

★★★★★ THE SPIRIT OF 1848: APHA 2024 REPORTBACK ★★★★★

TO: EVERYONE ON SPIRIT OF 1848 EMAIL BULLETIN BOARD
FROM: SPIRIT OF 1848 COORDINATING COMMITTEE
RE: REPORTBACK FROM THE 2024 APHA CONFERENCE (ver: 11/9/24)



We have finalized this Spirit of 1848 APHA 2024 reportback in the wake of the US election results, which are devastating. As shared on our Spirit of 1848 listserv on the morning of Wed, Nov 6, 2024, in a post submitted by the chair & co-founder of the Spirit of 1848 Caucus (N. Krieger):

The US election results – for president, for control of the US senate, and more – portend truly hard times ahead for the fight for health justice in its many forms, domains, and dimensions – within the US and globally.

Many on this listserv have share myriad postings about the dire implications of emboldened market and religious fundamentalism, in conjunction with minority rule, for people's health and human rights, as well as for the health and well-being of all life on this planet (per the already existing climate and environmental crises that will be worsened).

Hence the need for resolve to continue the ceaseless fight for health justice, each of us in whichever aspects of the fight we have taken on and continue to take on – and may we do so in solidarity with each other, grounded in the knowledge (not simply belief) of the embodied interconnections of our specific struggles, as they play out within both bodies and the body politic – and find and build strength with each other to make another better world possible.

In this context, we share our Spirit of 1848 Caucus reportback from the 152nd American Public Health Association Annual Meeting and Expo (APHA; October 27-30, 2024, Minneapolis, MN), which speaks to the values and ceaseless work we do to fight for health justice. Here, we:

- (a) share decisions we made at our labor/business meeting, plus our plans for APHA 2025 (Washington DC); and
- (b) give highlights of our APHA 2024 sessions

And: as usual, we are sending this reportback by email and in Dec 2024 we will be posting it on our soon-to-be-launched updated web site – and we encourage you to visit our current website to see our past reportbacks as well ([1995-2023](#)).

As for the growing numbers in our ranks, we are happy to report that:

- (a) As of October 14, 2024, **3,933** people (in the US & around the world) subscribe to our Spirit of 1848 listserv (up from 3,916 a year ago, i.e., Oct 25, 2023) – and another **112** signed up to join the listserv at the APHA 2024 meeting!
- (b) According to APHA, as of Sept 2024 (the most recent data provided), we had **556** Spirit of 1848 members who are active dues-paying APHA members (up from the 286 last year), a number which continues to put us well above the 2016 APHA policy which requires APHA caucuses to have 25 or more dues-paying members. According to our own Spirit of 1848 survey data (from our website), as of Aug 20, 2024, **605** Spirit of 1848 members affirmed they were also APHA members; we plan on updating our survey in the coming year – be on the lookout for an email in January 2025!

NOTE: The number of Spirit of 1848 members REALLY MATTERS – both EVERYONE on this listserv AND ALSO those who are APHA dues-paying members. Since 2006, we have been required to report ANNUALLY to APHA the number of Spirit of 1848 members who are ALSO dues-paying APHA members. Accordingly, we STRONGLY REQUEST that all of you reading this who are DUES-PAYING APHA MEMBERS please take a moment to find your APHA membership number & then do BOTH of the 2 following tasks:

- (a) fill out the [30-second survey](#) to affirm your affiliation with the Spirit of 1848 Caucus and APHA by providing **your name & APHA membership number & email address**; to do so, please go to:

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)

And so:

- 1) please share our update/report with interested colleagues & friends, and note that our update/report will be available, in Dec 2024, as a PDF that can 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 listserv! – directions for how to do so are provided at the end of this email and on our website.
- 3) If any of the activities and projects we are reporting, either in this reportback or on our listserv, 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.**
- 4) 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 sub-committee & designated alternative Chair contact); email: ae.birn@utoronto.edu
 - Luis Avilés (History sub-committee); email: luis.aviles3@upr.edu
 - Marian Moser Jones (History sub-committee); email: marianmoserj@gmail.com
 - Maria John (History sub-committee); email: Maria.John@umb.edu
 - Catherine Cubbin (Politics of public health data & Activist sub-committees); email: ccubbin@austin.utexas.edu
 - Zinzi Bailey (Politics of public health data sub-committee); email: zinzi@gmail.com
 - Craig Dearfield (Politics of public health data sub-committee); email: craig.dearfield@gmail.com
 - Joshua Osowiecki (Politics of public health data sub-committee); email: osowieckij@outlook.com
 - Lisa Moore (Pedagogy sub-committee; Spirit of 1848 co-representative to the APHA Governing Council and APHA Caucus Collaborative; e-networking sub-committee); email: lisadee@sfsu.edu
 - Rebekka Lee (Pedagogy & Activist sub-committees); email: rlee@hsph.harvard.edu
 - Vanessa Simonds (Pedagogy sub-committee); email: vanessa.simonds@montana.edu
 - Nylca Muñoz (Pedagogy & Activist sub-committees); email: nylca.munoz@upr.edu
 - Jerzy Eisenberg-Guyot (Activist sub-committee); email: jerzy.eisenbergguyot@gmail.com
 - Charlene Kuo (Student poster session & History sub-committees & Spirit of 1848 co-representative to the APHA Governing Council and APHA Caucus Collaborative); email: cckuo@umd.edu
 - Miranda Worthen (E-networking sub-committee, for social gatherings; Spirit of 1848 co-representative to the APHA Governing Council and APHA Caucus Collaborative); email: miranda.worthen@sjsu.edu

NB: for additional information about 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>

And: APHA next year will be in **Washington, DC (November 2-5, 2025)**; the official theme is “**Making the Public’s Health a National Priority**” – and our Spirit of 1848 theme, as usual, ups the ante -- and will be:

Making Health Justice: Everything Everywhere All at Once.

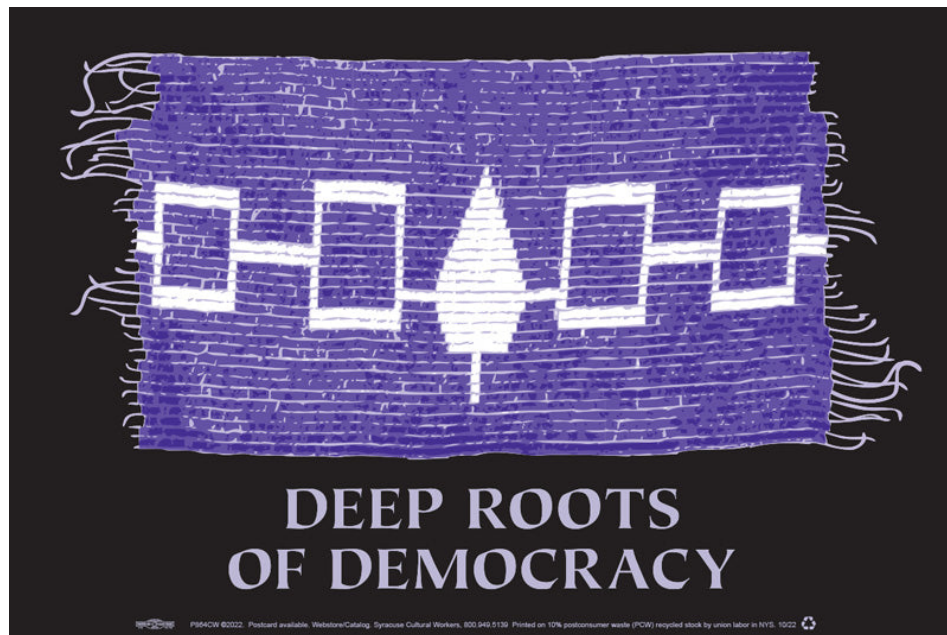


Image & text from [Syracuse Cultural Workers](#):

The Hiawatha Wampum Belt (shown above) symbolizes the peaceful unification of five formerly-warring nations – the Seneca, Cayuga, Onondaga, Oneida and Mohawk – into the Haudenosaunee (Iroquois) Confederacy over a thousand years ago.

Despite facing the onslaught of colonization, the Haudenosaunee provided inspiration and guidance to colonial leaders as they imagined and created a nation. The U.S. borrowed some ideas and symbols, but left out others – including women, participatory democracy and true equality for all.

In 1988, Congress passed H.Con.Res. 331 (100th), a concurrent resolution to acknowledge the contribution of the Iroquois Confederacy of Nations to the development of the United States Constitution. In 2010 the US mint produced a \$1 coin highlighting this same history. Unfortunately, few schools at any level include this important aspect of United States history.

Before creating any products with the Deep Roots words and wampum belt, we consulted with leaders of the Onondaga Nation to be sure they were comfortable with us using the words and images. Not doing so would be cultural appropriation. Royalties are also paid to the Onondaga Nation from the sale of these products.

Attended by 15 members:

(a) Spirit of 1848 Coordinating Committee members (alphabetical order; n = 6 in person): Zinzi Bailey (data); Craig Dearfield (data); Marian Moser Jones (history); Nancy Krieger (chair & integrative & data & e-networking); Charlene Kuo (student poster session; history; Spirit of 1848 co-representative to the APHA Governing Council & APHA Caucus Collaborative); Miranda Worthen (e-networking & Spirit of 1848 co-representative to the APHA Governing Council & APHA Caucus Collaborative)

[NB: 8 members were unable to attend but had been engaged in planning the meeting: Luis Avilés (history); Anne-Emanuelle Birn (history); Catherine Cubbin (activist & data); Jerzy Eisenberg-Guyot (activist); Maria John (history); Rebekka Lee (pedagogy & activist); Joshua Osoweicki (data); Vanessa Simonds (pedagogy)]

(b) additional Spirit of 1848 members (alphabetical order; n = 9): Daycan DuFelmeier; Marie Kaniekci; Toni Lee; Hadija Steen Mills; Meredith Minkler; Melissa Newsome; Dannie Ritchie; Erin Sweeney; Sarah Vos

1) **Spirit of 1848 mission.** We referred everyone to our Spirit of 1848 website, which includes the mission statement of the Spirit of 1848 (also at the end of this reportback & see also: <http://www.spiritof1848.org/>) – and which, among other things, describes our purpose, our subcommittee structure, and our history.

-- In brief, rooted in 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. Thus, 2024 is our 27th year as an official APHA Caucus – but: we held our 20th year celebration back in 2014, to recognize when we actually founded our group – and by that timeline, 2019 was our 25th anniversary, and we celebrated accordingly! *[This also means that this year's APHA conference in 2024 is in reality our 30th anniversary – something we mentioned in all of our sessions & celebrated at our joint “Resistance & Connection” social hour with Public Health Awakened!]* *[and this also means that in 2027, APHA will consider us to be 30 years old ...]*

-- Our 3 substantive foci are: (1) politics of public health data, (2) progressive pedagogy, (3) the social history of public health (with the sub-committee serving as liaison to the Sigerist Circle, an organization of progressive historians of public health & medicine). In addition to sub-committees that organize our sessions with these foci, we also have sub-committees that organize our student poster session, our activist session, and our integrative session, and we additionally have a sub-committee for e-networking, which handles our listserv, website, and social networking (including our joint social hour with Public Health Awakened).

-- We also have official co-representatives 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 meets annually at APHA and in between communicates regularly & frequently by email and occasionally via zoom, and its chair (and other members, as necessary) deals with all paperwork related to organizing & sponsoring & co-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) **Spirit of 1848 listserv & membership.** We happily reported that:

(a) As of October 14, 2024, **3,933** people (in the US & around the world) subscribe to our Spirit of 1848 listserv (up from 3,916 a year ago, i.e., Oct 25, 2023) – and another **112** signed up to join the listserv at the APHA 2024 meeting! (**48** at our Spirit of 1848 sessions & **64** at our joint social with Public Health Awakened!)

(b) According to APHA, as of Sept 2024 (the most recent data provided), we had **556** Spirit of 1848 members who are active dues-paying APHA members (up from 286 last year), a number which continues to put us well above the 2016 APHA policy which requires APHA caucuses to have 25 or more dues-paying members. According to our own Spirit of 1848 survey data (from our website), as of Aug 20, 2024, **605** Spirit of 1848 members affirmed they were also APHA members; we plan on updating our survey in the coming year. We typically are asked to report our N of dues-paying members at the end of the calendar year (i.e., Dec 31, 2024).

3) **Spirit of 1848 Sessions.** We reported back on how our various sessions went (see detailed descriptions below), discussing both attendance and content. This was the 3rd fully-in-person APHA since 2019 (with 2020 solely virtual, and 2021 hybrid, due to COVID-19, and 2022 resuming being an in-person meeting & also the 150th anniversary of APHA).

a) This year at APHA, *the N of persons attending equaled 11,000* – a tad lower than pre-COVID attendance, when in-person meetings included ~ 12,000 to 15,000 persons. By contrast, in 2021, attendance at the hybrid conference equaled 9,200 persons, of whom 5,787 (63%) were virtual, with only 3,413 (37%) in person.

b) Hence, although we can meaningfully compare our attendance in 2024 to 2023 and 2022, we cannot compare meaningfully to either 2021 (for which ALL Spirit of 1848 sessions were VIRTUAL, in the context of a hybrid conference) or 2020 (which was 100% virtual). That said, here are our data for 2019-2024 – noting that our 2024 attendance is on par with that in 2023, albeit with both lower than in 2022 and 2019, but still a good turn out!

Session	2024 (in person)	2023 (in person)	2022 (in person)	2021 (virtual)	2020 (virtual)	2019 (in person)
Scientific sessions (oral): total	515	525	780	~ 259	~ 419	765
Social history of public health	50	90	150	~ 36	158	175
Politics of public health data	125	110	250	~ 36	~ 69	180
Activist	50	60	95	~ 33	~ 71	95
Progressive pedagogy	35	60	60	~ 55	~ 54	90
Integrative session	130	130	225	~ 74	~ 67	225
Student poster session	~ 125	75	~100	~ 25	?? (no data)	60 to 90
Additional sessions:						
Spirit of 1848 labor/business mtg	14	12	19	18	36	19
Joint 1848/PHA social hour	~ 200	~150	~ 100 to 120	53	53	~ 100

* NB: we additionally estimate that approx 125 people came to the session we co-organized with the Socialist Caucus.

Throughout, our sessions underscored the need for both defensive and proactive work, per our 2024 theme: **Believe it or not: critical trust building, trust busting, & creating trustworthy public health science and practice.** See detailed descriptions of our sessions in Part II of this reportback.

4) **Spirit of 1848 engagement with the APHA history project.** We continue to have a liaison with the APHA history project, which was launched in 2018 in recognition that 2022 marked the 150th year of APHA (which was founded in 1872). Of note, our Caucus has been dedicated, from the start, to preserving our history, and on our Spirit of 1848 website you can find a copy of every single annual flyer and reportback we have produced since our founding in 1994! – see: <http://www.spiritof1848.org/apha%20reportbacks%20&%20attendance.htm>

We are also happy to report that our liaison to this project, Marian Moser Jones, who is on the social history subcommittee of the Spirit of 1848 & a member of our coordinating committee, is now in her 2nd year as one of the editors for the History section of the *American Journal of Public Health*.

5) **Institutionalizing our Spirit of 1848 policy about Land Acknowledgement and inviting submissions that bring a critical Indigenous lens.** Since 2019: (a) every Spirit of 1848 session starts with a Land Acknowledgement slide, as a very first step towards histories that must be acknowledged, as prelude to reparative action and creating better futures; and (b) our call for abstracts invite submissions that bring a critical Indigenous lens to the specific topic that is the focus of each session, drawing on Indigenous theories, knowledge, and methods. In 2024, one of our oral sessions (data) included a discussion of tribal sovereignty & public health data, presented by Meghan O’Connell, the Chief Public Health Officer of the Great Plains Tribal Leaders’ Health Board.

6) Joint social hour with Public Health Awakened.

This year we held our 6th joint social hour with Public Health Awakened – YAY!! We kept the title we collectively came up with in 2020 as an antidote to the physical distancing in these times of COVID-19: “*Resistance & Connection Social Hour.*” We are happy to report that approx. **200 folk** connected at an outdoor patio on a warm evening – our highest attendance to date! And: **64** new persons signed up for the 1848 listserv at the event! Miranda Worthen will continue to be the Spirit of 1848 Coordinating Committee point person for co-organizing this event.

Come connect with others pursuing social justice and public health – and have fun!

Resistance and Connection: Social Hour at APHA

Monday, October 28th
6:30pm - 8:30pm
The Butcher's Tale
1121 Hennepin Ave, Minneapolis
~10min walk from conference

Hosted by
Public Health Awakened and Spirit of 1848



Sophia Simon-Ortiz (PHA) & Nancy Krieger (Spirit of 1848) welcoming everyone! (photos by Miranda Worthen (1848) + PHA team!)



Lili Farhang (Co-Director, PIH) & Nancy Krieger (1848)

& everyone having a good time in a great place!

7) Recruiting new members to work on our Spirit of 1848 subcommittees: We are keen to recruit some more students to join our student poster session to help with the review of abstracts. If you are a student who is interested – or if you are a faculty member who might know of a student who would be interested – please contact Charlene Kuo (email: cckuo@umd.edu). At our labor/business meetings, several students agreed to join the student poster session!

8) APHA Caucuses & Governing Council. Lisa Moore and Miranda Worthen continue to be our co-representatives to the APHA Caucus Collaborative and also Governing Council, and as of this year’s meeting Charlene Kuo is our rep too!

Both Lisa & Miranda have been attending the quarterly Collaborative calls. Miranda this year attended the Governing Council sessions as our Spirit of 1848 rep, newly joined by Charlene. However, this year we did NOT attend the Caucus Collaborative Roundtable at APHA because of its timing. We also note that the APHA Caucus Collaborative once again surprisingly did not have a designated space at the Exhibition Hall this year, but we were able to work with APHA staff to rectify this problem,

Caucus Collaborative Breakfast

Not much new to report. At some point there will be a discussion of how the year-old new strategic plan affects the Memorandum of Understanding (MOU) that APHA and its affiliated caucuses need to renew every three years, but when this discussion will happen has not yet been finalized.

Summary from the Governing Council:

Miranda attended for our Caucus and sat at the table set aside for Caucus representatives (in contrast to such seats not being available to Caucus reps in prior years). Charlene was able to participate only as a member of the general public, since we were told by APHA staff that caucuses could only have one person sitting at the position for the caucus – despite there being numerous empty seats because only a few caucuses sent representatives to the Governing Council meetings. There were also new rules in place, reflecting higher security, with “the public” only able to attend in galleries way in the back (as discussed further, below).

[Nandi Marshall, DrPH, MPH, CHES, CLC, CDE](#) was elected APHA President; she is faculty at Georgia Southern University (based in Savannah, GA) and focuses on health equity and “fostering partnerships and relationships with grassroots organizations.” The three persons newly elected to the Executive Board are: [Donna-Marie Palakiko, PhD, MS, BS, RN, APRN](#) (“a Native Hawaiian mother, health strategist, community-based researcher and nurse” based at the University of Hawai’i), [Jimmie Smith, MD, MPH](#) (a family physician at Mercer University in Georgia who is focused on “general family medicine, public health practice, and public health policy”), and [Melissa Toledo-Ontiveros, MA, MCJ, MPA](#) (a “Project and Community Developer at Community Action Agency SNM” in New Mexico).

Several substantive topics were put forward on the agenda for the GC, as follows:

- (1) The bylaws committee proposed several changes ([Annotated Bylaws](#)), most of which were adopted through a consent agenda. These included a change to limit, for any given APHA committee, the number of committee members to 7. There was debate on a proposed change to merge the Women’s Rights Committee and Health Equity Committee into a combined Diversity, Equity, Inclusion, and Belonging committee. That motion failed, in part because the chairs of each of these committees said they had not been consulted about these changes, and the committees will continue in their current form.
- (2) The Joint Policy Committee put forward several new policies, some of which were smoothly debated, amended, and voted on ([2024 PPS Consent Agenda](#)). More disagreement existed over the Speaker’s *Ad Hoc Committee to Review the Proposed Policy Statement Development Process* to change the process for policy statements ([Proposed Policy Brief Process Book](#)) and attempts to introduce amendments to the proposal were cut short. The new policy was adopted with 84% of the vote without any amendments. The changes to the process are as follows:
 - (a) The new policy removes “Public Health Policy Statements” and replaces them with “Public Health Policy Briefs.”
 - (b) The Joint Policy Committee is dissolved, and the Science Board is replaced by the Evidentiary Review Committee, which will oversee the process.
 - (c) The process is extended to a 2-year 12-step process.

(d) There can be no late breakers and the emphasis will be on broad and “comprehensive” public health problems rather than specific (“e.g. it is better to have a policy on childhood hunger rather than a specific policy on childhood hunger in a particular part of the world”).

(3) The International Health Section put forward a proposal to develop an ad hoc special committee made up of members across the sections to organize a series of member engagement sessions on armed conflict ([IH Ad Hoc Committee Proposal](#)). The motion passed with 55% of the vote.

From the standpoint of the Spirit of 1848 representatives to the Governing Council (GC), there are several process and content issues that raise concerns, and in our view these contributed to the tone of the meeting being very tense, which in turn reflects the current state of political tension and conflict within the US and the world more generally:

(1) New protocols regarding who could be physically present were alienating, making notable distinctions between GC members and other APHA members:

(a) the GC newly used a rope to separate APHA members who wanted to observe the meeting from the members of the GC, and required these non-GC APHA members to sit far behind the GC member tables.

(b) GC members had distinguishing buttons and had a separate entrance.

(2) A new rule stated that “the display of non-approved signs, banners, posters, and other items is strictly prohibited in the Governing Council and Gallery. Use of audio and video recordings and photography is expressly prohibited in the Governing Council meetings.”

(3) It seemed that not all GC members were aware of the processes by which discussion could occur about some of the impactful votes that were taken.

(a) For example, in the discussion about the proposed changes to the bylaws, discussion was ended after the allocated time, after members voted on an unclear motion to end the discussion – whereby many people thought that they were voting on one motion rather than a motion to end all discussion. When this misunderstanding became clear, a GC member put forward a motion to overrule the chair and extend discussion. This motion was then passed by 75% of the GC, indicating that people had wished to continue discussion.

(b) Similarly, during the debate on the Speaker’s Ad Hoc Committee’s proposal to change the policy statement process, several speakers indicated that they had amendments to propose on behalf of their sections, but time was called at 15 minutes after only one amendment had been proposed. Debate was closed and the new policy was adopted with 84% of the vote, but several people rose to object, feeling that debate had been ended before they had a chance to hear other GC’s concerns. A motion to suspend the rules, to enable a broader discussion, failed, and there was no motion to override the procedure.

(4) Prior to the GC session at the annual meeting, the Executive Board had ruled against allowing a statement promoting a ceasefire in Gaza to come before the Governing Council at the spring GC meeting or as a late breaker. At the GC meeting, IH section leaders put forward a motion to suspend the rules to enable a statement to come forward for discussion outside of the JPC process. This motion was called to an immediate vote and failed. In response, around 30 APHA members in the gallery rose to protest silently. The Speaker called on the security to “clear the gallery” and all gallery observers were required to leave, including those who were not protesting. Despite calls to reopen the gallery, with GC members pointing out that the APHA bylaws require APHA members to be allowed to observe as votes are taken, the gallery was not re-opened until after all the votes had been taken and the Speaker was giving his closing statement on the meeting. Georges Benjamin, Executive Director of APHA, stated to the GC that his motivation to close the meeting to the public was due to death threats made against APHA Executive Board members and staff.

Tightening of rules about raising voices and dissent, and restricting the bounds of “institutional voice” and statements of solidarity (especially at times of crises) is not limited to APHA. In the US (and elsewhere) there are currently major conflicts over academic freedom and freedom of expression. These conflicts are tied to rising right-wing attacks on scientific evidence and academic institutions and also to ongoing conflicts about the year-long Israel-Gaza war (now spreading regionally), antisemitism, & anti-Muslim and anti-Palestinian discrimination. Moreover, within the US (but not only), there is rising weaponization of antisemitism to challenge anti-racist work and practices (including pertaining to “Diversity, Equity, and Inclusion”) and to contest federal funding of academic institutions, with such challenges coming from both in and outside academia (with US Congressional hearings on these issues still underway; see [here](#) and [here](#)). It is likely that the GC procedural issues and new APHA policies will continue to be a topic of discussion among various

APHA entities (including Sections & Caucuses), and if there are any notable updates in the coming year, before the next APHA meeting, we will share them on the Spirit of 1848 listserv.

9) APHA 2025: Below we describe our plans for next year's 153rd annual meeting of APHA, to be held in **Washington, DC (November 3-5, 2025)**..

The official theme for APHA 2025 is: *"Making the Public's Health a National Priority."* We in the **Spirit of 1848** take the next step and call for: **Making Health Justice: Everything Everywhere All at Once** – a task core to the mission of the Spirit of 1848 Caucus – and all the more important given results of the US elections.

This year, the Spirit of 1848 Coordinating Committee continued with our new practice (1st used in 2021) to develop the call for abstracts in advance of the APHA meeting, which we then discussed and revised at our Spirit of 1848 labor/business meeting. Our rationale was & remains that of avoiding the extremely hectic fast-paced process of the past, whereby we previously rushed to finalize the call after the meeting, to be ready in time for the mid-December APHA deadline for posting the call. With our new approach, we can use the time at our Spirit of 1848 labor/business meeting to have more engaged discussion about the proposed call, get feedback, and elicit ideas about potential speakers. And we had a great brainstorming session!! – with those present coming up with lots of ideas for possible speakers, including those in & around DC (where APHA 2025 will take place) – and each of us plans to reach out the various folk named to encourage them to submit an abstract (or recommend others who could).

SPIRIT OF 1848 CAUCUS LABOR/BUSINESS MEETING (Tues, Oct 28, 2024, 6:30-8:00 pm; Hilton Minneapolis Conrad A) – Come to a working meeting of THE SPIRIT OF 1848 CAUCUS. Our committees focus on the politics of public health data, progressive public health curricula, social history of public health, and networking. Join us to plan future sessions & projects!

And so:

1) Look at our preliminary call for abstracts, below, and think about whether you or anyone you know would be a good fit for the different sessions we propose – and also if you know any students (or faculty who teach students) in the DC area, since it is much easier for students who are be local to present (to avoid hotel & travel expenses).

2) Be on the look-out for the **APHA CALL FOR ABSTRACTS, which will go live on January 6, 2025.**

3) ALL abstracts – both unsolicited and solicited – will be due on March 28, 2025.

4) APHA continues to revise the structuring of times for general sessions and scientific sessions, so we are making our plans based on the time slots we were assigned this year (2024), recognizing that the time slots may change yet again.

5) As usual, we have \$0 to pay for any speakers to come (since we are a volunteer, no-dues Caucus, noting too that APHA policy expressly forbids paying for speakers). For unsolicited abstracts, we depend on finding speakers who can fund their own participation in APHA. We also have successfully obtained a limited number of complementary passes for invited speakers (permitted for non-APHA members only), and on some occasions we have sought out local groups who can fund travel costs as part of having the invited speaker also speak at their organization/university.

Call for APHA 2025 Spirit of 1848 sessions (listed in the order in which they take place at the APHA meeting)

Overall theme:

Making Health Justice: Everything Everywhere All at Once

We expect that our 5 scientific sessions and our Spirit of 1848 labor/business meeting will continue to be in the following slots, albeit with the caveat that APHA does shift around the times of sessions.

Spirit of 1848 sessions (APHA 2025) – by day, name, and LIKELY time, and whether an OPEN CALL for abstracts or INVITED ONLY			
Monday, Nov 3, 2025	Activist session	8:30 am to 10:00 am	OPEN CALL + invited
	Social history of public health	10:30 am to 12 noon	INVITED ONLY
	Politics of public health data	2:30 pm to 4:00 pm	OPEN CALL + invited
Tuesday,	Integrative session	10:30 am to 12 noon	INVITED ONLY

Nov 4, 2025	Student poster session	12:30 pm to 1:30 pm	OPEN CALL + invited
	Progressive pedagogy	2:30 pm to 4:00 pm	OPEN CALL + invited
	Labor/business meeting	6:30 pm to 8:00 pm	N/A

AND: we also plan to have a joint social hour again with Public Health Awakened! (date & time to be determined ...)

Here is a preview of what will be our official “call for abstracts” – and note that the **call for abstracts** will become live on the APHA website (<https://www.apha.org/events-and-meetings/annual>) on **January 6, 2025 & all abstracts (invited & open call) will be due on March 28, 2025.**

Instructions for what we are seeking for each session (listed in chronological order) are as follows:

1. Activist Session (Mon, Nov 3, 2025, 8:30 am to 10 am) – Open call and invited speakers

TITLE: Local, national, and international organizing for health justice, everything everywhere all at once

CALL: The Activist Session welcomes abstracts that describe organizing around the overall Spirit of 1848 theme of “Making Health Justice: Everything Everywhere All At Once” through an open call and invited abstracts. We encourage submissions about activism in a diverse range of spaces, from neighborhoods to worksites to college campuses and beyond. We especially aim to showcase local, national, and international organizing focused on building cross-national solidarity and countering imperialist threats to health justice, although we welcome submissions highlighting organizing around other issues. Given that the conference will take place in Washington D.C., we especially welcome abstracts from D.C.-based activists.

2. Social History of Public Health (Mon, Nov 3, 2025, 10:30 am -12 noon) – invited speakers

TITLE: Transnational and Indigenous Critical Historical Perspectives for Solidarity, Sovereignty, and Health Justice Everywhere

CALL: The Social History of Public Health Committee of the Spirit of 1848 Caucus will SOLICIT abstracts from speakers who can present historical and still ongoing examples of transnational, global, or transnationally resonant health solidarity struggles, as well as those within politically polarized nations. We are particularly interested in presentations that focus on international human rights including struggles for gender equality, racial justice, labor rights, queer justice, Indigenous struggles for collective survivance and health, as well as struggles that occur at the intersections of health, legal rights, resource equity, and access to political power. Invited presenters will provide case studies that speak to these themes and provide instructive and useful examples that can inspire ongoing collective struggles to realize health justice across many contexts.

3. Politics of Public Health Data (Mon, Nov 3, 2025, 2:30 – 4:00 pm) – open call and invited speakers

TITLE: Making Data for Health Justice: Everything Everywhere All At Once

CALL: This session and its speakers will focus on conceptual and empirical investigations into the ways national, tribal, and local priorities influence how we collect public health data for health justice.

Presentations could include a focus on answering any one (or multiple) key question(s):

- (1) How do national and/or local governments, in the US or globally, impede (or facilitate) access to data for health justice? (e.g., anti-DEI legislation and impacts on research and data)
- (2) How do changing “national priorities” intersect with and challenge who is part of the nation data-wise, especially regarding racial/ethnic categories, indigeneity, immigration, and incarcerated/detained populations?
- (3) How are U.S.-based classifications and approaches influencing other countries' national data collection standards?
- (4) How does nationalism – whether reactionary or as tied to progressive self-determination and human rights – affect the data we have to analyze to impact health justice?
- (5) What data and/or data infrastructure are necessary for assessing whether policies aimed at health justice are working?
- (6) What resources are available to construct data systems for health justice? Who is responsible for making the data or data linkages?
- (7) In what contexts are data and interventions for health justice weaponized against health justice (e.g., used to stoke anti-immigrant sentiments)?
- (8) What are the impacts of explicit policies to weaponize data for health justice?
- (9) In what ways are institutional review boards complicit in impeding access to national or local data for health justice?

4. Integrative Session (Tues, Nov 4, 2025, 10:30 am – 12 noon) – *invited speakers*

TITLE: Prioritizing Health Justice: Politics, Peoples, and our Planet – Everyone & Everything Everywhere All at Once

CALL: This session and its invited speakers will focus on prioritizing health justice in relation to global & national politics and institutions, Indigenous health, and planetary health (especially environmental & climate justice). A common thread will be the need for solidarity in all its forms, within and across specific issues, struggles, nations, and people – that is, solidarity with and for everyone & everything everywhere all at once.

5. Student Poster Session (Tues, Nov 4, 2025, 12:30 – 1:30 pm) – *Open call and invited speakers*

TITLE: Spirit of 1848 Social Justice & Public Health Student Poster Session Call for Abstracts

For the **APHA Annual Meeting 2025**, the **Spirit of 1848 Social Justice & Public Health Student Poster Session** is issuing an **OPEN CALL FOR ABSTRACTS** for posters that **highlight the intersections between social justice and public health** from a historical, theoretical, epidemiological, ethnographic, and/or methodological perspective.

This session will have an **OPEN CALL for submissions** by students (undergraduate or graduate) who are focused on work linking issues of social justice and public health. This can include, but is not limited to, work concerned with the Spirit of 1848's focus for APHA 2025 on **"Making Health Justice: Everything Everywhere All at Once."**

Per our Spirit of 1848 policy, we encourage submissions that bring a critical Indigenous lens, drawing on Indigenous theories, knowledge, and methods, to the specific topic that is the focus of this session, i.e., student posters on links between social justice & public health.

The submitted work can address one or more of many interlocking types of justice (e.g., racial, Indigenous, political and/or economic, gender and/or sexuality-related, environmental, restorative, etc.) We are interested in submissions not only from students in schools of public health and other health professions (e.g., nursing, medicine) but also from students in schools & programs focused on law, political science, public policy, social work, government, economics, sociology, urban planning, etc. For examples of abstracts selected in prior years, see our [annual reportbacks](#).

Abstracts will be evaluated on the following criteria: (1) Relevant to the Spirit of 1848's broader [mission](#) and APHA 2025 [theme](#) (**"Making Health Justice: Everything Everywhere All at Once"**); (2) The rigor of the research methods and theoretical foundation; (3) Originality; and (4) Scholarly or practical importance.

NOTE: to address the on-going problem of student uncertainty about funding, which has led to students with accepted posters withdrawing their submissions, we will continue with the successful approach we implemented in 2016, whereby we will: (1) accept the top 10 abstracts (the limit for any poster session); (2) set up a waitlist of all runner-up potentially acceptable posters (ranked in order of preference); and (3) reject abstracts that either are not focused on issues of social justice and public health or are not of acceptable quality. If any accepted poster is withdrawn, we will replace it with a poster from the waitlist (in rank order).

For any questions about this session, please contact Spirit of 1848 Student Poster Coordinating Committee member [Charlene Kuo](#).

6. Pedagogy Session (Tues, Nov 4, 2025, 2:30 pm – 4:00 pm) – *Open call and invited speakers*

TITLE: Teaching and Learning Health Justice: Everything Everywhere All At Once

CALL: Overall, we seek submissions for *practical presentations on pedagogy that enhances capacity for teaching and organizing with a focus on making health justice. This includes the pedagogies that are being (re)developed through decolonizing epistemologies and other ways of re-framing knowledge and voice, Indigenous methodologies outside of Western frameworks, and learning that happens outside of traditional academic settings.* We call for work that shows *how* such pedagogy can be carried out, in both: (1) training programs for community and workplace activists, organizations, and members and (2) diverse academic settings, e.g., universities and colleges (including community colleges), health professional schools (public health, nursing, medical, dental, social work, veterinary, etc.), high schools, and elementary schools. We also welcome student-led presentations focused on how to bring such pedagogy into their educational programs and communities. We also encourage pedagogies that link local and global solidarity and movement building.

Per our Spirit of 1848 policy, *we encourage submissions that bring a critical Indigenous lens, drawing on Indigenous theories, knowledge, and methods, to the specific topic that is the focus of each session*

If you have any questions, please contact the session organizers, who are Spirit of 1848 Coordinating Committee members Vanessa Simonds (email: vanessa.simonds@montana.edu), Lisa Moore (email: lisadee@sfsu.edu), Rebekka Lee (email: rlee@hsph.harvard.edu), and Nylca Muñoz (email: nylca.munoz@upr.edu)

★★★★★ HIGHLIGHTS OF SPIRIT OF 1848 SESSIONS (APHA 2024) ★★★★★

Our Spirit of 1848 sessions brought all of us attending APHA together once again in fraught times, only days before the US elections, with so much on the ballot – the president, control of the US Senate and House, all the state elections, and state ballot initiatives re abortion and also voting rights. Concomitantly, war is raging still in Ukraine, and the Israel-Gaza war, as long predicted, now involves not only the West Bank but also Lebanon and Iran, with horrific devastation. Attacks on public health are on the rise in the US and elsewhere, as is the volume and speed of disinformation, putting people's lives in danger and, via climate disinformation, a threat to all life on this planet. In this context, progressive organizing on so many fronts, both as responses and forward-looking, remains frenetic and multi-faceted.

Further attesting to the past year's intensifying backlash against progressive politics and equity-oriented work, including public health research, practice, and pedagogy, this year Dr. Georges Benjamin, Executive Director of APHA, opened the general session (after an apt land acknowledgment and stirring drum circle), saying the following words: "DEI, structural racism, LGBTQ, affirmative action, minoritized populations, white supremacy, eliminating health inequities" – and then observing that he was not struck down and no one was harmed or disadvantaged by these words – and he further stated that it is not possible to achieve health for all without addressing roots causes. He called on those in public health to shape the narrative, counter mis/disinformation and, while not being partisan, align work with core values regarding equity & justice -- and vote! He also said that APHA is now leading a new coalition, Alliance for the Public's Health, including 50+ organizations, with this type of work at the core of its mission.

All the more reason that our sessions focused on ***"Believe it or not: critical trust building, trust busting & creating trustworthy public health science and practice."*** The Spirit of 1848 is about the vision to go forward for health justice, mindful of the histories that bring each of us to where we are. And as usual, APHA gave those of us present a chance to regroup and replenish our spirits – and one of the many reasons we organize the Spirit of 1848 sessions as we do!

Our provisional counts for attendance indicate ~515 people came to our 5 scientific sessions. In chronological order, they comprise our Spirit of 1848: activist session (n ~ 50); social history of public health session (n ~ 50); politics of public health data session (n ~ 125); integrative session (n ~ 130) & progressive pedagogy session (n ~ 35)-- and over 125 came to our student poster session. Attendance for each of our Spirit of 1848 scientific sessions remains much higher than the average APHA in-person attendance of ~ 30 persons/session. Attendance for the two events co-sponsored by the Spirit of 1848 was as follows: the session with the Socialist Caucus (n ~ 125) and the joint social hour with Public Health Awakened (n ~ 200), both described below as well.

Our APHA 2024 Spirit of 1848 theme – **Believe it or not: critical trust building, trust busting & creating trustworthy public health science and practice** – was, as usual, a deliberately radical rendition of the official APHA conference theme, which for 2024 was: *"Rebuilding Trust in Public Health and Science."*

Motivating our theme was deep recognition, as stated in our "call for abstracts," that:

- trustworthiness is earned - it is not a given;
- public health and science more broadly are not monoliths: within these fields are those who have inspired us with their tireless work to advance critical ideas, research and practices integral to advancing health justice, while others have done the converse (as exemplified by past & present realities of scientific racism, eugenics, and more);

EVER ONWARDS:
ORGANIZING & WORKING FOR
HEALTH JUSTICE
& HEALTH EQUITY
& A BETTER
& SUSTAINABLE WORLD!



The Spirit of 1848
APHA 2024

SPECIAL FOCUS:
*Believe it or not: critical trust building,
trust busting & creating trustworthy public
health science and practice*

linking
issues of
social
justice &
public health

Mon, Oct 28	10:30 am - 12 noon	ACTIVIST SESSION / Organizing to Counter Attacks on Public Health and Earn Community Trust in Science (Session 3068.0, Minneapolis Convention Center (MCC), Room L100H)
	10:30 am - 12 noon	SOCIAL HISTORY OF PUBLIC HEALTH SESSION / Trust Building and Trust Busting in Public Health: Critical Historical Perspectives (Session 3166.0, MCC Room L100H)
	2:30 - 4:00 pm	POLITICS OF PUBLIC HEALTH DATA SESSION / Critical Science vs. Science Denialism: Building Trustworthy Public Data for Health Justice (Session 3295.0, MCC Room L100H)
Tues, Oct 29	10:30 am - 12 noon	INTEGRATIVE SESSION / Science, Causal Inference, & The People's Health: Implications for Trustworthy Public Health Research, Practice, and Activism for Health Justice (Session 4157.0, MCC Room L100H)
	12:30 - 1:30 pm	STUDENT POSTER SESSION / Spirit of 1848 Social Justice & Public Health Student Poster Session (Session 4189.0, MCC Exhibit Hall BCD)
	2:30 - 4:30 pm	PROGRESSIVE PEDAGOGY SESSION / Teaching to Counter Miseducation and Build Critical Pedagogy (Session 4273.0, MCC Room L100H)
	6:30 - 8:00 pm	SPIRIT OF 1848 CAUCUS LABOR/BUSINESS MEETING (Hilton Minneapolis: Conrad A)

SPECIAL EVENTS:

(1) Sun, Oct 27: 2:30-4:00 pm – Walter Lear History Session: Building the Worlds That Kill Us – Examining US history through a public health lens – co-organized with SCAPHA (Session 2100.0; MCC Room L100FG)

(2) Mon, Oct 28: 6:30-8:30 pm – RESISTANCE & CONNECTION SOCIAL HOUR – co-organized with Public Health Awakened at: [The Butcher's Tale](#) [with great veggie options!] -- open air Atrium – at: 1121 Hennepin Avenue, Minneapolis, MN & RSVP [here](#) ([bit.ly/resistanceandconnection2024](#))



Social Hour at APHA
Monday, October 28th
6:30pm - 8:30pm
Hosted by Public Health Awakened and Spirit of 1848
1121 Hennepin Ave, Minneapolis
-5min walk from conference

---FOR DETAILS, SEE OTHER SIDE---

American Public Health Association 152nd Annual Meeting and Expo: Minneapolis, MN, Oct 27-30, 2024
Spirit of 1848 website: www.spiritof1848.org Email bulletin board: spiritof1848+subscribe@googlegroups.com
Please copy & circulate *** ALL SESSIONS OFFER CME/CE CREDIT *** labor donated (ver 9/16/24)

- attacks on public health, science, and educational systems more broadly, while decades-old, are escalating, led by neo-liberal & right-wing groups variously committed to market fundamentalism, right-wing libertarianism, & naturalizing social inequality, who are opposed to public health and other government regulations that promote healthy, equitable, and sustainable societies, and whose disinformation campaigns, fueled by the scale, speed and scope of the internet & social media, are seeking to destroy, via Big Lie tactics, any sense of a shared reality in which evidence & public health matter;
- public health advocates and many others have displayed enormous resilience, creativity, and solidarity in not only countering these attacks but also bolstering critical analysis and action for building earned trust with communities and fostering inspiring, equitable, sustainable, joyful, and dignified futures for all.

• SPIRIT OF 1848 ACTIVIST SESSION

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69554>

Estimated attendance: ~ 50 people

ACTIVIST SESSION / Organizing to Counter Attacks on Public Health and Earn Community Trust in Science (Session 3068.0, Minneapolis Convention Center (MCC), Room L100HI) – Mon, Oct 28

8:30 AM: **Introduction.** Nylca Muñoz, PhD, JD, Rebekka Lee, ScD, Catherine Cubbin, PhD and Jerzy Eisenberg-Guyot, PhD

8:35 AM: **Industry shouldn't write its own standards: Organizing to improve transparency at the CDC and rebuild trust in public health.** Jane Thomason, CIH, Eleanor Godfrey and Rocelyn de Leon-Minch

8:55 AM: **The canvas as people power: 'citizen action' and the limits of coalition building in the fight for national health care, 1979-1988.** Caitlin McMahon

9:15 AM: **Healthcare abolition and public healing: A case study of the Healthcare Reparations Cooperative as a creative container for public health pedagogy.** Hadija Steen Mills, MPH

9:35 AM: **Q&A**

INTRODUCTION – Catherine Cubbin, PhD

-- **Mary Turner, RN**, the new president of National Nurses United (NNU), presented on: **"Industry shouldn't write its own standards: Organizing to improve transparency at the CDC and rebuild trust in public health."**

Her major points focused on:

- (1) the distrust CDC and the hospitals created due to how they treated nurses and other hospital workers during the onset of the COVID-19 pandemic, by: (a) disregarding the need for provision of personal protective equipment (e.g., adequate supply of N95 masks); (b) repeatedly claiming SARS-CoV-2 spread only by droplets, not aerosol transmission (thereby also undercutting the need to improve ventilation systems); and (c) allowing hospital industry representatives to dominate delineation of hospital safety standards; and
- (2) the ongoing organizing to ensure that updates to the Healthcare Infection Control Practices Advisory Committee (HICPAC) guidelines for infectious disease control that are underway (having last been updated in 2007) are based on accurate evidence, with transparency about the process and adequate input from nurses, other health care employees, and the public at large.

NNU has been leading the organizing for transparency, input, and accuracy, and working to counter the dominance of the health care industry & its primary concerns about profit (and not wanting to pay the costs for protection of the hospital employees); they have generated over 20,000 actions to urge CDC to follow the science and deal with the realities of aerosol transmission. Their campaign has been successful: when CDC approved the revision to HICPAC in November 2023 without adequate input, NNU led the protest against this, and in January 2024 CDC sent the HICPAC draft back for revisions, and they also added new representatives to the HICPAC group, for the first time ever including a nurse and an industrial hygienist (and not only infection disease control specialists); even so, the HICPAC group is still industry-dominated and the fight goes on.

ACTION ALERT: HICPAC will meet again this coming November 14-15, 2024, and it is important that there be good public turnout at the meeting and also that people send in their comments supporting the health and well-being of all who are at hospitals. For more information on their campaign, see:

<https://www.nationalnursesunited.org/cdc-and-hicpac> -- which includes the link to submit comments to HICPAC.

-- **Caitlin McMahon** presented on: **"The canvas as people power: 'citizen action' and the limits of coalition building in the fight for national health care, 1979-1988."**

Her main points focused on:

- (1) the work of Citizen Action (founded in 1979, with many of its leaders part of the 1960s New Left), its growth to include 32 state/local chapters, and its use of canvassing (then a novel technique) to counter the rise

of the right-wing direct mail approach, with the goal of building coalitions and public support to win tangible improvements;

(2) starting in 1985, they began campaigns to build a progressive caucus in Congress, and they also scaled up their canvassing efforts, to reach 40 to 50 thousand people every two weeks, or 100 million people per year;

(3) their major focus starting in 1987 was on “Health Care for All,” and while they were able to build support for the Kennedy-Waxman bill, it was defeated in both 1988 & 1989, and the coalition they built had to engage with tensions regarding consumer advocate approaches vs. those of the AFL-CIO (which was used to bargaining over health care coverage via their industry-specific contracts);

(4) after the failure of these bills, the coalition fell apart, and the AFL-CIO went its own way, while the Citizen Action chapters in numerous states had conflicts with the national organization over priorities;

(5) in 1994, Citizen Action folded with a debt of \$500,000 and its head resigned over financial scandals.

Reflecting back on the tensions and conflicts, McMahon noted the problems of organizing relying on dues-paying members and difficulties of building coalitions that span the divides of populist politics and consumer advocacy. She closed with the following questions: (a) what lessons can be learned from the struggles to build tenuous coalitions?; (b) how do campaigns determine how they frame problems and solutions, with what groups in mind?; and (c) what would effective coalition building look like?

-- **Hadija Steen Mills** presented on: “**Healthcare abolition and public healing: A case study of the Healthcare Reparations Cooperative as a creative container for public health pedagogy.**”

Their main points focused on:

(1) the need to draw on creativity & joy in political organizing, to transform power building and building trust among those working together on specific projects and campaigns (& as an example, distributed blank zines for people attending to jot down their ideas);

(2) for their work in health care abolition, they are employing political pedagogy, starting a systems pilot, and employing strategic communication & narrative change work, drawing on community-owned and driven research, and are setting up a SouSou fund which will redistribute 3% of the organization’s funds to community work in a way determined by the cooperative’s members;

(3) every month they organize their meetings around particular political themes, for discussion and to inform their work (e.g., “positionality & accountability,” “reparative healing”) and every session has a “joy action” and contributes to collective agenda setting.

During the **Q&A period**, comments & questions & discussion focused on:

(1) The time it takes to build trust, within and across groups & communities.

(2) Wanting examples of successful campaigns that have engaged with issues of trust and power to achieve tangible results for health justice; responses included:

(a) the work of Citizens Action, which led to the passage of the Massachusetts health care reform bill that in turn set the basis for the US Affordable Care Act;

(b) the NNU played a critical role in the Biden Administration’s COVID-19 Health Equity Task Force, for which 2/3 of the recommendations were put into effect, and which also led to Biden being the 1st US president to declare that “health care is a right, not a privilege,” plus their activism on countering the HICPAC & CDC emphasis on COVID-19 transmission via droplets was critical to advancing the shift to recognizing the evidence regarding aerosol transmission and implications for prevention and control;

(c) the Healthcare Reparations Cooperative is developing a pilot to see what a health care cooperative could look like, one that focuses on Black liberation, and how this can be developed in a sustainable way, not one that leads to burn-out among members.

(3) How to build trust with communities when working within a state health department that has not been transparent and trustworthy, with trust among the health department staff in the CDC also eroded – where can one go for conversations? – with replies including:

(a) get involved in campaigns, such as the NNU’s postcard campaign, to meet more like-minded folk; and

(b) join up in a study/discussion group with NACCHO's revised "Roots of Health Inequity Course Series" (which was previewed at a Spirit of 1848 session last year) – see: <https://www.naccho.org/programs/public-health-infrastructure/health-equity/roots-of-health-inequity#training-resources> – and they soon will be launching a newsletter!

(4) The need to understand the fights within and with the CDC over infection control in relation to the need to have clear and transparent processes for open dialogue about scientific evidence and disagreements, and to make these discussions public, as opposed to issuing only edicts from on high – and knowing this is essential to rebuild trust, so that the process of scientific discovery and debate is made clear, and so that people can understand the process of science and the strengths and weaknesses of the scientific evidence.

(5) Appreciating the introduction to the use of zines, with plans to use them in an undergraduate course!

(6) How to prevent burn-out among activists? – with:

(a) Mary Turner from NNU saying that NNU had learned the importance of re-framing the issues they encountered not in terms of "burn out" but as problems of "moral distress" re being forced to work in unsafe conditions that jeopardized their health, the health of patients, and that of their families as well – and she recalled vividly the early days of the pandemic, when 2/3 of the patients in the ICU would die, and nurses were working double-shift to do all they could to take care of patients, while the hospitals were refusing them adequate PPE, and nurses were afraid to go home to their families because they did not want to bring infection with them. She also pointed to the NNU's campaign for safe staffing ratios, and said she understood there was also inadequate funding and staffing in public health agencies, and that work needs to be done to counter the cycles of reactive funding, with increases when disasters hit and then cutting back, otherwise it won't be possible to avoid burn-out of critically needed public health staff;

(b) Hadija Steen Mills likewise calling for a reframing from "burn out" to "labor exploitation," and a need to be critically aware of the long history of exploiting Black labor; and

(c) Caitlin McMahon commenting on how canvassing requires not thinking about people as simply "resources" that can be used but also what their needs are to do the work sustainably and effectively.

(7) More sharing of experiences of being exploited as a canvasser (e.g., the questioner's own experience working as a canvasser on a utilities fee campaign while a medical student and being asked to collect contributions from the low-income people being canvassed, which was morally challenging as well as hard work), and reflecting on how many non-profits have long underpaid and over-worked staff, and this is not sustainable – and being effective going forward requires grappling with this longstanding problem.

• SOCIAL HISTORY OF PUBLIC HEALTH

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69555>

Estimated attendance: ~ 50 people.

SOCIAL HISTORY OF PUBLIC HEALTH SESSION / *Trust Building and Trust Busting in Public Health: Critical Historical Perspectives (Session 3166.0, MCC Room L100HI) – Mon, Oct 28*

10:30 am: *Moderator for "trust building and trust busting in public health: Critical historical perspectives."* Marian Moser Jones, PhD, MPH
10:40 am: *Rebellious technocrats, solidarity networks, and the rebirth of social medicine in Latin America.* Eric Carter, PhD
10:55 am: *How Taiwan beat COVID and then lived with it: History, geopolitics, and public health ramifications.* Wayne Soon, PhD
11:15 am: *The Minnesota AIDS project and the public health crisis in Minneapolis.* Chantel Rodriguez, PhD
11:25 am: *A commentary on trust building and trust busting in public health.* Charlene Kuo, MPH
11:35 am: **Q&A**

INTRODUCTION – Marian Moser Jones

--- Eric Carter, PhD, presented on: "Rebellious technocrats, solidarity networks, and the rebirth of social medicine in Latin America."

Drawing on his most recent book, [In Pursuit of Health Equity: A History of Latin American Social Medicine](#) (University of North Carolina Press, 2023), Carter focused on the broader intellectual and political history of social medicine in Latin America, in its geopolitical context, noting that this history is little known in the US and elsewhere, yet is a history that can open up the imagination to possibilities for work for health equity in the US and other countries. His key points were that:

(1) there were 2 waves of Latin American Social Medicine: the early period, in the 1930s and 1940s, as tied to construction of modern welfare states, and the recent period, starting in the 1960s (& in his presentation he said he would focus only on the latter, given time constraints);

(2) the primary agents involved in starting the 2nd wave were a group he called “rebellious Latin American health technocrats,” who worked in PAHO and diverse state health agencies, and who were alarmed by how these institutions ignored the structural determinants of health and rising authoritarianism; one key example was Juan César García, from Argentina, who was involved in student politics under Peron, and whose work in PAHO was on monitoring & evaluating medical education across Latin American countries -- which gave him the opportunity to set up clandestine seminars when visiting with colleagues in these countries, where they discussed Marx, Engels, Gramsci, Foucault, etc., and with this work leading to setting up the 1st graduate program in social medicine in 1975 in Mexico & then Brazil;

(3) during the 1970s, many of the leaders in Latin American Social Medicine became political exiles from the authoritarian regimes/dictatorships set up in Brazil, Chile, and Argentina, and after the 1973 coup in Chile, several of them were in contact with US social medicine leaders, such as Jack Geiger and Victor Sidel, who set up an APHA Task Force on Chile to foster solidarity work;

(4) one response to the need for collective action in the face of right-wing state violence was to establish the organization [ALAMES](#) (Latin American Social Medicine Association); another, following the defeat of the Brazilian dictatorship, was to adopt the approach of “collective health” as part of the mid-1980s democratic reconstitution of Brazil, leading to the establishment of Brazil’s unified health system and its recognition of health as a human right; and

(5) during the rise of the “Pink Tide” in the 1990s, two progressive health leaders who had been part of the mid-1970s social medicine program in Mexico gained appointments as: (a) Minister of Health of El Salvador (Maria Isabel Rodriguez), and (b) Minister of Health for Mexico City (Asa Cristina Laurell).

Key conclusions pertained to: (a) the need for international solidarity, bringing together health workers and health activists worldwide; (b) the importance of insider/outsider strategies (e.g., those who worked at PAHO also being part of autonomous networks) and the need for openness to ideological pluralism; (c) recognizing that Latin American Social Medicine demonstrates that more democratic and equitable health systems are possible; (d) recognizing that ideas matter! – whereby early academic discourse in academic communities did serve as the basis for subsequent political formulations and action; and (e) among the major contributions of Latin American Social medicine are to underscore: the right to health; the need for university departments of social medicine; and the need for academics, practitioners, and politicians to have spaces to think and work together. Carter closed by encouraging those unfamiliar with Latin American Social Medicine to read more about it and read the scholarship it has produced; his book provides a welcome introduction!

-- **Wayne Soon, PhD**, presented on: “**How Taiwan beat COVID and then lived with it: History, geopolitics, and public health ramifications.**”

Soon presented via a video on zoom, as he unfortunately had just tested positive for COVID and needed to stay home – in keeping with the sorts of disease control practices he discussed in his presentation! His major thesis was that the global history of COVID-19 matters, in part to reject the Euro-American and Chinese exceptionalism extremes, and to make people aware of the “3rd way” approaches used by Taiwan and other countries (including Singapore, South Korea, Japan, Australia, and New Zealand). In Taiwan, informed by their earlier experiences with the SARS epidemic, at the outset of the COVID-19 pandemic, they did adopt acute interventions such as lockdowns (albeit not as severe as those of China), and after the acute phase, they did not “return to normal” but instead shifted to a new sustainable normal (involving masking & ventilation, but not lockdowns), with a focus on balancing human rights and dealing with the virus. His key points re Taiwan were as follows:

(1) lessons learned from the SARS 2003 debacle included the need to coordinate national & local action, to have adequate PPE for hospital workers, to not quarantine health personnel in hospitals, to not extend community quarantines longer than necessary, and to not rely on WHO if its guidance was inadequate;

(2) hence, by mid-Jan 2020, Taiwan had already set up a national command center to coordinate COVID-19 action across the health sector, 2 weeks before the WHO declared a global emergency, and they also ignored WHO guidance re masking (which downplayed the need for masks at that time) and instead led a major

production drive to increase the supply of masks (enough to supply other countries too!) and they mandated masks on all public transportation, and leveraged technology and contact tracing to avoid lockdowns;

(3) in mid-2022, they lifted travel restrictions (which China kept in place through Dec 2022);

(4) they successfully promoted vaccination, such that $\frac{3}{4}$ of the population had received vaccines before Taiwan opened up for international travel (in contrast to only $\frac{1}{3}$ of the US population having been vaccinated prior to its opening up to international travel); Taiwan also drew on their own data showing that non-vaccinated persons were 10 times more likely to die from COVID-19 vs. those vaccinated – and as of August 2022, the US notably had 6 times more COVID-19 cases per 100,000 people as compared to Taiwan and South Korea;

(5) Taiwan provided air purifiers for classrooms, and has continued to promote use of masks (in contrast to the US, which scaled back on clean air policies by April 2022);

(6) as of August 2022, the US had cut back on clear air infrastructure support and the last indoor mask mandate ended by March 2022; by contrast, South Korea leads in clean air technology (portable HEP filters), which are widely used in classrooms and well as in airports and other public places;

(7) the infection disease approaches adopted for COVID-19 allowed Singapore to implement swiftly screening for incoming travels for mpox starting on August 24, 2024.

The larger point is that the global history of health matters and should not just be framed as “what the US offers to other,” but what each country can offer to the world – hence the importance of comparative analyses and comparative history. In the case of COVID-19, what still matters is: clean air, vaccine availability, and improving research on long COVID.

-- **Chantel Rodriguez, PhD**, presented on: “**The Minnesota AIDS project and the public health crisis in Minneapolis.**”

As part of framing her talk, Rodriguez noted that she would be using language pertaining to the “gay community” because that was the language used at the time (1980s) by the Minnesota AIDS Project (MAP), while recognizing that this community was part of the broader LGBTQIA+ community. She opened by stating that on Nov 7, 1987, over 1500 people attended a public health conference in Minnesota, the largest public health meeting ever in the state – one organized by conservative groups, focused on AIDS and opposed to gay rights; over 400 protestors, from numerous organizations, demonstrated against the conference, both inside and outside of its meeting.

Her talk then provided the history of the framing of AIDS at the time (especially in the early days, when infection led almost inevitably to death), and the organizing that led to the formation of MAP and its work to combat the stigma of the disease, the right-wing attacks on people with AIDS, and support work for those infected. Key points about MAP were that:

(1) it grew out of the gay liberation front;

(2) it provided services that no one else would and that were affirming of the gay community – including newsletters, seminars on safer sex, a Captain Condom comic, and buddy system for those who were sick;

(3) in 1985, it got a large grant from the state health department, and this is what led to the conservative attacks, who did not want state money spent on the gay community (and who viewed AIDS as god’s judgement of sinners) – and in 1987, these conservatives formed the Berean League, which opposed LGBT rights, defeated anti-discrimination legislation, supported quarantine for people with HIV, and organized their 1987 conference about AIDS to provide CME credits (so as to increase attendance);

(4) the protest led by MAP against the 1987 conference centered on how the Berean League’s positions both violated human rights and had no scientific basis, and their protest presence in and outside of the convention center quickly shrank attendance from 1500 to 600 people;

(5) the next fight was over the gay bathhouses, where MAP distributed safer sex information, but the Berean League succeeded in getting the bathhouses shut down in 1988;

(6) thereafter, MAP continued to do work for people with AIDS (including support services) and also expanded to issues involving housing and needle exchange;

(7) in 1992 the Berean League became the Minnesota Family Council, but in 1993, as testament to the power of the organizing of MAP and other groups, Minnesota passed a Human Rights Act that prohibited discrimination, overcoming Minnesota Family Council opposition to this legislation;

(8) MAP continued to expand, taking on the new name of “Rainbow Health”; the organization lasted until 2024, when it finally closed, due to the impact of the COVID-19 pandemic.

Concluding points emphasized the resonance between the early AIDS struggles and those now occurring that involve discrimination, human rights, and health care, including gender affirming care – and how the earlier struggles set the basis for Minnesota to now be one of the safer states in the US.

-- **Charlene Kuo, MPH**, served as discussant. To her, the key themes were: (1) the need for international solidarity, which does not automatically translate to following WHO guidelines without question; (2) the varied paths by which a conflict state, with authoritarian rule, can transform to become a democratic, more equitable state that can promote health justice; (3) the need to work together to oppose authoritarian rule; and (4) the need to oppose misinformation, in solidarity. Each of the panelists agreed with these points.

During the **Q&A period**, comments & questions focused on:

(1) Regarding issues of trust vs distrust in “the government” or “questioning authority,” the presentations all made clear that it matters who the politicians are in the government and the policies they advocate, and ditto who is claiming or contesting “authority” on what grounds – so in what ways did those involved in the 3 different case studies presented grapple with these complexities, i.e., recognizing that neither “government” or “authority” are monoliths, and that the values, priorities, and validity of the knowledge claims matter. Responses were:

(a) Carter: many of the leaders in Latin American Social Medicine wore multiple hats, using different language and different kinds of authority, were part of both social epidemiology and social movements, and were able to engage with different epistemic narratives; one contrast to the US (with its almost unrivaled levels of political complexity, involving federal, state, local govts) is that in Latin American countries, there is a much greater consensus about the role of state responsibility and authority when it comes to matters of health, with the one exception being Brazil under the right-wing government of Bolsonaro;

(b) Rodriguez: grassroots groups like MAP form because of the failures of government, and instead are motivated by recognition that if they want to get anything done (e.g., protect the gay community from AIDS), they have to do it without expecting government assistance – but they also can work to change who is in the government and its priorities, policies, and allocation of resources.

(2) A two-part query asking: (a) how to deal with the realities that non-profits and NGOs often relieve governments of responsibilities, and are chaotic and never can do work at the scale of what a government can do, and (b) why is the role of social medicine so overlooked in the US? – with the reply pointing to the role of McCarthyism in the US in the 1940s and 1950s in severely crimping the scope of US social medicine and limiting expectations of government responsibilities, deliberately shifting responsibility for health to individuals and non-state actors (such as non-profits & NGOs). Moreover, even while there was Latin American McCarthyism/anticommunism, it is important to look to the experiences in Latin America without always having the US or Europe as the reference point – and not to consider Latin American social medicine as derivative of European or US ideas; instead, Latin American social medicine was created in Latin America and is a “home grown” way of conceptualizing health and the role and work of health systems.

(3) What lessons do the presentations offer for current government public health workers, especially when the government agencies claim “objectivity” as a reason for not contesting conservative politics, so as to avoid having to repeat horror stories like what happened in Minnesota 30 yrs ago, when the state health dept did not stand up for the gay community with accurate science about AIDS? – with replies suggesting it might be useful to use the concept of “failed state” to analyze such situations, and also that in the US it seems that public health is always on the defensive, always is underfunded, and needs to be organizing to expand its resources and be able to stand up to political pressure.

(4) Thinking about the levels presented in the 3 different case studies (multi-country; national; hyper-local), what is gained from considering all of these levels for the work needed to make good on the claim “another world is possible”? – and can infusing critical public health history into the public health workforce be one avenue for change? – with responses including:

(a) Carter: one useful entry point being that of thinking about networks and how ideas travel within and across institutions and levels, as was the case with Latin American Social Medicine, and learning this history can help spur imagination for what people can do now; and

(b) Rodriguez: to get undergraduates interested in public health, she developed a public health course on “The History of Zombies,” which offered a unique and engaging way to get the students to think about contagion, bodily autonomy,

slavery, colonialism, and capitalism, as tied to the realities of conditions in Haiti and the realities and politics of zombies & voodoo; others teach courses on “Vampire public health” (and corresponding central European politics and conditions)

(5) What lessons can be drawn from how MAP battled conservative anti-gay politics in the 1980s for those fighting current political attacks on LGBTQ communities, and especially the growing political attacks on the health and well-being of transgender people? – with the answer focusing on how MAP started first to provide services to those in dire need who were marginalized by the state, and then it expanded to include political organizing, to change the state politics, and learned how to lobby; as testament to its success, the fight it started in 1983 to get a human rights bill passed took 10 years to win, but the bill was passed in 1993 and helps set the basis for Minnesota being a safer state now compared to many other US states.

• POLITICS OF PUBLIC HEALTH DATA

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69556>

Estimated attendance: ~ 125 people.

POLITICS OF PUBLIC HEALTH DATA SESSION / *Critical Science vs. Science Denialism: Building Trustworthy Public Data for Health Justice* (Session 3295.0, MCC Room L100HI) – Mon, Oct 28

2:30 pm: Introduction to “critical science vs. science denialism: Building trustworthy public data for health justice.” Craig Dearfield, Zinzi D Bailey, ScD, MSPH, Joshua Osowiecki, CHES, Catherine Cubbin, PhD and Nancy Krieger, PhD
2:35 pm: Tribal sovereignty in public health: how data access impacts health outcomes. M. O’Connell, MD, MPH
2:50 pm: The politicization of COVID-19 data: Evaluating when data is “good enough” to use. Rachel Kulikoff and Scott Greer
3:05 pm: The challenging work of improving demographic data collection: Lessons from the Medicaid program. Elizabeth Lukanen, MPH
3:20 pm: The cost of #backingtheblue: Which public investments really keep us safe? Devin English, PhD, Ty Robinson, EdM, Lori Hoggard, PhD, Felix Muchomba, PhD, Sharifa Z. Williams, Dr., Joel Cantor, Dr, Paul Duberstein, PhD and Brett Millar, PhD
3:35 pm: Q&A

INTRODUCTION – Craig Dearfield, PhD

-- Meghan O’Connell, MD, MPH, presented on: “Tribal sovereignty in public health: how data access impacts health outcomes.”

O’Connell started by stating she was a member of the Cherokee nation and Chief Public Health Officer of the [Great Plains Tribal Leaders Health Board](#), and that the work she was presenting built on their work together. She explained this group included 17 federally recognized tribes and 1 tribal community, within a region comprising North Dakota, South Dakota, Nebraska, and Iowa, and the Board is tribally led; in 2003, it voted to incorporate into its functioning the Tribal Epidemiology Center (TEC) for its region, one of 12 TECs across the US, plus one national TEC as well. She then asked those present to trust her regarding the following statements:

- (1) Tribes are sovereign;
- (2) Tribes have a unique relationship with the US government (not the same as a US state or county), as they are nation-states within the US;
- (3) Tribes and TECs are Public Health Authorities, and can receive PHI (protected health information) without individuals’ consent, just as all US states can receive PHI without individuals’ consent;
- (4) Data sharing is a problem for Tribes and TECs generally;
- (5) Data is essential for public health

O’Connell then provided a definition of tribal sovereignty, which is “The ability to govern and to protect and enhance the health, safety, and welfare of tribal citizens” – and exercising this sovereignty requires access to health data. Drawing on her experiences as a family doctor and Indian Health Services physician who also has an MPH in epidemiology, she then described two cases in which tribes and TECs were wrongfully denied data they needed.

- (a) First, in 2020, when dealing with the COVID-19 pandemic, she learned the hard way that tribes don’t have access to the health data that they need and which lawfully is theirs. Specifically, tribes and TECs were repeatedly denied access to vital records and infectious disease data by state health departments, and the CDC didn’t even have tribes included in their on-line visual schema for how they shared health data.

(b) This crisis was followed by another crisis involving syphilis, whereby cutbacks in services during COVID-19 led in part to increased cases of syphilis, including congenital syphilis – such that rates of congenital syphilis among American Indians/Alaskan Natives in 2022 equaled 647 per 100,000 – i.e., equivalent to what the US national congenital syphilis rate was back in 1941 (651 per 100,000), before there was penicillin (!!).

(c) Yet: congenital syphilis is both a serious and totally preventable disease – approximately 15-40% of infants born with congenital syphilis die after birth, but if the mother is treated with antibiotics at least 30 days before delivery, both the mother and fetus can be cured – and this requires knowing if the mother is infected, and leaves only a short time window to administer the needed drugs. Typically, for such infectious disease cases, the clinical data are routinely collected and routinely sent to the state health department, which routinely follows up with relevant public health interventions & treatment (including contact tracing, etc.) However, in the case of tribes, the clinical data are collected but are NOT relayed to the tribal public health authorities – and this failure makes clear that access to data affects: the power to act, the power to control narratives, the power to decide priorities, and even the ability to get grants (since funders require data).

(d) The key point was that tribes were asking for data that already existed (not new data that had to be newly collected). The tribes reached out to the CDC twice for help: the first time the CDC didn't want to assist, because the tribes didn't have the data to support their request for assistance (which underscored the serious problems due to lack of data sovereignty); the second time, the CDC started to find ways to improve access to data.

O'Connell further noted that the tribal response to congenital syphilis went beyond the usual contact tracing and treatment approach to disease control but instead took on a larger framing of the issues, and connected people as warranted to addiction programs, housing, transportation, prenatal care, and cultural supports. The larger point was that they saw sexually transmitted diseases as more than just a specific disease to be treated in isolation. The overall point is that data is power, and that a system that ensures unequal access to information is an unjust system – and it is critical to act to end this injustice.

-- **Rachel Kulikoff** presented on: “**The politicization of COVID-19 data: Evaluating when data is “good enough” to use.**”

Kulikoff's focus was on trust in government data, using the case example of reporting of COVID-19 mortality data. Prompting this research were allegations that in 2020 DeSantis, a Republican governor, deliberately made the Florida state health department mislead the public about COVID-19 mortality rates, and also a graph produced by the Georgia state health department (also with a Republican administration) which appeared to show mortality rates were declining, only the data points were temporally out of order, and if put in the correct order did not support this claim.

The study thus sought to test whether US state governors had the ability to manipulate COVID-19 data. The metric used was a ratio, whereby the reported mortality rate for COVID-19 was divided by the excess mortality rate (all cause mortality rate – expected mortality rate), such that a value of 0.5 implied half of excess mortality was due to COVID-19 deaths. One key assumption was that the excess deaths are a true reflection of COVID-19 mortality rates; another was that models used were robust. The study found no evidence of manipulation of the COVID-19 mortality data, and observed marked heterogeneity in the values of the ratio within and across states between 2020-2024.

-- **Elizabeth Lukanen, MPH** presented on: “**The challenging work of improving demographic data collection: Lessons from the Medicaid program.**”

Lukanen's work presented drew on work conducted for [SHADAC \(State Health Access Data Assistance Center\)](#), for which one focus is on providing technical assistance to states to improve the quality of their Medicaid data. Lukanen's presentation highlighted issues involving data disaggregated by key social (demographic) groups, categorized in relation to “race,” “ethnicity,” language (written and spoken), disability, and sexual orientation and gender identity (SOGI).

A key finding was that these demographic data usually were not of high quality, with states differing in whether they followed best practices (or even federal guidelines). Reasons include: demographic data in Medicaid are voluntary (to prevent discrimination when someone applies for Medicaid); the Medicaid data are collected using old systems that are difficult and expensive to change; and there is a mistrust by people getting Medicaid about how the data will be used. Consequently, when the US Centers for Medicare & Medicaid Services (CMS) rated the quality of Medicaid demographic data for the 50 states plus DC, 14 states were rated as being of “high concern” and the data for 1 state were deemed “unusable.” Lukanen then discussed the state heterogeneity in practices for collecting these data.

(1) For “race” and “ethnicity,” Lukanen reported 64 variations (despite there being only 50 states plus DC), and this was because in some states the on-line questions differed from the paper versions for the Medicaid forms (!). The range of number of response categories spanned from 5 categories (n = 7 states) up to 67 (n = 1 state); most states used the OMB standard that was in effect from 1997 to early 2024, when the new federal standard was announced.

(2) For SOGI data, only 6 states collect any SOGI data for Medicaid, and all the rest relied on the binary categories of “male”/“female”; Oregon is a notable exception, and has had considerable community engagement in developing the SOGI questions and modifying them over time.

(3) For self-reported data on disability, Lukanen noted that whereas 33% of Medicaid recipients have self-reported disabilities, only 11% qualify for disability aid; moreover, whereas almost all the states included some questions about disabilities, the data varied widely across states, and only Oregon’s approach was consistent with current best practices.

Lukanen also discussed the progress reflected in the new 2024 OMB standards for “race and/or ethnicity,” whereby all categories are now combined into one question, there is a new MENA category (Middle Eastern-North African), and the collection of detailed data is by default, using up-to-date terminology. CMS has now developed 3 optional SOGI questions (on sex assigned at birth, gender identity, and sexual orientation) – which, while not ideal, represents progress. She additionally noted that Massachusetts has used the Medicaid demographic data to inform its work on health equity and Oregon has used it to improve services for people affected by both COVID-19 and disabilities.

Lukanen concluded by emphasizing that building trust requires not only good data but sharing back the data and showing how it can be used to improve people’s lives. Stated another way, good data starts with trust – asking people questions requires: good communication; clear assurances about confidentiality; drawing on community input to shape the content and process; working with staff to train them in best practices; and sharing back data with communities to make it clear how these data can help improve conditions.

-- **Devin English, PhD** presented on: “**The cost of #backingtheblue: Which public investments really keep us safe?**”

English opened his presentation by reflecting on popular narratives of policing (e.g., TV shows), which typically displayed cops as heroes, and also on news reporting, which typically reports on spikes in crime, but not decreases in crime, and he also noted that many police precincts are increasingly using social media, with this practice having been shown to overreport Black crime rates. The net impact has been to forge a narrative of “increasing funding for police leads to decreases in crime” and he noted that between 1997 and 2021 US state and local funding for the police increased by 189% (from \$47 billion to \$135 billion, adjusted for inflation). Police also are increasingly being used to respond to mental health crisis (now comprising almost 1/5 of incident reports) and also are being deployed in schools. CDC data further show that between 2010 and 2020 rises in police funding track with rises in the rate of police killings of Black community members (with English showing a slide of the Minneapolis memorial to George Floyd, which includes the names of many others killed by the police); suicide rates are also on the rise and research has found increases of mental distress in communities associated with exposure to police violence.

Using a critical lens, English noted that police have long been key to Black oppression in the US, raising the question whether police funding might be associated with Black vs white inequities in police killings and suicide rates; the corresponding hypothesis is that increased funding for state and local police may harm health, whereas increased funding in social services might improve health. For their study, they thus looked at the associations (lagged by 1 year and by 5 years) between state and local funding for police and years of persons lives lost (YPLL, before age 75) due to police-perpetuated killings and to suicides. They obtained the mortality data from the CDC WISQARS system, and the funding data from the US Census of state and local government expenditures, and obtained data on funding for: police; K-12 education; higher education; public welfare; housing and community development; public health; hospitals; and roads; control variables included annual state Medicaid expenditures and annual data on fire arm policies. They employed dynamic structural equation modeling to take into account within and between state variation, over time, using lags of 1 and 5 years for the health outcomes.

Their key findings, using 2010 to 2020 data, were as follows:

- (a) across the states, funding for police was the 6th highest priority; the first was K-12 education, and the lowest was funds for housing and community development;
- (b) mortality rates for police-perpetuated killings were 2 times higher for the Black compared to white population;
- (c) suicide mortality rates were lower for the Black compared to white population, but were rising more quickly;

- (d) for the Black population, increased funding for police was associated with a rise in mortality rates due to police-perpetuated killings 1 year later; no such association was evident for the white population;
- (e) for suicide mortality, increased funding for police was associated with a rise in suicide rates both 1 and 5 years later for the Black population but not white population, and suicide rates also declined with rising investment in K-12, a finding which held for both the Black and white populations;
- (f) hence, for the 41 million Black persons in the US, every \$100 increase in police funding per capita led to 2000 more YPLL due to police-perpetuated killings and to 20,000 more YPLL due to suicides, with no such increases among the white population;
- (g) conversely, for every \$100 increase in K-12 funding per capita, there was a decline in 3,699 YPLL for the Black population and a decline of 10,975 YPLL for the white population, and for every \$100 increase per capita in funding for housing and development, there was a decline of 13,152 YPLL for the Black population.

The net implication is that increased investment in funding for police increases mortality due to police-perpetuated killing and suicide among the Black population, but that increased investment in education and in housing and development leads to decreases in mortality (i.e., declines in YPLL) among the Black population (and to decline among the white population, for education investment only).

During the **Q&A period**, points raised included:

- (1) What would be effective means for those of us in the audience & others in public health to improve data access for tribal nations and tribal communities in the US? – with the responses including: (a) need people on the inside who can advocate for the data access, including to PHI data that these tribal nations and tribal communities are legally authorized to obtain, noting that the policy is already in place allowing states to share PHI data; and (b) make explicit (via revised language) the inclusion of tribal nations and communities in extant data sharing policies that pertain to states.
- (2) How did the study testing hypotheses about possible state manipulation of COVID-19 mortality data take into account changes in who is reported as having died of COVID-19? (especially with the decline of testing and most COVID-19 deaths reported since 2023 restricted to hospitalized persons who had a COVID test) – since this implies the reported temporal comparisons are not valid? – with the reply being that the ratio used (COVID-19 to excess mortality) would address this point (but the problem remains that the ratio has different meaning at different times).
- (3) How can the CDC better deal with the complexities of tribal data? – with the response being that it was important to recognize that “AI/AN” (American Indian/Alaska Native) is not “simply” a demographic variable, but instead is a political classification, and this raises questions about who is a citizen of tribal nations vs. self-identifies as AI/AN but is not a tribal member, etc.
 - The larger issue is that tribes do not fit into the US structures of governance – and tribal reservations and lands routinely cross and are crisscrossed by state, county, ZIP code, and census tract lines, with the reality being “our land is there and they drew lines all over this land.”
 - Hence: states should give ALL their data to tribes, for the tribes to analyze as warranted, as opposed to trying to figure out how to give the tribes only the AI/AN data, which is not a practice ever followed for other groups (noting that if these data are not provided, comparisons to other groups are not possible).
 - The bigger problem is how tribal people can do their jobs, including in health agencies, “when the system is not built for us.”
- (4) With regard to policing, how can data be used to change the narrative? – with the response being that data actually aren’t necessary to uphold the dominant narrative, it’s just there; that said, English and co-authors are trying to get their study published – they’ve been rejected by 4 journals (with one reviewer even pushing back on facts regarding the history of policing in the US) and they have just sent it to a 5th journal and are also working on sharing results with relevant community groups as well.
- (5) Is the funding for police a direct measure of such funding or might it be a proxy for something else, and how accurate are the data? – with the response being that these are the data reported by states.

• INTEGRATIVE

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69557>

Estimated attendance: ~ 130 people.

INTEGRATIVE SESSION / Science, Causal Inference, & The People's Health: Implications for Trustworthy Public Health Research, Practice, and Activism for Health Justice (Session 4157.0, MCC Room L100HI) – Tues, Oct 29

10:30 am: **Introduction to: "science, causal inference & the people's health: Implications for trustworthy public health research, practice, and activism for health justice"** Nancy Krieger, PhD
10:40 am: **Too much of a good thing? the consequences of treating all causal effects as intervention effects on the trustworthiness of public health research.** Sharon Schwartz and Seth Prins
11:10 am: **Epistemic arrogance vs. uncertainty: Does well-defined mean well-received?** Zinzi D Bailey, ScD, MSPH
11:25 am: **Causal inference and health justice: Understanding (and changing?) the social world.** Nick Graetz and Michael Esposito
11:40 am: **Q&A**

INTRODUCTION – Nancy Krieger, PhD

-- In the introduction, Krieger noted that she invited Schwartz & Prins to prepare their forthcoming book, [*Causal Inference and the People's Health*](#) (NY: Oxford University Press, 2025; available as of Jan 9, 2025) as a volume for her book series "[Small Books Big Ideas in Population Health](#)" because of her concerns about how prominent epidemiologists engaged in recent work on "causal inference" were restricting what they deemed "causes" to discrete phenomena that could be manipulated by health professionals – and they likewise were treating "race" and "sex" as non-modifiable characteristics of people, with no regard for how racism and gender inequities shape population health. She thus invited Schwartz & Prins to prepare the book, one that could engage with the strengths of counterfactual approaches, but critically so. Krieger concluded by arguing that work for health justice needs to be grounded in recognition that, simultaneously (and, ironically, in contrast to usual counterfactual contrasts): (1) "there is no other world" (i.e., there is no Planet B), AND (2) "another world is possible," one in which health justice exists, and which is ecologically and socially sustainable for all life on this planet (humans and other species), because we make it so.

-- **Sharon Schwartz & Seth Prins** presented on: "Too much of a good thing? the consequences of treating all causal effects as intervention effects on the trustworthiness of public health research."

Schwartz started by noting that there are many facets to distrust in science, and that their presentation would focus on only one aspect: distrust in relation to question framing, since this influences scientific validity and is key to ensuring results are trustworthy. Noting that epidemiology and many other quantitative sciences are in the midst of a "causal revolution," she stated that epidemiologists and others are currently socialized to view the "potential outcomes" approach to generating estimates of causal effects as "best practices" – with the specific approach to framing a question being to mimic a "well-defined intervention in a randomized trial." The book's basic thesis is that this is a step taken too far – and that framing all causal questions as "well-defined interventions" will harm scientific validity and increase distrust in science.

To make her case, Schwartz briefly reviewed key contributions of the "causal revolution," including distinguishing between association, prediction, and causation, along with its critique of poorly defined "risk factors." The basic definition of a causal effect is the difference between two potential outcomes: Person A either takes the drug (the realized effect) or takes the placebo (the counterfactual). If this question is studied in populations, the causal effect is the average of the results across each individual. But of course one cannot "see" causation, because one never sees the counterfactual. Thus, assumptions necessary for comparing rates of outcomes among those who receive the drug vs. placebo require, among other things, "exchangeability," i.e., the people in both groups are "exchangeable" on all features potentially affecting the consequences of taking the drug vs. taking the placebo – and of course in real life, it is very hard to find two groups that are truly exchangeable. Sorting through these issues involves engaging with issues of selection bias and confounding, as well as positivity (the extent to which there are exposed and unexposed persons in each group), and sorting out these issues keeps methodologists very busy.

The crux of their argument, however, is that the assumption of "well-defined intervention" conflates etiologic questions (about the causes of outcomes) with intervention questions (which can assess the causal effects of interventions), and has led to the claim that all causal effects are intervention effects. This in turn has led to "causation" and "causal inference" being treated as the same, and has restricted "causes" to be those phenomena that could be manipulated (as per randomized trials). Only causes that could be studied using a randomized clinical trial were considered to be causes whose causal effects could be studied.

However, this approach excludes studying etiologic questions about harmful exposures and the harms they cause, and excludes study of causes that cannot be studied as a randomized trial. As an example of the kinds of "shape

shifting” required to force an etiologic question into a question about interventions, Schwartz critiqued research examining: (a) the effect of maternal urinary tract infections on low birth weight, and (b) the relationship between hypertension and cardiovascular disease via removing a specified dietary exposure – and in both cases, the assumptions required to render the “intervention” scenario plausible were in fact implausible, leading to untrustworthy science.

More broadly, the constraints imposed on what is considered “causal” in the potential outcomes approach precludes examining such social causes as structural racism, social norms, etc. Schwartz argued that the effects of the latter, however, can be validly studied as realized causal effects, asking the etiologic question “what was the causal effect the exposure had?” – which allows for contrasting fact vs. counter-fact. In contrast to the future-oriented questions of interventions, the etiologic questions are past-oriented and enable study of realized causal effects, for which all kinds of causes are welcome. No longer requiring the paradigmatic constraints of causation framed only as a “well-defined intervention” will help develop trust in scientific research.

-- **Zinzi Bailey, ScD, MSPH**, presented on: “**Epistemic arrogance vs. uncertainty: Does well-defined mean well-received?**”

Bailey’s key point was that in social epidemiology, it is not possible to wedge the realities of racialization into a randomized clinical trial, and that the impacts of racialization (as tied to structural racism) are best studied as realized causal effects. Trust involves confidence that the people working on a task will correctly complete it, and this in turn raises the questions of who is doing the work and who is supposed to be trusting it?

It thus becomes critical to challenge the framing of “race as a cause” by challenging the inherent racial essentialism core to such a question, whereby “race” becomes reduced to a set of immutable characteristics of individuals. In 2020, Galea and Hernandez tried to reassure social epidemiologists that not every study had to be or aspire to be a randomized trial, but they still put such trials at the top of their hierarchy of evidence, with its inevitable focus on individuals, not social action. A critical task is to deal with racialization directly, as an inherently multidimensional and relational social construct, one that is more than simply what some have referred to as a “bundle of sticks” (as if racialization could be reduced to a series of individual-level exposures), and which has led to researchers to ask what would the health of Black people be if they were instead white? – without dealing with the social realities that produce different lived experiences and exposures.

A contrasting approach would be to ask what would be the health profile of Black people if social conditions had changed? – that is, conducting research to study etiologic realized effects. Such an approach also requires being clear about theories of change, and also recognizes that it is the role of decision makers (including community members, not just policy makers) to design policies, not epidemiologists. Bailey stated it is epistemic arrogance to predict how a social intervention will turn out, especially when dealing with socially structured systems and exposures, with the “potential outcomes” approach ignoring both the passage of time and history. What’s needed instead is epistemic humility, drawing on such theories as ecosocial theory and critical race theory to ground the questions asked. At issue is shifting the balance of power, as tied to the work of community organizers, and not to have epidemiologists serve as gatekeepers of what is possible, which will not lead to increased trust in the research results.

-- **Nick Graetz and Mike Esposito** then presented on: “**Causal inference and health justice: Understanding (and changing?) the social world.**”

Graetz focused his comments on how researchers defined exposures, and distinguished between theoretical estimands and empirical estimands. He asked people to consider two very different questions: (1) how do housing vouchers affect hypertension rates? (a question in a form typically posed by policy makers), versus (2) how does housing insecurity affect hypertension rates (which relies on a different theory of change, involving power relations between landlords and tenants, and who has the power to set rents). He argued that organizers and tenant unions don’t see themselves and the issues they care about reflected in the Question 1 approach (focus on housing vouchers) but they can be engaged in the Question 2 approach (about tackling housing insecurity driven by power relations between landlords and tenants). A key task is identifying who is in the causal field, and he referred people to: Reynold M. Health Power Resource Theory: A Relational Approach to the Study of Health Inequalities. *J Health Soc Behav* 2021; 62(4):493-511; <https://pmc.ncbi.nlm.nih.gov/articles/PMC10497238/>

Esposito in turn raised the question: who trusts the state? – and discussed how explicit community engagement to elaborate theoretically the relevant causal field changed his team’s initial research question on whether aggressive policing increased distrust in the state, spilling over to affecting vaccine willingness. Bringing in community-based insights changed the study design and question. After conducting 60 focus groups to clarify which types of police aggressiveness decreased trust in the state, the researchers realized they had brought the community into the research process too late, and that the focus on police aggressiveness proposed by the researchers was too

limited an approach to understand what led to decreased trust in the state. Instead, the question became flipped to what increases the trust of white affluent communities in the state, and expanded the focus from the relationship between the vaccination rate and police contacts to the relationship between vaccination rates and state control that upholds the status quo – and, among other things, raised the question of what trust in the state would look like if Black communities received the same types of policing as affluent white communities.

During the **Q&A period**, points raised included:

- (1) Appreciation for the rigor of the advocacy lens and the need to focus on people in diverse institutions who make decisions, not just policy makers – leading to the question of whether any of the panelists would run for electoral office (uniform answer of “no” ...)
- (2) What would evidence-based policy look like? – with Prins responding that he was skeptical of “evidence-based policy,” since it seemed to him that what was most common was “policy-based evidence making,” and he likewise was critical of the distinction between “advocacy” and “science,” since such a distinction relied on reductionist and technocratic approaches to upholding the status quo.
- (3) The arguments raised underscored the centrality of theories of disease distribution (and other such theories for social phenomena) to drive and frame the hypotheses that researchers test (which is more than solely a matter of “causal inference”); instead, contrary to Popperian approaches, it is not as if hypotheses drop out of the sky or are idiosyncratic, and in the case of the ecosocial theory of disease distribution, core constructs include “agency and accountability,” which would resonate with the approaches proposed to elucidating the relevant causal fields for social phenomena and their embodiment as population rates of health, disease, and death.
- (4) What would it take to shift the field in its approach to causal inference and causal analyses? – with responses including: (a) Bailey: change the power structures, as per the work of the [Health and Power Organizing Project](#) she is working with, which is seeking to shift the focus; (b) Prins: can’t separate this question from the question of broader social and political change and need to start with theory, not a data set; and (c) Krieger: two useful approaches are to demonstrate concretely that researchers get the wrong answer if they use the wrong approach (since scientists don’t like to be wrong), and also to demonstrate that if researchers use the wrong approach they can cause harm (to populations as well as to individuals), noting that most people (psychopaths excepted) aren’t keen to harm other people.
- (5) A comment sparked by a [new study](#), led by a group of young researchers, that has been exploring the methodological challenges of answering the question: would monetary reparations reduce mortality in the US Black population? – and this work has raised questions about whether epidemiologists might be trying to answer questions that are better suited for historians to answer; the response from Schwartz was that she had read the paper and thought it was the wrong analysis, turning a question about the impacts of wealth disparity into a “well-defined intervention” question – and said it would be more appropriate to ask what are the effects of wealth inequities (a realized causal effect) instead of asking what the impact of reparations would be (because this would not be a “well-defined intervention,” since so many things in addition to wealth would change if reparations policies were actually adopted and implemented), meaning that unless it is clear what the reparations intervention would look like, it’s not possible to analyze what its impact would be.

• PROGRESSIVE PEDAGOGY

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69561>

Estimated attendance: ~ 35 people.

PROGRESSIVE PEDAGOGY SESSION / Teaching to Counter Miseducation and Build Critical Pedagogy (Session 4273.0, MCC Room L100HI) – Tues, Oct 29

- 2:30 pm: **Teaching to counter miseducation and build critical pedagogy.** Lisa Moore, PhD, Vanessa Simonds, Rebekka Lee, ScD and Nylca J. Muñoz Sosa, JD, DrPH
- 2:35 pm: **Addressing mistrust through innovative research methods & collaborative pedagogies in public health.** Ruth Murcia and Marina Hernandez
- 2:55 pm: **Democratizing rubrics: Building trust in a seminar class by having students edit rubrics.** Yesenia Merino, PhD, MPH
- 3:15 pm: **Pedagogy for participatory action research with people engaged in the sex trades.** Marie-Fatima Hyacinthe, Alice Miller, JD, Daniel Newton and Jessica Penaranda
- 3:35 pm: **Q&A**

INTRODUCTION – Craig Dearfield

-- Ruth Murcia & Marina Hernandez jointly presented on: “Addressing mistrust through innovative research methods & collaborative pedagogies in public health.”

Murcia gave the presentation, joined by Hernandez, and both introduced themselves as queer 1st gen Latine doctoral students, with Murcia also affirming her immigrant, refugee, and domestic worker lived experience. Their challenge was to experts who “claim to know more about their struggles than we do.” Key points concerned:

- (1) The making of (mis)trust via the impacts of eugenics, racism, and science denialism
- (2) Invisibility in the research process (at all stages) – who is visible, who is not
- (3) The benefits of fostering/cultivating data sovereignty – which increases ethical engagement in the research
- (4) The challenges of finding the time to build relationships
- (5) The importance of goodwill and critical dialogue – and encouraging students to apply their lived experience to their analysis of and engagement with the assigned material
- (6) The importance of being exposed to different epistemologies in other fields and to interdisciplinary work
- (7) Avoiding dehumanizing students by recognizing the significance of lived experience, positionality, and the impacts of colonialism

A resource they recommended is the NASEM report: [Branches From the Same Tree](#), a 2018 report on “The Integration of the Humanities and Arts with the Sciences, Engineering, and Medicine in Higher Education.”

-- Yesenia Merino, PhD, MPH presented on: “**Democratizing rubrics: Building trust in a seminar class by having students edit rubrics.**”

Merino presented on her seminar-style course, which is informed by use of critical theory, drawing on pedagogical approaches developed by Paulo Freire and bell hooks, and which emphasizes the need for critique, care, paying attention to those who are made invisible, and understanding education as a political act. Her overall approach to the class is healing-centered engagement (as opposed to trauma-informed), which requires being specific about how to engage with challenging material, being flexible, and transparent about course content and process. Key features of the course are:

- (1) two assignments: one about the hope & joy & outrage that keeps you going; the other an exercise in storytelling for non-technical audiences
- (2) editing the rubrics: the students do this on Day 1 of the course, whereby they review and potentially propose changes to the course overview, purpose, assignments and due dates, and grading approach; changes students have suggested include: starting the class with a brief check-in; requesting clearer language; better aligning the assessments to the assignment instructions; fixing typos; and expanding definitions for improved inclusion – with the net result being to build student trust in learning from and being engaged with the class

Supporting this revised approach to teaching, prior students in the class did a textual analysis of course evaluations, which they turned into a paper in which they reported that key strengths of the approach taken (including editing the rubrics) facilitated instruction, helped guide critical conversations, and attended to feelings.

-- Marie-Fatima Hyacinthe presented, with Jessica Peñarando, on: “**Pedagogy for participatory action research with people engaged in the sex trades.**”

The key research question of their projects was to find out what types of police violence were experienced by people engaged in the sex trades, and doing this work required critically engaging with what “community-engaged research” means and what shifts need to be made in pedagogical and methodological approaches to such work. The project they are doing is jointly based in New York City, NY and New Haven, CT, and sought to talk with, not about, people engaged in the sex trades.

- (1) Phase One: prompted by hearing reports from the [Sex Workers and Allies Network \(SWAN\)](#) in New Haven, CT about experiences of police violence directed against sex workers, the research team wanted to know how to address this problem and they both conducted a literature review as well talked with members of SWAN, with a focus on what could be done by whom to hold police accountable.
- (2) Phase Two involved “Praxis & Pedagogy,” to set the basis for doing critical participatory action research (PAR). This work is guided by critical theory, the lived experiences & participation of those affected by the problem, and their critical role in defining the problem and language used to analyze it (e.g., distinguishing between people engaged in the sex trades vs. people who are sex trafficked).

- (a) The cycle of praxis and pedagogy connected: “understanding” (what do we not know?) to “teaching and learning” (who do we need to partner with?) to “doing” (what methods should we use?)
- (b) This work also required addressing language injustice, whereby all research materials (including for recruitment) were bilingual in Spanish and English, and the budget included funds for interpretation and Spanish facilitation of the focus groups, and the researchers also budgeted for additional languages, including Cantonese and Mandarin.
- (c) Partnering with community groups required attention to: transparency (e.g., for the payment model, how to participate); accountability to the community (including showing up, knowing what’s at stake for whom); and supporting community expertise and leadership (via skills building, academic acknowledgment of community expertise) – all of which were vital for the training of the sex workers to do the research.
- (d) Also vital: being transparent about what kinds of data can be turned around in what time frame – this type of research cannot necessarily address specific crises, but can provide understanding about the larger problems that drive these crises.

Next steps will be: conducting the focus groups, putting the PAR team together, and doing the research.

During the **Q&A** period, comments and exchanges focused on:

- (1) What are creative ways to handle payment to groups not typically involved in academic research? – with one suggestion being to issue a subcontract to the organization (e.g., community-based group) and they can then issue cash gift cards without having to report the names of the people who get the cards (in contrast to rules for the academic institution if the researchers tried to issue such cards).
- (2) How best to teach students who have not previously been exposed to critical pedagogy? – with responses including: find out what works in other fields; find other faculty who have used such approaches to see what has worked for them; encourage book clubs with other students interested in critical pedagogy that draw in students from across the campus (i.e., many different disciplines); bring in ancestral wisdom; and use a style rooted in what one needed as a student.
- (3) Do approaches differ if the course is an elective vs. required, and also, given limits on faculty time, what realistic approaches can faculty take to learn more about teaching? – with response including: (a) the course with editing the rubrics was an elective, not required, and would likely only work with students seeking such a course, not a required course; (b) encourage students to be noisy (i.e., raise concerns to the academic institution) about what faculty need (e.g., more time supported for developing teaching approaches); (c) make the courses more worthwhile for the students and faculty by adding supplemental sections as needed (e.g., special session on critical pedagogy for students in fields that typically don’t take such an approach, e.g., epidemiology & biostatistics); (d) recognize that burn-out is a systemic problem and take a healing-centered approach for faculty as well as students; and (e) in required courses where not everyone is on the same page, start the class with a problem for students to solve, one that will engage the students and get them interested in the course material and approach.
- (4) How to address the power dynamics of grading? – with responses including: (a) the importance of having students review the grading rubric; (b) experiment with “ungrading,” whereby students do their own grading, in which they typically are honest about their not having done the reading, etc., and it helps them think about how they do and do not show up in class; (c) make the course pass/fail; and (d) engage with the students about “why am I doing this?” – i.e., not in the class just to get a grade, but to do something in the world based on the knowledge they learn.
- (5) How to address the problem of reading volume for courses, especially ones that are theory-heavy and typically assign a lot of reading? – with responses including: (a) important to be clear with students that being able to read large volumes of material is a critical skill, one that can be learned; and (b) refer students to learning services on the campus that can help them with their reading skills.

• STUDENT POSTER SESSION

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69558>

Estimated attendance: ~ 125 people (during the 12:30-1:30 pm slot)

Our 23rd “STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH” had 6 posters. As usual, for most of those sharing their student posters, it was their first time presenting at a scientific meeting – and the session gave them an opportunity to talk with each other, as well as all who came by to see their work. The student poster session accordingly continues to meet our objective of helping to bring forward & connect the next generation of public health professionals & practitioners linking social justice and public health in their work – and we surely need their enthusiasm, energy, outrage, insights, and organizing for all the challenges we face!

STUDENT POSTER SESSION / Spirit of 1848 Social Justice & Public Health Student Poster Session (Session 4189.0, MCC Exhibit Hall BCD) – Tues, Oct 29

- **Poster 1 – Structural drivers of health inequities: Lineages of scholarship and key conceptual components.** Gabrielle Young, MPH, Maren Spolum, MPP, MPH and Amy Schulz, PhD, MPH, MSW
- **Poster 2 – Investigating mental health use among Black immigrants in the United States: A systematized review.** Abena Yirenya-Tawiah, Anne Douglas Cousar and Catherin Cubbin
- **Poster 3 – No trust amidst deprivation: Economic injustice as a driver of lost trust in public health.** Anna Clyburn
- **Poster 4 – “care, not cops”: Exploring the demands of anti-carceral organizers and the role of public health.** Marie-Fatima Hyacinthe.
- **Poster 5 – Sociodemographic insights and recommendations for equity in communities targeted by predictive policing: A Los Angeles case study.** Melina Rodriguez, BS
- **Poster 6 – Individuals vs. infodemics: Moving towards an ecological understanding of health misinformation through a critical analysis of content moderation policies.** Amelia Jamison, MAA, MPH

• **CO-SPONSORED SESSION: WALTER LEAR HISTORY SESSION (WITH SCAPHA)**

<https://apha.confex.com/apha/2024/meetingapp.cgi/Session/69613>

Estimated attendance: ~ 125 people.

SPECIAL EVENT: Sun, Oct 27: 2:30-4:00 pm – Walter Lear History Session: Building the Worlds That Kill Us – Examining US history through a public health lens– co-organized with SCAPHA (Session 2100.0; MCC Room L100FG).

On behalf of the Socialist Caucus of the American Public Health Association (SCAPHA), Martha Livingston opened the session, followed by an introduction from Nancy Krieger, on behalf of the Spirit of 1848. Martha Livingston first provided background on Walter Lear (1923-2010), a progressive physician & public health activist, who among other things was active in the civil rights movement (and was the founder in 1963 of the Medical Committee for Civil Rights), was the first public health leader at a health department to come out and subsequently became a key defender of LGBTQ rights and health, as well as documented the history of LGBTQ organizing and related progressive public health organizing (see: <https://www.library.upenn.edu/collections/notable/u-s-health-activism-history> & <https://perspectivesofchange.hms.harvard.edu/node/176>). Nancy Krieger introduced the focus of the session by referring to the preview of the book that David Rosner had presented in the prior year at one of the Spirit of 1848 sessions, titled with reference to Fannie Lou Hamer’s iconic phrase “[I’m sick and tired of being sick and tired](#)” – and she provided background on when Hammer gave that speech in NYC in 1964, and Hamer’s call for facing the ugly facts of injustice and the need for urgent action – a call as timely now as it was then.

The session then shifted to discussion of the new book by David Rosner and Gerry Markowitz: [*Building the World That Kills Us: Disease, Death, and Inequality in American History*](#) (NY: Columbia University Press, 2024).

- (a) David Rosner presented the core idea of the book: the imperative to counter the dominant framing that disease is a result of bad luck or bad choices, instead arguing that much of the suffering that people experience, in terms of disease and death, is the product of worlds created and structural constraints. He described how the book traces inequalities in death and disease in the US from its colonial origins to now, with devastating impacts on Indigenous peoples, enslaved Africans and their descendants, and workers – drawing on Studs Terkel’s classic 1973 book

“Working: People Talk about What They Do All Day and How They Feel About What They Do,” which described the world of work using language of violence, in relation to assaults on people’s bodies and minds. His key point was that disease and death are not solely biological events – they are social phenomena as well.

(b) Gerry Markowitz then spoke to the book’s three interconnected themes: (1) political, economic, social, physical, and racist worlds constructed by people create diseases and causes of death; (2) the burdens of disease and death are inequitably distributed in societies; and (3) those most exploited and harmed and allied reformers organized & led campaigns to resist these conditions. The corollary is that because people created these harmful worlds, these worlds can be changed if people organize to create better worlds.

Three panelists then shared their thoughts regarding the book:

-- Mary Bassett’s comments focused on the importance of the book in grappling with structural racism, capitalism, and the settler-colonial origins of the US, along with the need to challenge the dominant view that “profit” is a driver of “progress.” She was particularly struck by the opening chapter, describing the two different versions of colonialism represented by the New England model (settler-colonialism, bringing families over to create a “new world” of their own making, while dispossessing the Indigenous peoples already there) vs the Jamestown model (which was a more extractive form of colonialism, one more lethal to the colonists along with the Indigenous peoples and indentured and enslaved workers). The larger point was that the colonists created worlds which has continued to benefit all persons who are not Indigenous and/or enslaved or descendants of enslaved peoples, and those benefitting have included the original colonists, their descendants, and other immigrants. This analysis has clear implications for whom will be in coalitions to contest the injustice of the worlds created by these colonists. She also found noteworthy the discussion of challenging current corporate power in the courts, and underscored the need to fight for gains to advance health justice; facts are not enough.

-- Marian Moser Jones then discussed how the book brought together the historians’ focus on detailed case studies with the telling of stories in ways akin to how reporters write and engage their readers. This linkage was familiar to her, as she had first worked as a health reporter before going to graduate school as a historian, where David Rosner was her advisor! She discussed how each chapter, in their chronological telling of the history of death and disease in the US, kept a central theme of how the pursuit of profit led to needless suffering and death, framed as a result of choice of those in power, and not as something inevitable. Another theme woven through each chapter was the history of – and need for – activism to challenge these harms. She emphasized the need to improve understanding of the linkages between all these issues, as per the public health work & community organizing re environmental justice, and urged attention to how people can be brought together to fight for better conditions.

-- Linda Rae Murray opened by saying she is not a historian, but the older she gets, the more she appreciates the importance of history, especially now when teaching younger people, who don’t know important aspects of history not taught – such as the long links, back to the 1960s, between liberation struggles for Black people in the US and Palestinians. She focused on the need to challenge ways in which she and so many others have been taught history – e.g., that things are just constantly improving, and instead said the reality was much more complex, that for every step forward, there has been a backlash sending things back four steps. Appreciating that history is messy at the same time opens up new ways of understanding of how, via activism, people can change the course of history, and she appreciated how historians can work with the mess of history to structure it and detect patterns and trends over time – while at the same time being clear that the point is not simply to remember history, but to change it. The challenge is to craft a new world and a future that is different.

In the Q&A, discussion focused on:

- (1) how health educators can use the framing in the session to go beyond the individualistic focus of so much of health education, while remembering too that sharing of information, including at the individual level, is key for democracy – and that part of what individuals can choose is to become engaged as activists, working with others to change the world;
- (2) the role of HealthPAC, in the 1960s and 1970s, in changing awareness of the political economy of health care; and
- (3) challenging the idea of education as the “great leveler” in the US, when school district funding is dependent on the tax base, ensuring more affluent communities get better education.

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 sub-committees to conduct our work:

- 1) Public Health Data:** this sub-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 sub-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 sub-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 sub-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 sub-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 sub-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 sub-committees--and we invite you to join in!

Community email addresses:

Post message:	spiritof1848@googlegroups.com
Subscribe:	spiritof1848+subscribe@googlegroups.com
Unsubscribe:	spiritof1848+unsubscribe@googlegroups.com
List owner:	1848.spirit@gmail.com
Web page:	www.spiritof1848.org

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

WHY "SPIRIT OF 1848"?

Selected notable events in and around 1848

1840-1847:

Louis René Villermé publishes the first major study of workers' health in France, *A Description of the Physical and Moral State of Workers Employed in Cotton, Wool, 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, including sex workers*; in England, Edwin Chadwick publishes *General Report on Sanitary Conditions of the Labouring 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); Friedrich Engels publishes *The Condition of the Working Class in England* (1845); John Griscom publishes *The Sanitary Condition of the Laboring Population of New York with Suggestions for Its Improvement* (1845); Irish famine (1845-1848) despite high agricultural output and protests against British agricultural and trade policies; start of US-Mexican war (in Mexico, known as "La invasión de Estados Unidos a México," i.e., "The United States Invasion of Mexico") (1846); Frederick Douglass founds *The North Star*, an anti-slavery newspaper in the United States (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* (*Medizinische Reform*), and writes 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" and radical measures rather than "mere palliatives"

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, 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, New York

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

Karl Marx and Friedrich Engels publish *The Communist Manifesto*

77 enslaved persons in the District of Columbia attempt to escape to freedom aboard *The Pearl* schooner. While the attempt is unsuccessful and many participants are sold to Southern plantations, the *Pearl Incident* provokes renewed activism for abolition of slavery in the U.S. Frederick Douglass highlights the hypocrisy of enslavers in Washington who stopped the Pearl while "feasting and rejoicing over" the 1848 democratic revolution in France.*

The Seneca Nation of Indians is founded as a modern democracy with a constitution and elected representative government, building on a democratic self-governing tradition begun in 1200 C.E. by the Hodinöhsö:ni' or Six Nations Confederacy.*

First Chinese immigrants arrive in California: Chinese immigrants comprise 90% of workers who build the Central Pacific Railroad and complete the transcontinental rail system. Paid 30% less than white workers, suffering high injury rates from this hazardous work, and excluded from citizenship, they persist and form the foundation of vibrant Chinese American communities (with parallel migration and exploitative labor experiences across the Americas).*

1849-1855:

European and US-settler prospectors, mostly White, flock to California during the 1849 Gold Rush, bringing disease, ecological destruction, and waves of genocidal violence against Indigenous communities. These events, followed by wars against Indigenous peoples throughout the West and Southwest U.S. (1849-1892), seed Indigenous resistance movements that continue into the 21st century.*

Elizabeth Blackwell (1st woman to get a medical degree in the United States, in 1849*) 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); 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); James McCune Smith (1st African American to get a medical degree, awarded in 1837 by University of Glasgow) co-founds the interracial Radical Abolitionist Party (1855)*

* denotes entries added since the original list created in 1994 (version: 6/21/22)