zinzi Bailey (email: zinzib@gmail.com), and Nancy Krieger (email: nkrieger@hsph.harvard.edu), plus new subcommittee member Craig Dearfield (email: craig.dearfield@gmail.com).

Pedagogy: Spirit of 1848 Coordinating Committee members Lisa Moore (email: lisadee@sfsu.edu), Rebekka Lee (email: rlee@hsph.harvard.edu), and Vanessa Simonds (email: vanessa.simonds@montana.edu), plus new subcommittee members Wesley Epplin (email: WEppling@hmprg.org) and Jennifer Tsai (email: jennifer_tsai@brown.edu)

Integrative: Spirit of 1848 Coordinating Committee member Nancy Krieger (email: nkrieger@hsph.harvard.edu)

Student poster session: Spirit of 1848 Coordinating Committee members Tabashir Sadegh-Nobari (email: tabashir@ucla.edu), and Nylca Muñoz (email: nylca.munoz@upr.edu), plus new subcommittee member Alicia Olave-Pichon (email: aolave@uic.edu).

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

Spirit of 1848 session* -- name, day, and time (listed in chronological order)
MONDAY: -- History (social/progressive history of public health): 10:30 to 12 noon
-- Politics of public health data: 2:30 to 4:00 pm
TUESDAY: -- Curriculum (progressive pedagogy): 8:30 to 10:00 am
-- Integrative session (history, data, pedagogy): 10:30 am to 12 noon
-- Student poster session: social justice and public health: 12:30 to 1:30 pm
-- Business/labor meeting: Tuesday, 6:30 to 8:00 pm

Our sessions together asked all of us present to engage critically with the idea of "health equity in all policy" and its implications for our commitment to understanding and strengthening links between social justice & public health. We considered this question in our Spirit of 1848 sessions in relation to:

(a) the social history of public health, via examples involving both colonialism and socialist revolution;

(b) the politics of public health data, and the evidence needed (quantitative, qualitative, institutional, and juridical) to advance policies and claims about health equity;

(c) progressive pedagogy that advances analysis of and policies and action for health equity, both within academia and within public health agencies, working together with community advocates; and

(d) all 3 of these themes combined, in relation to:

   (i) 20th c CE histories of global initiatives seeking to advance the ideas of the many kinds of policies needed to have healthy and equitable societies, and the political and economic blocks put in their way by those who gain from inequities;

   (ii) the current work of a progressive US city health department (NYC); and

   (iii) a Nation Building course focused on American Indian tribes and agencies

Additionally, in the session we co-organized with the LGBT Caucus, on health equity and trans/gender-variant people, discussed issues ranging from the daily interactions to public health and clinical practices to data to policy needed to enable all trans/gender-variant people – including those who are people of color and/or low-income – to not only survive but also thrive. This perspective notably aligned with the view of the song we sung last year to commemorate 20 years of the Spirit of 1848 – "Where all can truly thrive" (words by Makani Themba, to the tune of "Down by the Riverside"; see: http://spiritof1848.org/2014_spirit%20of%201848%20APHA%20reportback_final_1128s.pdf).

Overall, we estimate ≈ 390 persons came to our Spirit of 1848 sessions; this count does NOT include the many people who visited the very crowded student poster session or the ≈ 100 persons who attended the session we co-organized with the LGBT caucus on transgender health & health equity. The range of attendance for our scientific sessions was from ≈ 60 to 150 persons/session, all considerably higher than the average APHA attendance of ≈ 30 persons/session.

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

1) RADICAL HISTORY TOURS: we will soon be posting a link to a description of how the tours went, which is being prepared by the lead organizer for the tour: Wesley Epplin, MPH, Director of Health Equity, Health & Medicine Policy Research Group. Drawing on our experience co-organizing (with the Praxis Project) the radical history tours for New Orleans for APHA 2014, we provided advice to Wesley as he planned the tours, including on how to implement a fair process for signing up for limited slots. Several Spirit of 1848 members (including from the 1848 Coordinating Committee) went on several of the tours, which were all well-led, really interesting, and inspiring! The four tours (see: http://hmprg.org/Events/APHA+Tours) brought Chicago alive in relation to: (1) **Little Village Community Tour**; (2) **Haymarket Square Tour and Reenactment**; (3) **Old Cook County Hospital, John H. Stroger Cook County Hospital, and Community Nursing History**; and (4) **Jane Addams Hull-House Museum and UIC African-American Cultural Center.**

2) SOCIAL HISTORY OF PUBLIC HEALTH

This session was attended by ≈ 60 people (up from the ≈ 45 people last year).

CRITICAL HISTORICAL PERSPECTIVES ON HEALTH EQUITY IN ALL POLICIES: LOCAL EXPERIENCES AND GLOBAL AMBITIONS (Mon, Nov 2, 10:30-12 noon; Session 3189.0; MPCC Room W185bc)
  10:30 AM: **Histories of health equity in all policies: an introduction –** *Marian Moser Jones, PhD, MMPH*
  10:35 AM: **Historicizing participation and avoidance of health interventions: lessons from colonial East-African sleeping sickness campaigns –** *Mari K. Webel, PhD*
  10:55 AM: **Revolutionary medicine: the body as a battleground for socioeconomic development in Cuba (post-1959) –** *P. Sean Brotherton, PhD*
  11:15 AM: **Cleaning up our own backyards: the urban conservation movement's fight for sustainable communities and environmental health equity during the Northern African migration periods, 1895-1965 –** *Sylvia Hood Washington, PhD*
  11:35 AM: **Q&A**

Marian Moser Jones opened up the session, introducing the panel and the overall focus of the session.

-- **Mari Webel's** presentation on colonialism and sleeping sickness considered ways that health policies inevitably are entangled with and affected by other social policies. A key point was that efforts by the colonial powers to control the early 20th c epidemics of sleeping sickness in the Great Lakes region in East Africa (as an epidemic problem, closely linked to colonial patterns of land use and agricultural exploitation) – which are estimated to have killed 200,000 to 350,000 persons between 1901 and 1921 – by using such means as quarantine in designated camps, harsh and largely ineffectual drug treatment, and environmental actions to destroy the tsetse fly habitats (e.g., clearing of bush) at the same time ended up being measures that affected people's migration patterns, agricultural production, labor force participation, and political relationships (e.g., between villagers and their king), which in turn also influenced outbreaks of sleeping sickness, social inequalities in their incidence, and when and whether local populations would "avail themselves" to treatment. Appreciating the dynamic interplay among health policies, social policies, economic activities, and health inequities thus underscores the importance of analyzing how societal inequities not only cause but can be shaped by health inequities.

-- **P. Sean Brotherton's** presentation compared social and health policies, and social and health conditions, in pre- versus post-revolutionary Cuba. Key shifts were from a society with great social, economic, and health inequities to one that was committed to eliminating these inequities, via collective efforts. For example, with regard to the objective of lowering infant mortality, policies not only involved the health sector (e.g., having health personnel visit newborns and their families every day for the 1st three months of life) but also the provision of day care and improving women's workforce participation and working conditions. Health campaigns encouraging healthier behaviors (e.g., eating a good diet) took on new meaning in a society that was committed to literacy and to ensuring that everyone had adequate food, i.e., very different from giving "lifestyle" advice to people who could not read or who did not possess the resources to avail themselves of this "advice." Similarly, the emphasis on biomedical technology and the production of a large physician workforce in post-revolutionary Cuba cannot be viewed as purely "technical" fixes for population health, given how the revolution sought to meet the material needs of the Cuban population. The larger implication is that the implementation and evaluation of health interventions, including in relation to health equity, depends on the social and economic policy context in which these interventions are developed – thereby offering another lens by which to understand what it means to think about "health equity in all policies."

-- **Sylvia Hood Washington** unfortunately was not able to be present at the session; according to her abstract, her talk was going to have discussed how efforts by African American communities in the US north to help settle African Americans migrating up from the US South during the Great Migration in the first part of the 20th c CE led to some of the first US urban efforts to tie together economic, environmental, and health development.

During the **Q&A period**, comments focused on: (1) the utility (or not) of using the frame of "health equity in all policies," which makes it seem that "health" leads, when in fact it is but one of many considerations; (2) the framing of the production of physicians in Cuba as a moral as well as economic "good"; (3) differences between Cuba and both China and USSR, in terms not only of size and scale, but also what happened to the health workforce when the revolutions occurred (in Cuba, most physicians left the country, which was not the case in China or Russia). The overall question raised by the session was whether it might be more productive to shift the focus from "health in all policies" to "all policies produce health" – and how they do so in turn depends on political and social priorities of these policies.

3) POLITICS OF PUBLIC HEALTH DATA

Our session was attended by ≈ 85 people (somewhat less than ≈ 120 people last year, but more than the 60 in 2013).

POLITICS OF PUBLIC HEALTH DATA: EMPIRICAL RESEARCH TO INFORM HEALTH EQUITY IN ALL POLICIES, FROM GLOBAL TO LOCAL LEVELS (Mon, Nov 2, 2:30-4:00 pm; Session 3395.0; MPCC Room W185bc)
  2:30 PM: **Introduction** – *Zinzi Bailey, ScD, MPH*
  2:35 PM: **Working towards health equity: the co-production of Health in All Policies (HiAP) strategy and ordinance in Richmond, CA** – *Jason Coburn, PhD*
  2:50 PM: **Does data protect health? Reflections from District-Level Assessments in Kerala** – *Devaki Nambiar, PhD*
  3:05 PM: **Empowering community access to data on police use of force** — *Rachelle Annechino, MIMS*
  3:20 PM: **Politics of Indigenous health: acting in good faith** – *Gail Dana-Sacco, PhD, MPH, CHES*
  3:35 PM: **Q&A**

Zinzi Bailey opened up the session, raising the question of how analysis of "health equity in all policies" can empirically illuminate the health impacts of structures of power.

-- The first presentation was given by **Gabino Arredondo** on behalf of **Jason Coburn**, who was at WHO to discuss the very types of work that were the focus of the Spirit of 1848 presentation he and his team had prepared. The presentation reviewed the public health work and political organizing that led up to the city of Richmond, CA taking the novel step, this year (2015), of incorporating into its city ordinances a commitment to "health in all policies," framed as: "city services through the prism of health" (see: http://www.ci.richmond.ca.us/2575/Health-in-All-Policies-HiAP). Among its many requirements, this ordinance mandates annual reports on the city's health in relation to this policy. The first-ever report will be delivered to the city in about one month from now, and for each initiative, it will discuss: (a) the health plan, (b) the measures used for target setting and evaluation, (c) the health equity objectives, (d) the responsibility of different city departments for meeting the city objectives, and (e) the desired directionality of change (e.g., increase the percent of residents with access to health care; decrease the percent of residents exposed to air pollution). Building on the idea of the "co-production" of health equity by diverse sectors and diverse pathways, core principles pertain to: "place matters," "intersectionality," "anti-essentialism," and "integrated evidence," from the standpoint of the precautionary principle and with an emphasis on prevention; also key is having public health professionals and community residents work together to generate evidence, solutions, and monitor progress. Goals are framed in terms of sets of outcomes (via a "spider diagram"), i.e., for a given neighborhood, not solely asthma, but asthma + parks + access to healthy foods, etc. The impact on governmental action was illustrated by the example of a school-based outreach project involving the built environment, which brought together 3 sets of city agencies - the school district, the health district, and city planning – to work jointly on the project. Other examples pertained to neighborhood safety and community policing, and to linking a climate action plan to environmental monitoring of air pollution.

-- **Devaki Nambiar,** from Kerala, India, next shared her presentation via video. She began by noting how, in 1985, Kerala was highlighted in a famous Rockefeller report on "good health at low cost" (i.e., low health sector cost). However, the report said relatively little about the political rights and context that produced this phenomenon: Kerala had been a region in India whose policies emphasized political and economic rights, welfare, and well-being, which were policies conceived and enacted in relation to political reforms and revolutionary ideas (the CP had led the Kerala government since 1956), as opposed to be framed as a "health policy" per se. Yet, in 1985, at the very time this report was issued, the World Bank imposed new policies on Kerala, which led to drops in social investment, rises in private health sector spending, including rising medical care costs, privatization of the water supply and sanitation, and rising poverty. As a result, by 2013, Kerala was no longer a success model and no longer had "good health at low cost." One recent successful organizing campaign to challenge these reversals was a two-year struggle against Coca-Cola, in relation to issues of water theft and water pollution. A new Public Health Protection Agency has also recently been established, which is trying to introduce a "health in all policies" approach. The social and technical challenges involved underscore the value of assessing the health and health equity impacts of policies, while keeping the focus on ensuring all policies promote equity (in and outside of the health sector).

-- **Rachel Annechino** in turn discussed the importance of public health agencies collecting data on police violence to inform efforts to reduce this type of violence. She reported how, in California, a survey on tobacco use among youth of color revealed that a key concern of these youths was police violence, yet governmental data on the extent of police violence are virtually non-existent. After detailing the data gaps, she discussed how the lack of data on police violence has led to loss of trust and a lack of willingness to call on the police for assistance. Her argument was that a public health approach should emphasize community wellness and reduction in risk of exposure, thereby extending the idea of "health in all policies" to policing policies.

-- **Gail Dana-Sacco**, a member of the Passamaquoddy tribe in northern Maine, then analyzed how tribal-state relations and interagency structures produce tribal health inequities. After reviewing how American Indian nations have had longer relationships with US states than with the federal government, she discussed how, for the Passamaquoddy, governmental relations are further complicated by their being also international relations with Canada as well. She further emphasized that an expectation that the state can be a force for health equity needs to be critically assessed, given the well-documented genocidal practices of the US state at the federal, state, and local levels. Such concerns are raised by not only past practices, such as the imposition of boarding schools to remove American Indian children from both their families and their culture, but also new practices, as revealed by current struggles over fishing rights. Both sets of policies and policy clashes have had profound health effects, within and across generations, yet the health impacts typically have been

ignored. As Dana-Sacco argued, resource issues are at the core of such conflicts, and the resolution of these conflicts will require more than solely focusing on "health in all policies."

During the **Q&A** period, comments and questions focused on: (1) different approaches to obtaining data on deaths caused by police violence (reframed as a public health, and not solely criminal justice, issue); (2) how rights and policies are necessary but not sufficient, because residents need to learn how to hold politicians' accountable; a concrete example pertained to citizens' having the advantage of being able to go directly the City Manager, whereas staff members of the city health department have to go through proper administrative channels; and (3) the need to be clear about the timeframe expected for changes across a variety of disease, versus changes in, say, social cohesion (which can be brought about more swiftly than changes in health outcomes, per se).

4) PROGRESSIVE PEDAGOGY

This session was attended by ≈ 100 people (twice the ≈ 50 from last year!).

PROGRESSIVE PEDAGOGY: HEALTH EQUITY IN ALL POLICIES (Tues, Nov 3, 8:30-10:00 am; Session 4074.0) MPCC Room W185bc
  8:30 AM: **Introduction – *Rebekka Lee, ScD***
  8:35 AM: **Where dialogue and action coexist: organizing leaders and building capacity to advance Health Equity in All Policies– *Lili Farhang, MPH***
  8:50 AM: **Role of a state health agency in expanding the understanding of what creates health – *Edward Ehlinger, MD, MSPH***
  9:05 AM: **Developing health leaders to champion health equity — *Harry Heiman, MD, MPH***
  9:20 AM: **Anti-racism in public health education: a student-driven model for changes in a Master's of Public Health Program – *Ariel Hart, MPH***
  9:35 AM: **Q&A**

Rebekka Lee introduced the session, highlighting the breadth of the pedagogy included, with programs involving graduate students, postdoctoral fellows, members of local health departments, and state health departments.

-- **Lili Farhang**, the Co-Director of Health Impact Partners (Oakland, CA; http://www.humanimpact.org/), described their capacity-building training program to develop local leaders, in local health departments, who can advance the work on health equity in all policies. This program fits within their overarching mission: "Bringing the power of public health science to campaigns and movements for a just society." The impetus for creating their Public Health and Equity Cohort (PHEC), funded by the Kresge Foundation, is recognition of a diverse set of obstacles that hinder local health departments from carrying out the kind of work needed. These obstacles include: (a) the disconnect between academic work on "social determinants of health" and actual social justice movements; (b) the tendency of health departments to be risk averse (given leadership that is politically appointed, and also the energy and courage needed to push, politically, for change within agencies); (c) the lack of capacity and resources to do the work; (d) a lack of clarity regarding the most effective "policy levers" for making policy change; (e) the lack of allies from the "outside" (in the community/communities) who can help push for change to affect the "inside" work done within the health departments; and (f) limited peer support and "space" for emerging leaders to develop their capacity. The first cohort (November 2014-January 2016) includes one dozen participants from local health departments from across the US. The model is one of co-learning, whereby Health Impact Partners is the convener (not sole expert). Components include: (1) three in-person training sessions when everyone meets together, for co-learning about both theory/concepts (e.g., narrative worldviews; structural racism; targeted universalism) and applied practice (e.g., power analysis; using a social equity tool) (Months 1, 7 and 15); (2) monthly video conferences; (3) a listserve; (4) engagement with mentors (10 leaders from public health agencies and elsewhere), and (5) a project-based component, whereby participants connect with community organizers to determine useful inside-outside strategies to advance their shared goals. The two sets of projects chosen pertain to: (a) minimum wage (which has sparked political push-back), and (b) early childhood programs (for which there has been less push-back). Strengths include: no pre-determined content, but instead tailored to the specific participants, in relation to real-time interests and struggles, as well as orientation to co-learning, collaboration, and peer-to-peer engagement. Challenges include: the program is time and resource intensive, video conferencing is unsatisfying, and the participants face constraints on how they can apply what they learn. A key benefit is that participants gain credibility, and thus increase capacity for pushing for change within their health department and become seen as a resource, in and outside the agency.

-- **Ed Ehlinger**, the President of the Association of State and Territorial Health Officials (ASTHO; http://www.astho.org/) and Minnesota Commissioner of Health next discussed his organization's new strategies to expand understanding –

among public health professionals, policymakers, and the public at large – as to who and what creates health and health equity. Recognizing that health departments are most successful when the community asks them to do what they already want to do, he underscored the necessity of creating a narrative change to shift away from the common lifestyle and biomedical view that good health depends on solely the "right choices" of individuals and good medical care to a public health framework that emphasizes the importance of building community capacity for community health and health equity (as per what the US public health leader CEA Winslow argued back in the 1920s). Demonstrating the need for this change are data he presented on adverse US trends, over the past 30 years, in on-average health and health inequities; for example: life expectancy for African Americans is only now equal to what it was for the US white population in 1980, and their infant mortality is still higher (African American for 2011: 11.42/1000; white American for 1980: 10.9/1000). Noting that health care costs have been relentlessly rising, he argued it was time to go beyond the IOM's "Triple Aim of Health Care" (an individual health model) and instead employ a "Triple Aim of Health Equity" approach (http://www.astho.org/Health-Equity/2016-Challenge/), whose 3 components are: (1) Implement Health in All Policies, (2) Expand understanding of health, and (3) Strengthen community capacity to create their own healthy futures, which requires enhancing civic skills, democratic governance, and making "healthy choices" not only "easy" but also possible, by working to build communities of opportunity. Along these lines, ASTHO has newly obtained funding from Kellogg and the Robert Wood Johnson Foundation to create an academic consortium of Big Ten Universities (including land grant universities) to have them work together to advance the "Triple Aim of Health Equity." Concrete examples he provided from work of the Minnesota Department of Public Health included: supporting the campaign for increasing the minimum wage; conducting health equity impact assessments; improving data gathering on race/ethnicity and language barriers; and working with communities to increase their capacity to change their health status.

-- **Harry Heiman**, the Director of Health Policy for the Satcher Health Leadership Institute at Morehouse School of Medicine (http://www.msm.edu/Research/research_centersandinstitutes/SHLI/), discussed their postgraduate training program, instituted in 2009, and which thus far has had 26 program graduates. The focus is on leadership development, health policy, and health equity, in relation to race/ethnicity, economic position, gender identity, sexuality, physical disabilities, and mental health. The common theme is countering health inequities produced by histories of discrimination and exclusion. Using the approach of "everyone teaches and everyone learns," the program curriculum includes: core didactics, policy leadership experiences, and community-based practicum experience; all fellows also hold faculty appointments in the Morehouse School of Medicine Faculty Development Program. Publications by the program's fellows on the work they have accomplished appear in myriad journals, and attest to the many strategic partnerships the fellow have been able to create between public health professionals, public health agencies, and community-based organizations.

-- **Ariel Hart** then spoke compellingly about the creation of the first-ever anti-racist MPH program, based within the University of Washington (UW) School of Public Health. She received her MPH from UW in 2015 and is currently a Clinical Instructor in their Department of Health Services, as well as a Trainer-in-Training for the People's Institute for Survival and Beyond (PISAB), whose approach (see: http://www.pisab.org/) informed the creation of the UW MPH program. Emphasizing that "anti-racism" is a noun, she clarified that it refers to both a way of seeing the world and "an active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices, and attitudes, so that power is redistributed." Development of the MPH program was spurred by both increased visibility of anti-racist community organizing (e.g., #BlackLives Matter) and recognition of the need to act now. Its principles include: understanding racism; learning from history; liberated gatekeeping; accountable relationships; analyzing power; understanding internalized racial oppression. Led by students, along with participation of faculty champions (e.g., Amy Hagopian) and input from PISAB, the work to create the MPH program focuses on: program culture; faculty hiring; curriculum; admissions; and community relationships. For curriculum, there is now a new 1-credit elective on racism on public health, along with development of case examples that can be included in other courses, as well as required training on undoing racism. The community issues being addressed include: juvenile incarceration, gentrification, and immigrant detention. Work with the admissions committee is underway, as is work on including language about anti-racism in job postings. She encouraged people interested in the program (whether to enroll as students, to extend its model to their own schools, or to have trainings on anti-racism in their own organizations/programs) to contact her (email: anhart@uw.edu).

During the **Q&A** period, comments and questions focused on: (1) the utility (or not) of convening a national meeting to pull together public health and other health professional students working on institutional and curricula change (anti-racist and promoting health equity); (2) the need to expose barriers encountered to creating change (e.g., faculty resistance to having students undergo a mandatory anti-racism training session; faculty lack of interest in student-led conferences and initiatives on racism and health), so as to create accountability; (3) how to get public health practitioners to incorporate anti-racist principles in their work, recognizing that this is a multi-year endeavor, one that requires negotiation and

pushing back against resistance, as well as ongoing technical support; and (4) the utility (or not) of also focusing on "white privilege," with discussion emphasizing that this latest "buzz word" is not a substitute for being clear about anti-racism and the need to change power structures and take action (as opposed simply to recognizing one's individual "privilege"). The energy in the room in support of advancing the anti-racist work and work for health equity was palpable.

5) INTEGRATIVE

This session was attended by ≈ 150 people (slightly down from the ≈ 175 persons last year, but on par with the ≈ 150 in 2013). It is called the "integrative" session because its different speakers typically address the 3 foci of the Spirit of 1848: social history of public health, the politics of public health data, and progressive pedagogy.

CRITICAL WORK ON HEALTH EQUITY IN ALL POLICIES – HISTORY, DATA, PEDAGOGY, AND ACTION (Tues, Nov 3, 10:30 am – 12 noon, Session 4172.0) MPCC Room W185bc
   10:30 AM: **Introduction –** *Nancy Krieger, PhD*
   10:35 AM: **All for health? Historical perspectives on WHO's initiatives to promote intersectoral approaches to health** *– Anne-Emanuelle Birn, MA, ScD*
   10:55 AM: **Role of public health data in advancing health equity in all policies** *– Mary Bassett, MD, MPH*
   11:15 AM: **Universities and Indian Country: case studies in tribal-driven research** *– Dennis Norman, EdD, ABPP*
   11:35 AM: **Q&A**

Nancy Krieger opened up the session, saying it was intended to raise critical question about what it means to advocate for – and implement – "Health Equity in All Policies."

Anne-Emanuelle Birn, Professor at the University of Toronto, and a member of the Spirit of 1848 Coordinating Committee and its sub-committee on the social history of public health, offered a critical analysis of the multiple understandings and incarnations of the notion of "Health in All Policies" from the early 20th c CE until now – with roots extending back to 19th c CE social medicine analyses (per Virchow), the early post-WWI work of the League of Nations on housing, nutrition, and employment, and also Salvador Allende's 1939 classic work ("Chilean Socio-Medical Reality"). She noted there have been a succession of technical, political, bureaucratic, and academic discourses, emphasizing interdisciplinary approaches and equity as a basis for intersectoral work. However, just as the WHO was founded in 1948, it turned away from the growing interest in intersectoral approaches (IA), concerned with producing health, to focusing instead on technical interventions to control disease. The re-birth of IA was at the 1978 Alma Ata International Conference on Primary Care, whose intent was to push forward an IA approach to what would now be called "Health Equity in All Policies." The IA sessions at Alma Ata were nevertheless not well attended. Work moving forward on IA was further blocked by the 1980's ascendancy of neoliberalism and its negative impact on Alma-Ata approaches and WHO's budget. Even so, a WHO office with 1 staff member (and almost no resources) was set up in 1980 to "enable countries to identify non-health variables which affect health in order that they can plan interventions to modify them." Led by Aleya Hammad (an Egyptian PhD nurse and daughter of the first ambassador to the USSR of Egyptian President Nasser [a leader of the non-aligned movement and of Arab socialism]), it was also advised by Godfrey Gunatilleke (Director of the Marga Institute in Colombo, Sri Lanka). Gunatilleke guided a set of case studies of "Intersectoral Linkages and Health Development" (1984) that traced the historical evolution of intersectoralism in key locales such as Jamaica, Norway, Kerala, and Sri Lanka. However, it was overshadowed by a competing report, funded by the Rockefeller Foundation, on "Good Health at Low Cost" (1985) – which drew on much the same evidence, except that the low cost referred only to the health sector, and the text was depoliticized and did not discuss all the social investments required to achieve the low cost [nb: see also the comments on this report in the presentation by Nambiar in the 1848 data session]. In 1986, the WHO passed an IA resolution (WHA39.22) and also issued a technical document on IA (WHA 39: "Intersectoral Action for Health"), but these were eclipsed by concurrent impositions of structural adjustment programs by the World Bank, a turn to "health promotion," and efforts in the1990s to defund WHO, in part led by the *British Medical Journal*, which ridiculed IA. New attempts to resurrect IA have continued to suffer from a lack of institutional commitments, lack of funding, and turf fights over leadership and resources.

Mary Bassett, New York City Health Commissioner, next spoke to the role of public health data and community organizing to advance health equity in all policies, in a way that bolsters, rather than threatens, the work of sister agencies in local government. She started by acknowledging the context in which we do our work in the US (given its historical founding as a settler-colony and slave republic) and clarified that in her position, she has dual roles: (1) technical – to assure and track the health of everyone in NYC, and (2) political – as a political appointee in a progressive administration. She further noted she was only one of many agency heads, with a comparatively small budget (<2% of the city budget, and greatly eclipsed by the budget for the police department, education, housing, hospitals, etc.). She first discussed how

she and her teams are using data to make health inequities visible, especially via use of maps, with the express intent being to increase community awareness and demands about changing these inequities (in mortality, morbidity, and their structural determinants, such as elementary school absenteeism, incarceration, poverty, and unemployment). She next discussed their new re-launch of "Community Health Profiles" (see: http://www.nyc.gov/html/doh/html/data/nyc-health-profiles.shtml), which had last been produced in 2006, with the data being made available for all 59 NYC community districts, which are the smallest unit of local government and decision making within NYC. Decisions as to which data to include were made in conjunction with community advocates, so as to be policy relevant, and the profiles accordingly include data on both health outcomes (such as diabetes and asthma hospitalizations) and also measures pertaining to air quality, housing quality, supermarket square footage, etc. The graphics provided show, for each community district, where it ranks compared to the rest of the community districts and also to the city average and the average for its borough. The hope is that the data shown will make people angry, because the health inequities displayed are in principle preventable. These profiles diagnose the problem; the next step is setting equity targets, so that the twin aims are to lower rates and reduce gaps, and this is linked to the new campaign "Everyone's Health Counts," that is part of the "Take Care NY 2020" initiative (see: http://www.nyc.gov/html/doh/html/about/tcny.shtml) to create healthy neighborhoods, for every neighborhood and every New Yorker, and which sets targets for accountability. The approach employs a geographic lens, as opposed to focusing solely on "health services," as a way of linking actions by different agencies in each neighborhood. Winning the support of the other agencies has involved clarifying that "Health in All Policies" does not mean other agencies are supposed to do the work of the health department, but instead that these other agencies can work with health department staff to identify the added value – i.e., health benefits – produced by their programs. One new report by her agency, for example, just analyzed the health benefits of an increase in the minimum wage. The overall argument is thus not for simply "Health Equity in All Policies," but rather "Equity in All Policies and Planning."

Dennis Norman, Faculty Chair of the Harvard University Native American Program (HUNAP; http://hunap.harvard.edu/) and a member of the Southern Cheyenne Nation, then spoke about a unique "Nation Building" course he directs (see: http://hunap.harvard.edu/nation-building-course), which was started by an economist dedicated to economic development, and to which he additionally brings his insights as a clinical psychologist. The course is in its 14th year and has encompassed 94 projects involving 161 students. Among these projects, health and social services has been the primary focus for 19, educational development for 32, education for 29, and government for 13 – but virtually all have involved health issues. Consonant with key Nation Building principles – pertaining to sovereignty of nations and self-determination, and also that culture matters, institutions matter, and leadership matters – all of the projects are requested by and initiated by Tribal governments and tribal agencies, and the role of the students is to do background research and look for case examples of best practices. It is the sovereign choice of the community to partner with HUNAP, so as to strengthen capacity to be a healthy community. The goals of the course are to serve the community client, to have an equal and respectful exchange of knowledge, and to introduce the kinds of issues affecting Native communities to both Native and non-Native students, so as to train a new generation in the principles and practices needed to address these issues. Examples of some of the projects with a specific health focus include: (a) tribal consideration for participation in studies collecting DNA (especially given abuses of such research, including the recent case involving the Havasupai Indians in Arizona; the student component involved researching best practices for setting up a community-based IRB and addressing intellectual property issues); (b) methamphetamine use in Pine Ridge (the student project found that none of the key agencies working on different aspects of this problem were talking to each other, e.g., health agencies, criminal justice agencies, educational agencies, etc, and so helped them to work together on the problem); (c) historical trauma and its implications for health (this project was not a public case study, but instead was intended to assist the tribe in exploring these issues in relation to its own well-being); (d) cancer and autoimmune disease; and (e) evaluation of emergency medical services. Challenges include explicitly addressing well-founded Native distrust of projects involving Universities, the tight timetable for students to carry out the project, and raising funds to support the course. Other Universities are now beginning to develop similar courses (e.g., in Arizona), with one focused solely on health issues (at University of Washington), and more University partners are needed. Universities control who has knowledge and who can do what, and these courses can expand knowledge, address human needs, and make clear how community health is bound up in all other aspects of community well-being and the policies that affect communities.

During the **Q&A** period, comments and questions focused on: (1) addressing power issues within Native communities (who in these communities requests and is charge of the projects?); (2) whether measures could be added to the NYC Community Health Profiles on who is producing inequities (e.g., banks and housing foreclosures and gentrification, with the reply noting that for NYC, most residents cannot afford to be homeowners and instead are renters, leading to the decision to focus on housing quality as a key indicator); (3) the importance of visibility of Native Americans in public health and their inclusion in public health initiatives; (4) the connections between power, place, and the people's health; (5) what the processes are to get community residents active in advocating for community health (for NYC, the health

department has actively reached out to community activists, with an invitation to hold the health department accountable); (6) the importance of building relationships between academia, health departments, and communities, to work together for health equity; (7) the value of framing what's needed as "equity in all policies," and of focusing on neighborhoods/communities, as well as being savvy about how governments function, so as to avoid problems of elevating "health" above all other considerations and also getting internally caught up in debates over "intersectoral" work – and two examples of successes brought up in the Q&A pertained to: (a) new projects (funded at the city-level, not by any one agency) to promote community-level participatory budgeting (which can help address problems posed by inabilities of agencies to share budgets, let alone credit), and (b) using deep knowledge of governmental relations, which enabled tribes to get the federal, as opposed to state, rates for Medicare reimbursement (which dramatically increased funds and coverage of health services).

5) STUDENT POSTER SESSION

Our 14th **"STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH"** had 10 posters accepted, and 9 of the students whose work was accepted were able to be presented for the session (listed below; presenters' names in **bold font**). Abstracts for the posters are available at: http://spiritof1848.org/apha%202015.html#S4191

A constant flow of people came to see the posters, giving the student presenters many opportunities to discuss their work. Suggesting our session is meeting its objective in helping bring forward the next generation linking social justice and public health in their work, for many students the session was the first time s/he had shared results at a scientific conference and/or attended an APHA annual meeting. Overall, the students 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.

STUDENT POSTERS: SOCIAL JUSTICE & PUBLIC HEALTH (Tues, Nov 3, 12:30-1:30 pm, Session 4198.0) MPCC
Exhibit Hall F

Board 1: **Examining the use of race in preclinical medical education: student-driven curricular reform –** *Jennifer Tsai, BA, MS1*

Board 2: **Quantification of segregation in southeastern Wisconsin as a marker for economic disadvantage –** *Amin Bemanian*

Board 3: **LGBT health: a key curricular component in the pursuit of health equity –** *Ali Talan, MsC*

Board 4: **An untold story: abortion rates among black women of different socioeconomic positions –** *Hannah Philips, AB candidate*

Board 5: **Theatre arts for health promotion: using performance art for sex education and HIV prevention for North Carolina youth –** *Niranjani Radhakrishnan, BSPH*

Board 6: **Feasibility of sourcing local produce to small Latino food stores in low-income communities for improving the food retail environment –** *Jennifer Sanchez-Flack, MPH*

Board 7: **Ethnic bias in eugenic sterilization practice - a quantitative analysis of 15,000 sterilization records from state institutions in California, 1921-1952 –** *Nicole Novak, MsC, Doctoral Student*

Board 8: **Challenges of community partnership in HIA: a qualitative comparison of experiences from community organizers and HIA conductors –** *Laura Blue, MPH student*

Board 9: **"White Coats for Black Lives" – Racial violence as a public health concern for medical students nationwide –** *Jennifer Tsai, BA, MS1*

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6) Other:

a) we co-sponsored the following highly attended (≈ 100 participants) and well-received session, for which the primary sponsor was the APHA LGBT Caucus:

GENDER AFFIRMATION AND HEALTH EQUITY FOR TRANS/GENDER-VARIANT PEOPLE IN THE US: CONNECTING STRUCTURAL AND PERSONAL DIMENSIONS (co-organized with the APHA LGBT Caucus) (Mon, Nov 2, 8:30-10:00 am; Session 3055.0; MPCC Room S105bc)
 8:30 am: **Introduction –** *Sari Reisner, ScD*
 8:43 am: **Navigating the medical, health, and administrative systems –** *Channyn Parker*
 8:56 am: **The role of public health policy in gender affirmation and health equity for trans/gender-variant people in the US –** *Kellan Baker, MPH, MA*
 9:09 am: **Trans Life: Programmatic ways of addressing structural and socioeconomic barriers to health –** *Josie Paul, MA, LCSA*
 9:22 am: **Advancing health equity for transgender and other gender minority people in the US: gender affirmation and health –** *Gretchen Van Wye, PhD, MA*
 9:35 am: Q&A

-- The session was jointly introduced by **Sel Hwang** (from the LGBT Caucus) and **Zinzi Bailey** (from the Spirit of 1848 Caucus), and its origins lay in a connection between the Spirit of 1848 and the NYC Dept of Health, which was then extended to the LGBT Caucus, who then took the lead on organizing the session, with input from the Spirit of 1848.

-- **Sari Reisner,** a research fellow in the Harvard T.H. Chan School of Public Health Department of Epidemiology, Associate Scientific Researcher in the Division of General Pediatrics at the Boston Children's Hospital/Harvard Medical School, and Affiliated Research Scientist at the Fenway Institute at Fenway Health, and a transgender health advocate, provided a quick overview about the need for gender affirmation, distinctions between biological sex and social gender and gender expression, and results of a systematic review (soon to be published in Lancet) documenting the dearth of quantitative research on transgender health (N = 116 studies, worldwide, between 2008 and 2014, mostly conducted within the US, Brazil, India, and Australia, and 0 in most African countries, China, and Russia). He also discussed the concept of "gender affirmation," as introduced into the literature in 2013 by Sevelius. A key point is that gender diversity does not equal pathology, and there is a critical need to move away from "transgender" as being framed as a "disorder" to being an identity-based category (with no presumption of pathology).

-- **Channyn Lynn Parker**, the program intake coordinator at the Chicago TransLife Center and Board member of the LGBT Board for Diversity and Inclusion, spoke to the critical need for programs to focus on protecting the personhood of transgender people, such as herself, as opposed to seeing them only as targets for viral suppression who should not be infecting other people with HIV. Programs instead should address the full needs of transgender people, in relation to housing, violence, discrimination, poverty, etc., and do so from the standpoint of affirming the personhood of transgender individuals and enabling them to thrive. She discussed how, in her work in the Department of Corrections, she found that when she asked 20 inmates which was more important – hormones or drugs for their HIV? – 19 of the 20 replied "hormones," because although HIV might kill them in 20 years, they faced immediate risk of being killed now, if they did not appear to be cis-gender (i.e., appear to have their gender expression match what would be assumed to be their sex assigned at birth). She also discussed the issue of "system fatigue," in relation to dealing with health care providers, jails, and also research studies and surveys, especially when there are no returns to the community for its involvement in the research. She then gave an example from her own life, where she had experienced abdominal pain, but delayed going to a health care provider, because she did not want to be asked, yet again, when her last menstrual period was; additionally, when provider said it would be necessary to do an exam using a speculum, she had to reveal, with great fear, that she was transgender – and although her appointment ultimately was helpful, many times this is not the case.

-- **Kellan Baker**, based at the Center for American Progress, next spoke about the need for data collection to understand and improve transgender health. He reviewed four different types of data collection (research; population surveys; administrative and program data; electronic health records), and spoke about gaps and deficiencies affecting questions and data about sexuality, gender identity, and gender expression, as well as efforts to overcome these problems. For example, for the ACA ("Affordable Care Act"), the revised marketplace application will now include two questions (Q1: "what is your current gender identity?" – response options: male, female, transman, transwoman, another identity; Q2: what sex was listed on your original birth certificate?? – response options: male, female, declined to answer). A key basis for getting questions into the relevant types of data bases is that of prohibiting discrimination on the basis of sex, sex stereotyping, and gender identity.

-- **Josie Lynn Paul**, Director of the Translife Center, and a proudly out transwoman, then provided a description of the many services offered, on-site, on a drop-in basis, by their Center, for which 80% of clients/participants are transgender women of color. The 9 beds the Center offers to homeless transgender persons is only a small (albeit important) part of what they do. What's key is to connect people to resources – to address homelessness, to get medical care, and to get legal documents, because the first thing people are asked when they seek services is to provide an ID card, and on this ID card the "sex" needs to match the rest of the "identity" (name, appearance, etc). The services provided are participant-centered, as opposed to being program-centered, with an emphasis on confidentially and professionalism. Underscoring the need for gender affirmation and for helping to create conditions in which people can thrive (e.g., involving access to housing, medical care, and legal services), she said it was crucial that the Translife Center offered service to help transgender individuals however they needed help, as opposed to restricting their focus just to HIV/AIDS.

-- **Gretchen Van Wye**, Assistant Commissioner of the Bureau of Vital Statistics, Division of Epidemiology, in the NYC Department of Health and Mental Hygiene (NYC DOHMH), next described the steps taken by her agency to streamline and improve the process for people to change the "sex" on their birth certificate, so that it matches their gender identity. She explained that since 1971, the health code for the NYC DOHMH has authorized release of a new birth certificate, but it required that individuals both undergo a sex change operation and also a name change. In 2011, a model law was proposed which removed the requirement for a sex change operation, and 5 health departments have made this change (VT: 2011; DC: 2013; CA: 2014; NY State: 2014; Oregon: 2014); in 2010, the US State Department likewise removed the

surgery requirement for re-issuance of a passport. On Dec 9, 2014, the NYC Board of Health took the additional step of removing not only the requirement for a sex change operation but also the requirement for a name change. Instead, the on-line application for changing the gender marker on NYC birth certificates requires filling out a single form and including an affirmation or affidavit from a US-licensed health or mental health provider (see, respectively: http://www.nyc.gov/html/doh/html/services/vr-birth-correct.shtml and http://www.nyc.gov/html/doh/downloads/pdf/vr/gendermarker.pdf). Once the change is made, the original records are put under seal. As part of implementing the new program, all 185 members of the Bureau have undergone training to be trans-friendly, an on-line toolkit has been created to make the process as easy as possible, and the agency has changed the website and also phone script for the NYC 311 service to be inclusive. They also have done outreach to 300+ trans provider groups, recognizing that individuals with a NYC birth certificate may live in many places other than NYC, and also did a webinar with these groups (to help train the trainer). Throughout, they have an evaluation process in place, to detect any problems that need to be corrected. Since January 12, 2015, they have processed 267 requests for gender marker changes, a 10-fold increase compared to the prior year. Among these requests, 57% have been for male-to-female, and 43% for female-to-male; 87% had MDs fill in the health care provider affidavit, and the turn-around for processing the requests was less than 1 week. The next project will be to develop and implement a process to change the gender marker on the death certificate.

During the **Q&A** period, comments and questions focused on: (1) the need to change the gender marker in health records and have health care providers pay attention to these data in the medical records, so that people who are transgender don't have to tell their story every time they go for a medical appointment; (2) problems imposed by funding being so HIV-focused (including from HRSA), thus continuing to keep the focus on pathology, rather than quality of life and well-being; (3) the ways in which a focus on HIV has also obscured the need for pap smears and anal smears, with limited data from Chicago indicating that HPV infection is a problem for both transwomen and transmen; and (4) the issues discussed making clear how a framing of policy as "distal" and "gender identity" as "proximal" distorts the embodied realities that intimately connect these levels, and that the issues discussed about the structural barriers to affirmation of personhood and dignity experienced by the transgender population both require concerted attention (as per the initiatives discussed in this session) while at the same time sharply illuminate systemic problems that affect the conceptualization of health and delivery of health care and other social services more broadly.

b) We also, as usual, co-sponsored the Occupational Health and Safety health activist dance on the Tuesday night of APHA. Background to this party is the phrase attributed to Emma Goldman, to wit: "*If I can't dance, I don't want your revolution!*" Given a focus on equity in all policies, it's perhaps worthwhile to read the full text which has been distilled into this apocryphal saying, whereby Goldman states, in the following paragraphs in her 1931 autobiography "Living My Life"

I became alive once more. At the dances I was one of the most untiring and gayest. One evening a cousin of Sasha, a young boy, took me aside. With a grave face, as if he were to announce the death of a dear comrade, he whispered to me that it did not behoove an agitator to dance. Certainly not with such reckless abandon, anyway. It was undignified for one who was on the way to become a force in the anarchist movement. My frivolity would only hurt the Cause.

I grew furious at the impudent interference of the boy. I told him to mind his own business, I was tired of having the Cause constantly thrown into my face. I did not believe that a Cause which stood for, a beautiful ideal, for anarchism, for release and freedom from conventions and prejudice, should demand the denial of life and joy. I insisted that our Cause could not expect me to became a nun and that the movement should not be turned into a cloister. If it meant that, I did not want it. "I want freedom, the right to self-expression, everybody's right to beautiful, radiant things." Anarchism meant that to me, and I would live it in spite of the whole world — prisons, persecution, everything. Yes, even in spite of the condemnation of my own closest comrades I would live my beautiful ideal.

(see: http://theanarchistlibrary.org/library/emma-goldman-living-my-life.pdf; pp. 40-41)

And, also as usual, we had our 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 (Die Medizinische 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

Seneca Nation of Indians adopts its Constitution

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)**