SPIRIT OF 1848: APHA 2010 REPORTBACK (November 22, 2010)

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 138th annual meeting of the American Public Health Association (November 6-10, 2010, Denver, Co). 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 2010 sessions.

We are sending this reportback by email and posting it on our web site. Currently, 2,926 people (up from 2,756 last year) – from both the US and elsewhere in the world – subscribe to our email bulletin board. We expect still more to sign up, given the interest expressed at the APHA meeting. Attendance at our sessions was very good this year: over 675 persons came to our sessions (not counting those who visited the very crowded student poster session or the sessions that we co-sponsored), up from 400 in 2009 and also from 600 in 2008. As per usual, our sessions had very good attendance by APHA standards, noting that average attendance for APHA sessions is 30 persons/session, and our 2010 attendance ranged from 120 to 275 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 Simmonds (Politics of public health data committee); email: VSimonds@salud.unm.edu
--Anne-Emanuelle Birn (History committee); email: aebirn@utoronto.ca
--Alexandra Minna Stern (History committee); email: amstern@umich.edu
--Luis Avilés (History committee); email: laviles@upm.edu
--Suzanne Christopher (Pedagogy committee); email: suzanne@montana.edu
--Lisa Moore (Pedagogy committee); email: lisadee@sfsu.edu
--Rebekka Lee (student rep for the Student poster session); email: rlee@hsph.harvard.edu
--Jennifer Garcia (student rep for the Student poster session); email: jennifergarcia@ucla.edu
--Pam Waterman (E-networking committee and Spirit of 1848 representative to the APHA Governing Council); email: pwaterma@hsph.harvard.edu

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

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

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

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

A) SPIRIT OF 1848 BUSINESS MEETING (Tues, Nov 9, 2010, 6:30-7:30 pm)

Attended by: (a) Spirit of 1848 Coordinating Committee members (alphabetical order): Catherine Cubbin (data), Jennifer Garcia (student rep), Nancy Krieger (chair & integrative), Rebekka Lee (student rep), and Pam Waterman (e-networking and Spirit of 1848 representative to the APHA Governing Council), and (b) additional Spirit of 1848 members (alphabetical order); Olivia Carter-Pokras, Amie Fishman, Allegra Gordon, Shawn Kimmel, Azar Mehrabadi, Stacey McConlongue, Cheryl Merzel, Sarah Ramirez, Cassandra Ritas, Liz Samuels, and Natalie Stahl.

Spirit of 1848 Coordinating Committee members who were unable to attend (but provided input in advance) were: Luis Avilés (history), Anne-Emanuelle Birn (history), Suzanne Christopher (pedagogy), Lisa Moore (pedagogy), Vanessa Simmonds (data), and Alexandra Minna Stern (history)

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

2) We reported back on how our various sessions went (see detailed descriptions below), discussing both attendance and content. The estimated attendance for our sessions was as follows: Social history of public health ($n \approx 130$); The politics of public health data ($n \approx 120$); Progressive pedagogy in public health ($n \approx 150$); "integrative session" ($n \approx 275$). As noted above, attendance at these sessions was generally higher than their counterparts in previous years (last year history was $\approx$ 100; data was $\approx$ 175, pedagogy was $\approx$ 25, and the integrative session was $\approx$ 95). 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.

3) After our Spirit of 1848 business meeting, Pam Waterman represented the Spirit of 1848 at the now annual APHA all-caucus breakfast, held on Wed, November 10, and reported back that:

> The Caucus breakfast was well attended, with representatives from a majority of the Caucuses present.
>
> Dr. Benjamin informed us that APHA is seeking funding to cover travel and lodging for one member from each caucus to attend a 1-day meeting in Washington in the Spring. The focus of the meeting will be the future of APHA Caucuses, with a goal of emerging from the meeting with a document that, along the lines of the Memorandum of Understanding, would continue to clarify the status, relationship, and responsibilities of the Caucuses vis a vis APHA and vice versa. Prior to the proposed meeting, Dr. Benjamin suggested that we all think about 5- and 10-year goals for our individual caucuses.
>
> As part of the general breakfast discussion, many Caucus members expressed the need to grow their memberships. Suggestions were made to combine strengths (and money) across caucuses to, e.g., rent a large multi-Caucus booth in the Exhibition Hall during the annual meeting to increase visibility and recruit new members. Although we support the efforts of the other Caucuses to expand their membership, I noted that the Spirit of 1848 was not necessarily interested in, e.g., sharing the cost of a booth (especially since we are NOT a dues-paying Caucus), and I requested that as the discussions continue, the other Caucus leaders and the APHA staff remain mindful of the needs and

desires of Caucuses that are not interested in growing in that manner. Dr. Benjamin confirmed the necessity of making sure that the concerns of Caucuses like ours, which are "primarily listservs" be heard, and he commended our Caucus as being an "extraordinary dissemination vehicle."

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:

> There was no discussion that arose during the meetings that related to the Caucuses as a whole, or to the Spirit of 1848 in particular. However, I note that during the proceedings, in the course of discussing a proposed resolution, for the first time ever, a member of a Caucus -- who happened to be the co-author of the resolution -- was able to speak without having to first request special permission from the Council. This point was met with applause.

4) With regard to sessions for next year **(139th annual meeting of APHA, Oct 29-Nov 2, Washington, DC, with a theme of *"Healthy Communities Promote Healthy Minds & Bodies"*)**, 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 17, 2010.**

(b) **abstracts will be due between FEBRUARY 7-11, 2011.** 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 communities in their larger societal context, as follows:

History: This session will accept **only solicited abstracts** that critically examine the history of community health centers – including community mental health centers – in both the US and other countries. It will be organized by Spirit of 1848 Coordinating Committee members Anne-Emanuelle Birn (email: aebirn@utoronto.ca), Alexandra Minna Stern (email: amstern@umich.edu), and Luis Avilés (email: laviles@upm.edu).

Data: This session will have an **open call for abstracts – and also solicit abstracts** -- that critically examine the many ways that community and individual health is harmed by discrimination – of multiple types, at multiple levels, and across both the lifecourse and multiple generations, via multiple pathways (not solely psychosocial). It 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 Simmonds (email: VSimonds@salud.unm.edu)

Pedagogy: This session will have an **open call for abstracts** – and also **solicit abstracts** -- that critically examine teaching, both in and outside of traditional academic settings, that promotes the health of communities, including in relation to links between community development and health. 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 communities and health, as linked to issues of both political economy and political ecology, 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 Spirit of 1848 Coordinating Committee members Nancy Krieger (email: nkrieger@hsph.harvard.edu), Anne-Emanuelle Birn (email: aebirn@utoronto.ca), and Luis Avilés (email: laviles@upm.edu).

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

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

Spirit of 1848 session* -- 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 well attended, thought provoking, and clearly useful to those who came. We estimate that approximately 675 persons came to our sessions (not counting those who visited the very crowded student poster session or the sessions that we co-sponsored), up from 400 in 2009 and also from 600 in 2008. As per usual, our sessions had very good attendance by APHA standards, noting that average attendance for APHA sessions is 30 persons/session, and our 2010 attendance ranged from 120 to 275 persons per session. Additionally, approximately 70 persons attended the memorial session for Walter Lear that we co-sponsored and about 90 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 ≈ 130 people (up from the ≈ 100 in 2008 and 2009, the ≈ 120 in both 2006 and 2005, and the ≈ 70 in 2007 and ≈ 45 in 2004).

THE LONG STRUGGLE: BUILDING SOCIAL JUSTICE & PUBLIC HEALTH – AND CHALLENGING CO-OPTATION – FROM 19TH C SOCIAL MEDICINE TO 20TH C PROGRESSIVISM AND CIVIL RIGHTS
MON, NOV 8 ***10:30 AM-12 NOON (SESSION 3154.0) * CO CONV CTR (CCC) RM 605**
10:30 AM — Moderator. Alexandra Stern, PhD
10:35 AM — Illness-generating conditions of capitalism and empire: The contributions of Engels, Virchow, and Allende. Howard Waitzkin, MD, PhD
10:55 AM — What does real power exchange look like in public health? – insights from the life and work of W.E.B. DuBois. Arthur McFarlane
11:15 AM — Disrupting the narrative of race and malnutrition: Black women activists and medical researchers in 1960s' Memphis. Laurie Green, PhD
11:35 AM — Question & answer period

Anne-Emanuelle Birn opened up the session, on behalf of Alexandra Stern (who was unable to attend APHA), with an overview that reminded us of the need to look at struggles for social justice & public health with a long view, that is, a history replete with victories, defeats, backlashes, and also co-optation and resistance to this co-optation.

Howard Waitzkin then discussed what he termed a "1-1/2 centuries of remembering and forgetting" how social conditions become embodied, as revealed by the works of Friedrich Engels and Rudolf Virchow (both in the 1840s, in the UK and Germany respectively) and Salvador Allende (from the late 1930s to 1973, in Chile). Waitzkin first recounted the detailed and pathbreaking analysis Engels provided, in his classic text on *The Condition of the Working Class in England in 1844*, of the profound links between working conditions, economic exploitation (per early industrial capitalism), and poor physical and mental health. He then described Virchow's role, as one of the founders of social medicine, in documenting that abject social conditions increased susceptibility to epidemic disease. Next Waitzkin summarized key points of the 1939 popular front platform on health – focused entirely on social determinants of health -- authored by Allende, who was mentored by one of Virchow's students. To Waitzkin, all three thinkers converged in their views on how capitalism and imperialism inherently generated unnecessary illness and premature death; they diverged, however, in their emphases, with Engles focused on economic production, Virchow on distribution and consumption, and Allende on class structure in the context of empire and underdevelopment. Additionally, as solutions, Engels called for revolution, not reform; Virchow, for reform, not revolution; and Allende, for socialist transformation of society by peaceful means. Waitkzin then invited the audience to once again think the "unthinkable" – about a world free of the political and economic priorities that produce health inequities – and to take action to make health equity possible (see Waitzkin's forthcoming book on *Medicine and Public Health at the End of Empire*).

Arthur McFarlane next discussed the pathbreaking work of his great-grandfather, WEB Du Bois, especially his 1899 study on the health and lives of the "Philadelphia Negro," which was commissioned by the University of Pennsylvania. For this study, which broke ground for both sociological and public health analyses of community well-being, DuBois personally interviewed the residents of Philadelphia's 7th ward, and linked their poor health status to conditions of work,

wages, housing, and discrimination. Jumping to the present, McFarlane argued that Du Bois' insights and critiques were still valid, and that there is an urgent need for real power sharing between health departments and community members, not just "partnerships" in which the public health departments retain all the power.

Laurie Green next presented her analysis of the reframing of infant and children's malnutrition in Memphis in the 1960s – led by black women community members and activists committed to self-determination and the physicians they involved from a key local hospital for children – from being a problem of "race" (i.e., due to alleged innate biological differences) to a socially-caused problem. As part of this reframing, community members developed new food distribution networks, for which physicians wrote prescriptions for food. This work continued on through the early 1970s, after the passage of the Civil Rights legislation of the mid-1960s, and critically shaped the 1972 legislation that created the WIC program (i.e., supplemental food for women, infants, and children). Much of this history, however, has been lost, even to the communities who created this critical reframing, such that recovery of this history is critical, including for new work challenging the still-high rates of infant mortality in Memphis.

During the **Q&A period**, comments focused on the critical need to: (a) regain critical history (recognizing that such history typically is "lost" because of repression, not "forgetfulness"), and also (b) not reduce issues of discrimination and health to a matter of solely psychosocial stressors – instead, full attention to the structural determinants of health inequities is required.

2) POLITICS OF PUBLIC HEALTH DATA

Our session was attended by ≈ 120 (fewer than in prior years, whereby attendance was ≈ 175 in 2009, ≈ 250 in 2008, ≈ 220 in 2007 and 2005, and ≈ 140 in 2006).

THE POLITICS OF PUBLIC HEALTH DATA: THE MAINSTREAMING OF SOCIAL JUSTICE IN DATA SYSTEMS AND MONITORING HEALTH INEQUITIES – POSSIBILITIES AND PROBLEMS
MON, NOV 8 ***2:30 PM-4:00 PM (SESSION 3348.0) * CO CONV CTR (CCC) RM 605**
2:30 PM — Introduction. Catherine Cubbin, PhD
2:35 PM — Measuring social determinants of health within Statistics Canada. Jillian Oderkirk
2:50 PM — Closing the measurement-action gap in health inequities. Kumanan Rasanathan, MD, MPH, FAFPHM
3:05 PM — Inside "Inside the neighborhood": data, politics and participatory democracy in a Venezuelan intersectoral program. Carles Muntaner, MD, PhD, Haejoo Chung, RPh, MSc, PhD, Qamar Mahmood
3:20 PM — Healthy People 2020 and social determinants of health: a national policy tool for health equity or continuing inequity? Shawn D. Kimmel, PhD
3:35 PM — Question & answer period

Catherine Cubbin opened up the session, introducing the speakers and also the theme of the session – the tensions between needing to monitor health inequities yet not have such monitoring co-opted or be a substitute for action to reduce these inequities.

Jillian Oderkirk opened the session by providing a comprehensive look at how Statistics Canada has been framing and implementing its program to monitor health inequities. To address data gaps regarding social determinants of health, Oderkirk described steps taken to link health data to census data, and also to use area-based socioeconomic measures when individual-level data were lacking; examples including analyses pertaining to socioeconomic disparities in life expectancy and infant mortality and in causes of death amenable to medical care, and also disease-specific hospitalization rates among Canada's Indigenous peoples. She additionally described several population health surveys, both longitudinal and cross-sectional, and flagged new work geared to addressing the health costs of health inequities.

Kumanan Rasanathan next discussed insights gained from work with the WHO Commission on the Social Determinants of Health. Questioning the oft-invoked phrase "what gets measured, gets done," Rasanathan noted that new data and new knowledge did not, by themselves, reduce health inequities – and asked how the new tools being developed to measure and monitor health inequities could better be used to help translate knowledge to action. Among the issues he noted were: (a) problems with the "deficit" approach, whereby ill use of adverse health indicators can result in victim-blaming (depending on how the data are used by whom), as opposed to revealing social inequities harming health; (b) lack of data

on the efficacy of interventions intended to reduce health inequities, along with lack of evidence to inform "evidence-based policy," and (c) the "measurement-action" gap. Using examples from several countries (New Zealand, Chile, Sri Lanka), Rasanathan argued for the importance of considering the process by which – and what – data are gathered by whom, to what end, with the reminder that data is a tool, not an end in itself.

Carles Muntaner then talked about his experiences in Venezuela during the past decade with regard to the "Barrio Adentro" program, designed to improve access to health care as part of Venezuela's Bolivarian revolution. According to Muntaner, understanding what data are and are not available about the program requires understanding links between data, politics, and participatory processes. For example, the focus is on absolute numbers, not rates, e.g., the number of new community health center is recorded, as is the percent of the population enrolled, whereas data are lacking on changes in rates of morbidity and mortality. To start to fill in the gaps, Muntaner described a project of "concept mapping" that underscored how greater participation, with more of an emphasis on information and dissemination, is vital for ensuring that communities have the data they need to improve their health.

Shawn Kimmel then asked, given how the US did not meet its goals for *Healthy People 2010* vis a vis reducing health inequities, how the *Healthy People 2020* process could be better structured to keep attention focused on action needed to meet this objective. Noting that the final proposal for *Healthy People 2020* will not be released for another month, Kimmel described some steps already taken to improve possibilities for addressing social determinants of health, e.g., the establishment of a Federal inter-agency group, involving 23 agencies, that is focused on health disparities. He further noted that considerable effort is being expended on creating a web-site to enable individuals to assess information on what will be the over 500 specific objectives of *Healthy People 2020*, but questioned whether and how this website will contribute to initiatives to reduce health inequities.

During the **Q&A**, comments underscored the importance of: (a) not letting data on health inequities be an end in themselves, even as governments (including Canada) must be pushed to address the deficiencies in their data to monitor these inequities, and (b) illuminating the ways the production of data is itself a political process, such that how the data are conceptualized, collected, and interpreted – by whom, with what kinds of participation – must be part and parcel of the work to reduce health inequities.

3) INTEGRATIVE

This session was attended by ≈ 275 persons (up considerably from the ≈ 90 who attended in 2009, and also the ≈ 150 who attended in 2008, albeit less than the ≈ 550 who attended our integrative session in 2007, which was focused on how to use the then new film series *"Unnatural Causes: Is Inequality Making Us Sick?"*). 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.

MAKING SOCIAL JUSTICE THE FOUNDATION OF PUBLIC HEALTH: GAINING GROUND AND CONFRONTING CO-OPTATION – CRITICAL PERSPECTIVES FROM PUBLIC HEALTH HISTORY, THEORY, PEDAGOGY, AND PRACTICE
MON, NOV 8 ***4:30 PM-6:00 PM (SESSION 3421.0) * CO CONV CTR (CCC) KORBEL BALLROOM 3A/B**
4:30 PM — Introduction. Lisa Dorothy Moore, DrPH
4:35 PM — WHOse international health? Cooptation and resistance in the context of health and development, 1970-present. Anne-Emanuelle Birn, MA, ScD
4:55 PM — Theories of disease distribution and the politics of public health data: an ecosocial perspective. Nancy Krieger, PhD
5:15 PM — Maintaining a commitment to social change in public health through Leadership Development. Hahrie Han, PhD
5:35 PM — From Harlem to Harare: lessons in how social movements and social policy change health. Mary T. Bassett, MD, MPH
5:55 PM — Question & answer period

Lisa Moore opened up the session, noting that issues of co-optation have been raised since at least the work of Piven and Cloward 40 years ago, on how poor people's movements were absorbed and co-opted in order to neutralize the threat they

posed to the established social and political order on account of their system-changing efforts to promote equity. Arguing that work in public health was especially likely to be co-opted, due to its emphasis on reducing suffering and having service-oriented work be funded by the state, Moore said the session was designed to reveal issues of power and inequity as critical to action linking social justice and public health.

Anne-Emanuelle Birn commenced by saying that although it is of course good that the APHA was recognizing the importance of social justice to public health, it is equally important to put this statement in context, and to review critically the dangerous watering down of what such ideas can mean over the past half-century. She next reviewed key meetings and documents from the early 1950s on through the 1978 Declaration of Alma Ata, signed by 134 nations, which addressed the political and social determinants of health, called for comprehensive primary health care as a means of reducing health inequities between and within countries, and set the goal of "health for all by the year 2000." Yet, as soon as this Declaration was announced, it was co-opted by mainstream health systems leaders, who opted instead for the strategy of "selective primary health care" as a more "rational" and realistic approach, one that was technology-driven and donor-driven, inviting victim-blaming while avoiding any mention of the political and social determinants of health. Similar problems beset current work to address health inequities, whereby major donors (e.g., the Rockefeller Foundation, the Bill & Melinda Gates Foundation) are reframing work in this area as a matter of improving technology and also investment possibilities; the WHO similarly has been captured by "partnerships" whereby 80% of the budget is earmarked by donors and hence not voted on by the World Health Assembly. Thus, it remains more important than ever to resist co-optation, and to practice "reverse co-optation," i.e., change the co-opted terminology of "food security" to the more radical language (and idea) of "food sovereignty," and to speak not solely of the "causes of causes" (e.g., poverty as a cause of disease), but of the "causes of causes of causes" (e.g., the political and economic priorities of contemporary capitalism that ensure the continuation of poverty and its health-damaging consequences).

Nancy Krieger then presented on the importance of epidemiological theories of disease distribution for documenting, analyzing, and addressing health inequities. Theories covered included: (a) the dominant biomedical and lifestyle approaches, and (b) the three different schools of social epidemiologic theories – sociopolitical, psychosocial, and ecosocial – which overall agree on the importance of societal conditions in shaping population health and health inequities, even as they differ in their foci and extent to which they engage with political and biological phenomena. Included among the sociopolitical frameworks were the social production of disease/political economy of health, Latin American social medicine and collective health, health and human rights, and the increasingly depoliticized approaches of "population health" and "social determinants of health." Concrete examples of the difference that choice of epidemiologic theory makes included: (a) the contrast between the political economy of health analyses of exploitation in social class relations under capitalism versus psychosocial emphasis on relative standing in a ranked hierarchy and contingent implications for measuring social class versus status in health research, and (b) the contrasting understandings of the recent diabetes epidemic among the Pima Indians in Arizona afforded by the different epidemiologic theories of disease distribution and their implications for interventions. More detailed discussion of these issues can be found in Krieger's forthcoming book *Epidemiology and The People's Health: Theory and Context* (to be published by Oxford University Press in February 2011).

Hahrie Han next discussed ideas relevant to teaching organizing, with an eye to staying true to values so as to reduce the risk of co-optation. Among her key points were that: (1) organizing is about holistic system change and identifying pockets of agency within a system that can change the system, as opposed to designing specific policies; (2) per the insights of Marshall Ganz, what's key for organizing is enabling others to achieve purpose in the face of uncertainty (since if there were no uncertainty, all that would be needed is management, not organizing); conversely, organizing is not about building up "shining stars" but is about enable others to achieve common purpose; (3) people come together because of values, motivation, and understanding, with strategizing understood as a dynamic process that involves values narratives, creating relational commitments, and setting measurable benchmarks for a campaign that can be seen as a process with a beginning, middle, and end; and (4) because people with power want to localize conflicts (so as to absorb and/or suppress them), those organizing for change need to combine national purpose and – and with – local organizing. The contrast is to work that focuses solely on providing services or creating marketing and products (including provision of services). The central message was that clarity on values, creating capacity, and building commitments and the accountability of leaders to those engaged in organizing was essential to counter recurrent pressures of co-optation.

Mary Bassett then tied together the session's themes by reflecting on her experiences getting a medical degree 30 years ago in Harlem, followed by public health training, then working in Zimbabwe for 17 years (1985-2002), and then

returning to Harlem and working in the leadership of the NYC health department. Her central points were that: (1) there have been periods with substantial gains in reducing health inequities, and that these have come about largely by community mobilization and when the policy context supports health equity; and (2) the international context matters, e.g., during the 1960s and 1970s, when the US sought (in the context of the Cold War) to portray itself as the beacon of democracy, it had to address its own domestic politics of inequality and apartheid – and now, in 2010, we are at a time of more major global shifts in politics and economics, including a decline in US power, all of which is likely to have important ramifications for the magnitude of – and efforts to address -- health inequities in the US and globally. In the case of Zimbabwe, Bassett recounted the initial successes vis a vis improving population health and reducing health inequities after Rhodesia was transformed into Zimbabwe in 1980, only to have these efforts undercut starting in the 1990s by both structural adjustment programs (which decimated the public sector and greatly increased the number of sources of income people had to find in order simply to survive) and HIV/AIDS. Returning to NYC in 2002, Bassett found that, in a context of entrenched racial residential segregation and soaring rates of imprisonment (whose costs per year equaled the entire public health budget), chronic diseases were a major contributor to health disparities. The main focus of the health department, which lacked any senior black or Latino leadership (except when Bassett was one of the Deputy Commissioners), was in the sphere of policy, e.g., the calorie labeling initiative, restricting trans-fats; less attention and resources were made available for community mobilization. Contrasting the "top down" versus "bottom up" approaches to making public health change, Bassett warned of the dangers of focusing only on the former, since it is the latter that has been essential for successes in tackling health inequities.

In the far-too-short **Q&A** period, discussion focused on: (1) yes, policy matters, but it is essential to address the context in which policy is formulated and carried out, by whom (i.e., not enough only to label calories); (2) the dangers of unaccountable donor-driven policies and philanthro-capitalism (even as non-governmental groups typically can more rapidly act and innovate than government agencies, but with what implications?), and (3) the importance on placing struggles for health equity in their larger context of social movements, and why the mutual engagement of these movements is necessary, e.g., health struggles need to clarify for both the health sector and the other movements the health implications of, say, militarism, apartheid, and neo-liberalism.

4) PROGRESSIVE PEDAGOGY

This session on links between pedagogy and addressing co-optation of teaching about social justice & public health was attended by ≈ 150 people, way up from last year (when only ≈ 25 people attended, noting that in 2008, ≈ 100 attended, in 2007, ≈ 250 attended, and in 2006 ≈ 50 attended).

PROGRESSIVE PEDAGOGY FOR PUBLIC HEALTH: TEACHING AND THE CO-OPTATION OF SOCIAL JUSTICE
TUES, NOV 9 * 8:30 AM-10:00 AM (SESSION 4066.0)*** CO CONV CTR (DCC) RM 603**
8:30 AM — Introduction. Lisa Dorothy Moore, DrPH
8:35 AM — Making the invisible visible: effective learning on equity and the social determinants of health. Fran Baum, BA (hons) PhD, Angela Lawless, BSc MPHC, Gwyn Jolley BSc MSc, Michael Bentley BSc, Toby Freeman BSc Phd, Miranda Roe BSW PhD, Frank Tesoriero MWs PhD
8:55 AM — Has social justice become the new diversity? A critical examination of public health pedagogy driving community engagement. Makani Themba-Nixon
9:15 AM — Resistance to co-optation: success and failures from the field. Bonnie Duran, DrPH and Nina Wallerstein, DrPH
9:35 AM — Question & answer period

Lisa Moore opened the session by observing that if we don't teach about or learn about how co-optation happens, then we get surprised by it – hence the focus of this session, on progressive pedagogy and teaching skills to understand and resist co-optation.

Fran Baum then discussed the approach she and colleagues are taking at Flinders University (in Australia), as informed also by Baum's work as a Commissioner on the WHO Commission on the Social Determinants of Health, to train the public health and medical workforce to understand the social determinants of health framework and its implications for the work of public health agencies and health service institutions. The basic logic was to point out that it did little good to

treat people's ills only to send them back to the same conditions, over which they had little or no control, that made them sick in the first place. Key barriers identified included: (1) individualism (easily leading to victim-blaming); (2) the tendency to focus only on the tip of the iceberg (i.e., focus on illness and not its social determinants); (3) prior training being highly curative, with little focus on prevention; and (4) the dominance of the medical imagination, with little space for the sociological imagination. Addressing these barriers requires: (a) addressing values directly, including making the ideologies of the dominant individualistic approaches apparent; (b) challenging behaviorism (including empirically, via research demonstrating the importance of social determinants of health, e.g., in Australia, demonstrating that two of the major determinants of smoking for members of the Aboriginal population were being incarcerated and having endured being what is termed "stolen," i.e., removed from their families by the state and missions and forced to be their wards instead); and (c) using multi-pronged strategies premised on the participation and leadership of those affected by health inequities.

Makini Themba-Nixon next asked if social justice for all, at the societal scale, is what we need, then is it already a co-optation to focus only on injustice and health inequities? Arguing that we need to move beyond problems-to-be-solved to achieving a world with social justice, she proposed shifting the analysis from "problem people" and "problem conditions" and changing distributions to transformative visions about how we share power and build democracy and co-governance, as per new work on participatory budgeting. Themba-Nixon also emphasized the importance of bringing in Indigenous knowledge, alternative visions (e.g., moving from "there is no alternative" to "another world is possible"), and advancing stories that make solutions visible. Urging creation of intersectoral, process-oriented, democratic spaces, she referred the audience to concrete examples of creating this sort of transformative action, available at the following website: http://www.transforming-communities.org; examples pertain to education reform, food retailing, the Blackfeet clean air resolution, and analysis of UK efforts to "mainstream equality."

Bonnie Duran and **Nina Wallerstein** then jointly presented on what co-optation entails and the critical questions is raises for community-based participatory research (CBPR). Duran first reviewed key definitions of co-optation, all focused in one way or another on how those with power seek to absorb and de-fang social movements and organizing that threatens their power, with one contemporary example pertaining to "greenwashing." Wallerstein next discussed key aspects of CBPR, including its academic legacy traced back to Lewin's work in the 1940s on "Action Research," followed by a surge in work on participatory research in the 1970s, including Friere's emphasis on imagining into the future. Noting that there presently is a continuum of what is termed "CBPR" that spans from research "on" to "in" to "with" the "community," and noting that a study she and colleagues are doing is finding a surprisingly small fraction of the hundreds of CBPR studies that NIH has funded employ language of actual "partnering," Wallerstein raised the question as to whether CBPR could inappropriately absorb what is happening in communities into the scientific world. She likewise noted that as CBPR gets a higher profile in NIH, it is being used not to advance social movements, but as a way of increasing recruitment of what NIH terms "minorities" into clinical trials – a trend also raising questions as to whether CBPR is being co-opted into science and being moved away from its vital role in making social change. Duran then discussed, using the example of Indigenous knowledge development, how research, including CBPR, can instead be used to counter co-optation directly and advance the work of social movements, but only insofar as it stays clear on the politics. Illustrating this perspective was a quote from Linda Tuhiwai Smith, a Maori scholar and activist from New Zealand, who in 2005 wrote: "Research, like schooling, once the foil of colonization, is very gradually coming to be seen as a potential means to reclaim languages, histories, and knowledge, to find solutions to the negative impacts of colonialism and to give voice to an alternative way of knowing and of being." Together, both emphasized the importance of reflective practice to maintain integrity of the work, in the academy and with allies.

During the **Q&A** period, comments addressed: (a) the postcolonial theory query as to whether the "subaltern" can speak without necessarily being "co-opted" as a "safe person" – coupled with the tensions, constant self-questioning, and related challenges of being the first or one of the "firsts" (in ones family, community, etc) to gain the higher education in order to challenge social injustice; (b) the need to be cognizant that co-optation and backlash arise precisely because social movements do gain ground – and we should expect this, as a sign that our work is becoming too important to ignore, and hence the need to continue to be explicit about the need to challenge unjust systems of power and individualism in our teaching and our work; (c) the need to use clear language to make the dynamics of power visible and to frame the work we are doing, so that it is not co-opted; (d) the need to question just how much compromise we are willing to make, tactically, as part of strategically advancing the social justice goals; and (e) the need to have progressive standards for CBPR clearly articulated in the mainstream public health and medical journals, so as to prevent its co-optation.

5) STUDENT POSTER SESSION

Our 9th **"STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH"** had 10 posters accepted (of which 2 had to withdraw). Throughout the hour for this session there was a constant flow of people coming to see the posters, giving the student presenters many opportunities to discuss their work. The eight posters displayed were as follows:

STUDENT POSTER SESSION: SOCIAL JUSTICE & PUBLIC HEALTH

TUES, NOV 9 * 12:30 -1:30 PM (SESSION 4153.0)*** CO CONV CTR (CCC) HALL A/B**

Board 1 — Medical research on ethnicity continues to neglect social context. ***Dane Bay, MPH Candidate and Daniel Cook, Phd***

Board 2 – Social justice symposium at Mel and Enid Zuckerman College of Public Health. ***Catherine Luik, MPH Candidate***

Board 3 – Going upstream: applying a public health perspective to interventions for incarcerated youth. ***Annie Fishman, MPH***

Board 4 – Discrimination in healthcare reported by transgender persons in Virginia: results from a statewide needs assessment survey. ***Sari L. Reisner, MD and Judith B. Bradford, PhD***

Board 5 – Applying a "social determinants of health" framework to a community-based health equity project. ***Lindsay Schubiner, BA***

Board 6 – Examining health equity through a race theory lens. ***Andrea Corage Baden, MPH, Ph(c)***

Board 7 – Costs of co-optation: a case example in the movement to end gender-based violence. ***Althea Swett, RN/WHNP candidate 2012 and Elizabeth Samuels, MD/MPH candidate 2012***

Board 8 – Marketmakovers.org: a digital video-based guide to corner store conversion. ***Arianna Taboada, BA***

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) Working with the Socialist Caucus, the LGBT Caucus of Public Health Workers, and the Medical Care Section, we co-sponsored and helped organize the Sunday session *"If I can't dance, I don't want to be part of your revolution!" -- a tribute to the life and work of Dr. Walter J. Lear,"* which was attended by ≈ 90 people. It started with videos from the memorial service organized for Walter in Philadelphia, which recounted his work in the 1960s organizing against racial discrimination in the medical profession and in health care, including his work as a founder of the Medical Committee for Human Rights, his coming out as the first openly gay US public health official and shortly thereafter founding the APHA LGBT Caucus, his work on the APHA Committee on Women's Rights, and his work and activism as part of the US health left, including his creation of the US Left Health Archive, which he donated to the University of Pennsylvania. Additional presentations touched on these many aspects of Walter's life (1923-2010) and how he touched so many of us active in APHA progressive politics, with the focus of the Spirit of 1848 presentation (given by Nancy Krieger and Anne-Emanuelle) examining the many ways we worked with Walter since our inception. And, appropriately, there was also music, song, and all of us dancing to a video of the closing finale from the Spirit of 1848's 1998 extravaganza celebrating 150 years of the Spirit of 1848, for which Walter was one of the invited participants (with the music being a jazzy rendition of the "Internationale").

b) 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 ≈ 90 people, much higher than the ≈ 50 people in 2009 and the ≈ 35 in 2006, and more on par with the ≈ 100 people in 2008 and ≈ 75 people in 2007. Speakers included: (a) Martha Livingston, on behalf of the Socialist Caucus, on the many reasons why advocates still need to fight for single-payer health care; (b) Ellen Shafer, on behalf of the Medical Section and also in her role as co-

director of the EQUAL health network (which offers progressive analysis of and advocacy pertaining to health care reform), on what was achieved, for the good, with health care reform, as well as the many significant social justice challenges that remain (including in a context of the last 30 years of structural adjustment, with its signature features of deregulation, privatization, and constraints on public services and civil society, and the growing corporatization of health care), and (c) Cindy Pearson, on behalf of the Women's Caucus and also in her role as Executive Director of the National Women's Health Network, on the work needed to ensure that abortion and reproductive services are included in health care reform and how reversing the setbacks cutting them out with require grappling with issues of stigma and class and challenge the social divisions in the women's health movement that enabled the Hyde Amendment to be passed in 1977. The two discussants were: (a) Nancy Krieger, chair of the Spirit of 1848 Caucus, who spoke to the need to challenge free market fundamentalism, to use human rights approaches combined with analyses of the political economy of health to push for progressive alternatives in health care reform, clear on the necessity of reproductive health services, mindful of both how racism intertwines with stigma and class (and the flip-side of the denial of abortion rights being sterilization abuse), along with the need to see our work in the context of the long-term political struggles with their victories and setbacks; and (b) Kumanan Rasanathan, from WHO's Department of Ethics, Equity, Trade and Human Rights, who spoke to how health systems reflect the societies in which they are embedded, and the need to be clear about the values and political struggles reflected in more equitable health systems (with examples including the long-term work required to build Brazil's SUS and Familia program, or New Zealand's welfare state, etc), along with the need to be sure systems work in the 21st century, which will require challenging the dominant pharmaceutical model of health services and instead have health systems expand to address social determinants of health inequities.

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

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

Onwards! ....
Spirit of 1848 Coordinating Committee

SPIRIT OF 1848 MISSION STATEMENT

November 2002

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

Purpose and Structure

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

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

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

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

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

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

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

Community email addresses:

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

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

NOTABLE EVENTS IN AND AROUND 1848

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

1848: World-wide cholera epidemic

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

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

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

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

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

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

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

Karl Marx and Frederick Engels publish The Communist Manifesto

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