December 21, 2005

TO: EVERYONE ON SPIRIT OF 1848 EMAIL BULLETIN BOARD
FROM: SPIRIT OF 1848 COORDINATING COMMITTEE
RE: REPORTBACK FROM THE 2005 APHA CONFERENCE

Greetings! The Spirit of 1848 Caucus is happy to share our reportback from the 133rd annual meeting of the American Public Health Association (Philadelphia, PA, December 10-14, 2005). Below we:

(a) present decisions we made at our business meeting, including the call for abstracts for APHA 2006, and

(b) give highlights of our sessions.

We are sending this reportback by email and posting it on our web site. Currently, 2,300 or so people subscribe to our email bulletin board (up 500 from last year at this time), from both the US and elsewhere in the world … !

Please encourage interested colleagues & friends to subscribe to our bulletin board too, and feel free to email them this update/report. Also, if you know of someone who wants our report but does not have access to email or the web page, please feel free to send them a copy OR email their address to Pam Waterman (at: pwaterma@hsph.harvard.edu) and we'll send out a copy by regular mail.

If any of the activities and projects we are reporting to you 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.**

And, if you have any questions, please feel free to contact any of us on the Spirit of 1848 Coordinating Committee (with each committee having 2 co-chairs, for good company & to move the work along!):

--Nancy Krieger (Chair, Spirit of 1848, & data & integrative & e-networking); email: nkrieger@hsph.harvard.edu
--Catherine Cubbin (Politics of public health data committee); email: CubbinC@fcm.ucsf.edu
--Anne-Emanuelle-Birn (History committee); email: ae.birn@utoronto.ca
--Suzanne Christopher (Curriculum committee; student poster session); email: suzanne@montana.edu
--Lisa Moore (Curriculum committee); email: lisadee@sfsu.edu
--Luis Avilés (integrative session); email: laviles@uprm.edu
--Pam Waterman (E-networking committee); email: pwaterma@hsph.harvard.edu
--Vanessa Watts (student rep for the Student poster session); email: vwatts@hsph.harvard.edu

Finally, our webpage (with information on our mission statement, past year's programs & activities, including selected presentations & syllabi from prior sessions, etc) can be found at:

http://www.Spiritof1848.org

I. SPIRIT OF 1848 BUSINESS MEETING

Present (19 persons):
1) Coordinating committee members: Nancy Krieger (Chair/CC), Catherine Cubbin (CC/data), Lisa Moore(CC/curriculum), Luis Avilés (CC/history), Pam Waterman (CC/e-networking),Vanessa Watts (CC/student posters); Unable to attend but provided updates by proxy: Suzanne Christopher (CC/curriculum, student poster session); Anne-Emanuelle Birn (CC/history)
2) Additional persons attending meeting (in alphabetical order): Joel Albers, Diana Burgess, Nadav Davidovitch, Bianca Encinias, Dani Filc, Emily Galpern, Megan Gaydos, Connie Gates, Bob Griss, Birgit Reime, Sarah Shannon, Merrill Singer, Rose Wilde.

A. Review of scope & structure of Spirit of 1848

1) We reaffirmed that we are volunteer network of folk drawn to the combination of politics, passion, and public health, seeking to connect issues of social justice and public health in our lives and work and multiple communities, large and small—and that we want to do this bolstered by a sense of history, learning from the experiences (for good and for bad) of those who have come before (see our mission statement, at end of this report). Our origins lie among folk who began working together in the late 1980s as part 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.

2) We reviewed the structure & purpose of our 4 sub-committees: (a) politics of public health data, (b) progressive pedagogy & curricula, (c) history (with the sub-committee serving as liaison to the Sigerist Circle, an organization of progressive historians of public health & medicine), (d) e-networking, which also coordinates the student poster session. We also reaffirmed that, to ensure accountability, all projects carried out in the name of the Spirit of 1848 are approved by the Spirit of 1848 Coordinating Committee. The Coordinating Committee communicates regularly (by email) and its chair (and other members, as necessary) deals with all paperwork related to organizing & sponsoring sessions at APHA and maintaining our Caucus status. The subcommittees also communicate regularly by email in relation to their specific projects (e.g., organizing APHA sessions). We likewise reaffirmed the purpose of our bulletin board and website, and thanked Pam Waterman for ensuring their smooth functioning.

3) We will continue with the same APHA time slots that we had this year, and also keep to our new policy (established last year) of only co-sponsoring sessions we have helped organize and accepting co-sponsorships from only groups that have helped with organizing sessions for which we are the primary sponsor. We also decided that, given that we now have many more student posters submitted than the 10 slots available for this session, we will no longer offer a prize as an incentive; instead, the incentive is the satisfaction of being included in a Spirit of 1848 session.

NB: the Spirit of 1848 time slots (assigned by APHA) remain as follows:

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

Which should keep us all rather busy …. !! ☺

4) We also learned that the TFAIR proposal, regarding how APHA and Caucuses will individually work out Memoranda of Understanding regarding the relationship between each Caucus and the APHA, passed at the Governing Council. Our Caucus played an important role in shaping the content of the resolution, along with aiding networking among the various Caucuses in giving feedback. Pam Waterman spoke on behalf of Spirit of 1848 at the Governing Council. So, sometime during the next 3 years our Caucus and the other Caucuses will each be working out our "Memorandum of Understanding" with APHA! The text of the approved TFAIR proposal is as follows:

Caucus and APHA Relations (Executive Board)

1. APHA and each Caucus shall enter into a written "Memorandum of Understanding" that defines the mutual responsibilities and expectations of APHA and the Caucus. These Memoranda of Understanding should be flexible documents that contain at least the following provisions:

2. REQUIRED PROVISIONS – these two (2) provisions shall be in the Memorandum of Understanding:

    a. a provision that Caucuses report annually (no later than August 1 of each year) to APHA the names of all APHA members who are members of the Caucus; and

    b. a provision for communication and coordination between the Caucuses and APHA in the form of one yearly teleconference and one face-to-face meeting.

3. OPTIONAL PROVISIONS – these provisions shall be discussed by APHA and the Caucus, but are not required to be in the Memorandum of Understanding:

    a. a provision describing whether the Caucus is willing to provide to APHA:

        1. the number of Caucus members who are not APHA members;

        2. a list of the names, addresses, affiliations, telephone numbers and e-mail addresses of Caucus members who are not members of APHA; and

    b. any additional provisions that APHA and the Caucus agree would be mutually beneficial.

4. Not later than February 1, 2006, the Executive Board shall enter into negotiations with the Caucuses to:

    a. examine in more detail the services and resources needed by Caucuses from APHA;

    b. examine in more detail the resources and information needed by APHA from Caucuses;

    c. examine the circumstances under which APHA and Caucus activities should be coordinated, and when such activities should be separate;

    d. determine an appropriate length of time by which the Memoranda of Understanding, once signed, need to be reviewed and renewed;

    e. examine how to strengthen the relationships of the Executive Board, APHA and the Caucuses; and

    f. determine how such matters shall be included into the Memoranda of Understanding between APHA and the Caucuses.

5. The Executive Board shall report to the Governing Council during or before the 2006 annual meeting. To the extent possible, its report shall contain specific language to be included in the Memoranda of Understanding.

6. After February 1, 2009, no new Caucus shall be formed unless it has entered into a written Memoranda of Understanding with APHA.

7. After February 1, 2009, no existing Caucus shall continue to be affiliated with, or recognized by, APHA unless it has entered into a written Memoranda of Understanding with APHA.

B. Plans for the coming year

Next year's meeting, focused on the theme of "*Public Health and Human Rights,"* will be in Boston, MA, (Sat, Nov. 4 through Wed, Nov. 8, 2006), with the opening general session mid-day on Sunday, Nov. 5, 2006. We believe a progressive perspective on, plus critique & elaboration of, human rights approaches to addressing social determinants of health and health inequities will be quite useful – and we plan to take on this challenge in our various sessions.

NOTE: on December 19, 2005, the APHA website for the CALL FOR ABSTRACTS went "live" and included a PRELIMINARY call for abstracts from the Spirit of 1848 Caucus. As part of preparing this reportback, we have finalized our call for abstracts (see below), which is now included on the APHA website. ***All unsolicited abstracts will be DUE during the week of February 13, 2006.***

SPIRIT OF 1848: CALL FOR ABSTRACTS FOR APHA 2006

1) POLITICS OF PUBLIC HEALTH DATA SESSION

For APHA 2006, the focus of our session will be:

"Health & Human Rights: Methodologies, monitoring, and the politics of data"

Empirical population-based analysis of the connections between health and human rights, particularly in the U.S. context, is in its infancy. Various kinds of data and approaches are used--or could be used--to evaluate and monitor human rights standards, and their promotion and violations, as they relate to public health. This panel will examine the kinds of data and methodological approaches that are being used to document links between population health and human rights, critically assessing their strengths and limitations, and focusing on the political, economic, and social context in which health and human rights are considered. The session will consist of three presentations, followed by a discussant who will reflect on the presentations and discuss common themes and future challenges. We are particularly interested in U.S.-focused presentations, even as we welcome research conducted in other countries and/or at a global level, and encourage creative visual aids to accompany the speakers' presentations. We will consider both solicited and unsolicited abstracts that address--but are not limited to--the following topics:

1) innovative population-based approaches to documenting links between population health and human rights, whether for purposes of monitoring or for etiologic research on social determinants of health.

2) strengths and limitations of a human rights approach for documenting and analyzing inequities in health.

3) creative applications to collecting health and human rights data at the global, national, or local level.

4) effects of government- or university-generated influences on health and human rights research.

This session will be in the Monday afternoon 2:30 pm to 4:00 pm APHA time slot.

2) SOCIAL HISTORY OF PUBLIC HEALTH SESSION:

For APHA 2006, our session will focus on:

"Health & Human Rights: Critical Historical Perspectives from the Cold War to the New World Order"

The discourse of human rights and the values underpinning the notion of health as a human right fundamental to all aspects of human life and well-being are widely invoked yet little explored in historical context. This panel will examine the emergence and development of health and human rights frameworks through the 20th century, presenting case studies to enhance understanding of the motives/influences, features, and application of health and human rights approaches in various time periods and settings. The panel will offer a critical historical perspective on human rights and health discourses and practices internationally, with a particular focus on the United States.

We encourage submissions that explore -- but are not limited to -- the following themes:

1) the tension between the United States' employment of health and human rights discourse globally and its tolerance of more than 45 million uninsured people domestically.

2) historical development of the definition of the right to health (from the post World War I notion of children's rights to the Universal Declaration of Human Rights and WHO definitions of health and human rights in the wake of World War II to the Alma Ata declaration of 1978).

3) the contextual role of the Cold War in the shaping and application of health and human rights principles and their employment as tools of foreign policy.

4) the promise and perils of health and human rights frameworks in the pursuit of social justice by activists, advocates, professionals, and social movements.

5) the implications for the right to health of the debates that have occurred in the latter half of the 20th century over human rights as individual versus collective rights, as political/civil and/or social/economic rights; and why a "health equity" framework has been proposed as an alternative to (rather than a complement of) a health and human rights approach.

We are seeking abstract submissions via this open call for abstracts and also will directly solicit some presentations.

This session will be in the Monday morning 10:30 to 12 noon APHA meeting timeslot.

3) PROGRESSIVE PEDAGOGY SESSION:

For APHA 2006, our session will focus on:

"Health & Human Rights: Teaching in the community and the classroom"

The movement linking public health and social justice has increasingly been informed by human rights perspectives. The data and analytic frameworks produced by human rights workers have proven to be invaluable in understanding the determinants of health and premature mortality. However, much less work has been done examining how to systematically integrate this work into university curricula, community-based education and into the process of teaching.

The pedagogy session of the Spirit of 1848 has, for the last three years, devoted itself to how activism is engendered through teaching. We wish to continue that discussion, with a focus on human rights. The session will consist of three presentations, followed by a discussant who will reflect on the presentations and discuss common themes and future challenges. We are particularly interested in U.S.-focused presentations, even as we welcome research conducted in other countries and/or at a global level, and encourage creative visual aids to accompany the speakers' presentations. We will consider both solicited and unsolicited abstracts that address--but are not limited to--the following topics:

1. Innovative courses on health and human rights for undergraduate, graduate and clinical training

2. Methods of integrating human rights across health curricula

3. Examples of teaching human rights and health in community-based settings

4. The praxis of human rights in relation to pedagogy and public health

This session will be in Tuesday morning 8:30 to 10:00 am APHA time slot.

4) INTEGRATIVE SESSION:

Starting with the APHA 2002 Conference, the Spirit of 1848 has added a new oral session, in which we integrate the 3 themes of our Caucus. These pertain to the inextricable links between social justice & public health, as embodied in: the politics of public health data, the social history of public health, and progressive pedagogy. The integrative session complements our 3 other oral sessions, which provide opportunities for more in-depth discussion regarding each of our 3 themes.

For the APHA 2006 meeting, our integrative session will focus on:

"Social justice, human rights, and health: from rhetoric to reality"

The session, which will include only invited speakers, will focus on the conceptual, methodological, and political issues involved in turning human rights into a meaningful tool for improving population health and reducing health inequities. The 3 invited speakers and 1 invited discussant respectively will: (a) critically review the history of human rights and the development of the health and human rights framework, especially in the US context; (b) present an example of a new human rights tool for monitoring population health in relation to human rights, for purposes of accountability and making policy change; (c) discuss approaches to teaching about health and human rights to both health professionals and advocates; and (d) reflect on the 3 presentations from a global perspective and discuss future challenges to making health and human rights a reality in our troubled world.

No unsolicited abstracts will be considered for this session.

This session will be in the Monday afternoon 4:30 to 6:00 pm APHA time slot.

5) STUDENT POSTER SESSION:

Title: *"Social Justice & Public Health: Student Posters"*

The Spirit of 1848 Caucus is soliciting abstracts from students of public health and health-related programs that highlight the intersection between social justice and public health from a historical, epidemiological, and/or methodological perspective. We welcome abstracts on topics ranging from public health research to public health practice to student-initiated courses on connections between social justice & public health. The work presented can be global, country-specific, or local.

We will encourage students at ALL levels of training in their work on public health to submit abstracts, whether undergraduates, master students, MPH students, or doctoral students; submissions will judged in accordance to expectations appropriate for each level of training. Postdoctoral fellows are NOT eligible to submit posters.

Abstracts should focus on furthering understanding and action to address the ways that social inequality harms, and social equity improves, the public's health. Examples of social inequality include inequitable social divisions within societies based on social class, race/ethnicity, and gender, as well as inequitable relations between nations and geographical regions. Given the theme of the conference, we especially welcome abstracts regarding links between public health and human rights.

All posters for this session will be selected from contributed abstracts.

This session will be in the Tuesday afternoon 12:30 pm to 1:30 pm APHA time slot.

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If you have any questions about the proposed Spirit of 1848 sessions, please contact the relevant subcommittee contacts for these sessions, listed below:

1) Public Health Data:	Catherine Cubbin (cubbinc@fcm.ucsf.edu)
2) Curriculum:	Suzanne Christopher (suzanne@montana.edu)
3) History:	Anne-Emanuelle Birn (ae.birn@utoronto.ca)
4) Integrative session:	Nancy Krieger (nkrieger@hsph.harvard.edu)
5) Student poster session:	Suzanne Christopher (suzanne@montana.edu)

II. SPIRIT OF 1848 SESSIONS AT APHA

Within a context of overall reduced attendance at the APHA conference (due to the shift from New Orleans to Philadelphia; n = ≈ 11,000 instead of the usual 15,000 or more), our sessions were generally well attended, thought provoking, and clearly useful to those who attended them. In total, we estimate approximately 510 persons attended our 4 oral sessions (down from 725 last year), and approximately 50 also attended the P. Ellen Parsons session we co-organized/co-sponsored.

The specifics, in chronological order, are as follows, with our choice of topics reflecting the theme of the overall APHA conference, on *"Evidence-based Policy and Practice."* Common to all our oral sessions was a concern with the politics of evidence. Thus, as demonstrated by the diverse content of our sessions (as described below), presenters discussed situations in which rigorous evidence is essential for moving forward progressive public health concerns and situations in which calls for certain types of "evidence" can represent conservative efforts to derail progressive public health initiatives and evidence. The basic message was that of course work in public health requires evidence and has always required evidence, such that we need to ask why is the slogan of "evidence-based public health" is gaining currency now – and we cannot afford to be naïve about the politics of evidence.

Presentations from the different sessions will be available, per authors' permission, on the Spirit of 1848 website (http://www.Spiritof1848.org).

1) HISTORY

Our very thought-provoking session, attended by about 120 people (up from 45 people at our history session last year!), was as follows:

EVIDENCE-BASED PUBLIC HEALTH: CRITICAL HISTORIES & CONTEMPORARY CRITIQUES
MON, DEC 12 ***10:30 AM-12 NOON (SESSION 3136.0) * PHIL. CONV. CENTER (PCC) 102A**
10:30 AM — Introduction: The neglect of historical evidence. **Luis Avilés, PhD**
10:35 AM — Reconstructing data: evidence-based medical care in context. **Nadav Davodivitch, MD, Dani Filc, MD, PhD**
10:55 AM — Which evidence? Racial inequalities in mental health. **Kirby Randolph, PhD**
11:15 AM — Evidence-based medicine & evidence-based public health: a critical perspective. **Seiji Yamada, MD, MPH**
11:35 AM — Question & answer period (moderated by **Nancy Krieger, PhD**)

Luis Avilés, in his introduction, underscored the importance of taking a critical perspective on "evidence" – not only the types of evidence considered "valid" but also important types of evidence that are neglected. His key point was that an uncritical approach to "evidence" can lead to bad and harmful science.

Nadav Davodivitch and Dani Filc offered a joint presentation encouraging a critical perspective on both the rise of "evidence-based medicine"/"evidence-based public health" and the nature of "evidence" itself. Their central argument was that to understand why, historically, we are experiencing these demands for "evidence-based" approaches now (and their hierarchies of valid forms of evidence, with the highest being the randomized clinical trial) – given that the call for numerical evidence is nothing new and, in medicine, can readily be traced back to Pierre Louis in the18th century – we have to step back and understand the impact of neoliberal priorities and politics. At issue are neoliberal efforts to: (a) cut funds for social services, including medical care, under the rubric of "cost-effectiveness" and "cost-containment," and (b) further strengthen professional monopolies on "expertise" and the theoretical orientation of "rational choice" as a guide to policy, so as to shut out from policy discussions other sorts of relevant evidence (e.g., advocate testimony) or any sense that there might well be conflicts of interest that are not about "rational choice" but about power.

Kirby Randolph discussed the history of the and racist use of flawed data on mental health of Black Americans, plus their underrepresentation of among mental health professionals, as important reasons why mental health services continue to be inadequate for Black Americans. In particular, she discussed how during much of the 19th and 20th century, rates of admission to mental institutions among Black Americans was conflated with their rates of mental illness, with no acknowledgment that the former often involved involuntary commitment and also rates of arrest and availability of mental health institutions as alternatives to incarceration. Moreover, building on a dominant racist medical literature in the 1860s, following emancipation, which held that Black Americans were unable to handle the stress of being free (and thus advocated re-creating the "master-slave" relationship to stem the tide of "Black insanity"), the US mainstream psychiatric

literature argued up until the 1960s that the mental health of Black Americans was impaired by too rapid cultural change. Her basic point was that it is wrong to treat "everyone alike" when these different histories and experiences of institutionalized racism in mental health services mean that treatment, if it is to be healing, has to treat people the way they want to be treated and take account of this history.

Seiji Yamada in turn presented an analysis, drawing on philosophy and history of science, that critiqued naïve and positivist views that "science" (and especially reductionist science) represents or attains an "unmediated view of reality." Instead, arguing that science is a social product, he drew on the philosophy of Rorty to say that no discipline has "privileged" access to reality. He also draw on Ellus to caution about where an emphasis on "efficiency" and "instrumental rationality" can lead, per the technologies of inhumanity as played out in the Holocaust, in war, and in acts of power and subjugation.

Nancy Krieger, as moderator, argued that rather than frame the problem of knowledge and evidence as positivism versus relativism that we instead need to consider what kinds of evidence we need to answer which questions – and also that some kinds of questions can be partially answered by various types of evidence (as noted by Jerry Morris in one of the first epidemiology textbooks, published in 1957, where he stated that epidemiology is the only way to answer some questions, one way to answer others, and not at all a way to answer yet others). Thus, for example, we do want randomized clinical trials to address whether social class confounds the relationship found in observational studies between "hormone replacement therapy" and reduced risk of cardiovascular disease (with the RCTs showing that such confounding has been at play, with more affluent women at lower risk of cardiovascular risk more likely to have access to and be prescribed HRTs). Conversely, we also want to know when we need to invoke the precautionary principle, precisely because it may be difficult if not impossible to show the impact of one chemical at a time when we need to be thinking about classes of chemicals with myriad and possibly interacting effects (per concerns about pollutants acting as endocrine disruptors). Also, as a concrete demonstration of how theoretical frameworks can affect science, she contrasted research premised on the false notion of "race" as an innate biological variable (allegedly reducible to gene frequency) versus research acknowledging the social construction of "race" and explicitly examining the impact of racism on health. All too often, the former type of hypothesis is deemed "scientific" by the mainstream, whereas the latter is treated as "ideological" – but the evidence in fact suggests the latter is a far more powerful approach to explaining health disparities by race/ethnicity. The net implication is that we have to be careful as to how the politics of evidence plays out.

During the **Q& A**, audience members also pointed out the current politics whereby the federal government doesn't care about evidence as it advances its conservative agenda. This is demonstrated by its encouraging teaching of intelligent design (as if it were a scientific theory, versus evolution), blocking stem cell research, blocking use of effective reproductive technologies, and keeping the DARE anti-drug program in the schools despite evidence that it is ineffective and/or harmful. In each of these cases, the administration advances its claims on the grounds of either spurious "evidence" and/or "morals." Hence in such a context it is important to present a sophisticated critique of "evidence" rather than simply deem all "evidence" equally suspect.

[NOTE: during the lunch break that followed, a good number of APHA members, including people who attended our history session, then went to a demonstration to protest Bush's policies on Iraq, given his speaking that day in Philadelphia to the American Council of Foreign Affairs. He had originally been scheduled to speak at the Marriot, but once the organizers of their conference realized APHA was holding sessions at the Marriot, which also was adjoined to the Philadelphia Convention Center, with ample APHA members opposing the war in Iraq, they moved the conference to another hotel a few blocks away! About 1000 demonstrators lined the street next to the hotel where Bush was speaking and then, accompanied by protest signs and chants, when his motorcade exited the scene, visibly and loudly voiced opposition to the war in Iraq and called for US troops to be brought home.]

2) POLITICS OF PUBLIC HEALTH DATA

Our very engaging session, attended by about 220 people (down from 500 last year, with last year having very high attendance in part because of being the special 10th anniversary session of the Spirit of 1848), focused on:

WHAT COUNTS AS EVIDENCE AND TO WHOM? A PROGRESSIVE CRITIQUE OF EVIDENCE-BASED PUBLIC HEALTH DATA.
MON, DEC 12 ***2:30 PM-4:00 PM (SESSION 3316.0) * PHIL. CONV. CENTER (PCC) 114**
2:30 PM — Introduction. **Catherine Cubbin, PhD**

2:35 PM — Challenges in documenting the impacts of community based participatory research on environmental justice policy. **Meredith Minkler, DrPH, Victoria Breckwich Vasquez, DrPH, MPH**
2:50 PM — Global Health Watch – An Alternative World Health Report. **Sarah Shannon**
3:05 PM — Evidence-based activism: activating the evidence. **Ana M. Malinow, MD, Brian H. Howard, MPH**
3:20 PM — Evaluating the relation between ethnicity and occupational health in Canada**. Stephanie Prejmi, Karen Messing, PhD, Katherine H. Lippel**
3:35 PM — Discussant. **Nancy Krieger, PhD**
3:45 PM — Question & answer period

Catherine Cubbin, PhD introduced the session & speakers, noting the range of kinds of approaches to obtaining and using evidence that would be presented.

Meredith Minkler, DrPH, described a study designed to document the policy impact of community-based participatory research (CBPR) projects focused on environmental justice issues, involving both community-based and academic partners. They identified 8 to 10 such projects and focused on 4 to do an in-depth analysis. One project, based in Los Angeles, compiled compelling evidence disproving the myth that the reason there is an association between the percent of the population that is of color and proximity to urban toxic locations is because these populations move to where the land is cheap; rather, they were able to show that the placement of these toxic sites was because of the population already living there. This project also had important policy successes revising downwards permissible cancer risks and also changing risk assessment from an individual to cumulative basis. Despite these successes, the partnership responsible for these changes was rarely named as such in any of the public coverage of the issues, thus making it hard to identify the success of the partnership in making policy change. The second project, a partnership based in North Carolina, focused on problems linked to the proliferation of hog farms. One important obstacle noted by project members is that they had to be exceedingly careful about saying anything about policy, given restrictions on uses of their government funding. Thus, they took the stance that they don't "do policy" but instead educate legislators, again making it difficult to identify the impact of the project, publicly, on policy. The third project, concerned with tribal efforts against lead poisoning from tail minings, likewise reported that it could not explicitly discuss policy, given constraints imposed by the government funding for the project. Thus, members of the partnership could talk with legislators and write letters only identified as "citizens" and not project members. Finally, the fourth project, concerned with high rates of asthma in Harlem, was very successful in generating data showing the high levels of air pollution in the area and was able to mobilize to make several policy changes, including getting more permanent EPA air monitoring stations (with placement determined by community input), getting buses to switch from dirty to clean diesel fuel, plus passage of a statewide environmental justice policy statement. In this partnership, however, only the community partner could be explicit about policy efforts; the scientists focused more on discussing the scientific gaps in evidence the project was addressing. The net effect again was to make it difficult to document the impact of the partnership on policy. Thus, while the study did demonstrate that CBPR is making a policy difference, that difference is hard to document – yet it must be documented, to show that this kind of work, and not just randomized clinical trials, are essential for improving public health.

Sarah Shannon, the Executive Director of the Hesperian Foundation, described the recently issued *Global Health Watch* (2005-2006), an alternative health report, informed by a grassroots advocacy and human rights perspective. Noting that the 1978 Alma Ata declaration had called for health for all by the year 2000, but that obviously this had not been achieved, 1500 health activists from over 80 countries met in Bangladesh in 2000 for the first People's Health Assembly. One achievement of this Assembly was to create the People's Health Charter, concerned with the root causes of ill health and lack of access to health care. Its analytic framework is premised on the view that poverty and inequality are the biggest epidemics the world faces and underlie the manifest health inequities within and between countries. The goal was to aid civil society in holding government and non-governmental organizations, including corporations, responsible for these health inequities. Part A of the report focuses on "globalization and health" and corporate responsibility for population health. Part B focuses on the public sector, especially health care services and systems. Part C is concerned with the needs of vulnerable groups, especially indigenous populations and people with disabilities. Part D discusses the wider health context, regarding determinants of health that lie outside of the health sector, including climate change, water, food, education, and war. Finally, Part E delineates the accountability of global institutions (e.g., WHO, UNICEF, the World Bank), transnational corporations, and richer countries for improving the world's health and decreasing health inequities. The next report will be issued for 2007-2008. Additional activities include setting up Global Health Watch chapters and coalitions in diverse countries and regions, plus also cooperate with the WHO Commission on the Social Determinants of Health. More information on the report and the People's Health Movement can be found, respectively, at: www.ghwatch.org and www.phm-usa.org.

Ana M. Malinow, MD discussed a project for systematically and strategically using evidence to motivate health activism to achieve policy change and document the effectiveness of doing so. The specific project was focused on using a photography exhibit, focused on 4 personal stories, to build support for universal health care coverage in Texas. The health care crisis in the US provides a classic example of good evidence not leading to needed policy change: the crisis is well documented, with over 46 million people uninsured, over $520 billion per year spent on paperwork, and 2 people dying every hour due to a lack of health insurance – yet we still have no universal health care. The implication is that evidence, while necessary, is not sufficient. For evidence-based activism, it is necessary to get good evidence and use it for targeted work with two groups: policy makers and those who influence them, e.g. the voters, media, faith-based groups, etc. Useful evidence can come from academic sources but also news, visual reports, film, personal stories, etc., so as to enable activists to target both public opinion and salience to get policy makers to act. They took the photography exhibit to 6 cities in Texas, documented who was involved in getting it shown, who spoke at it, who came to it (over 16,000 viewers), and the impact of the exhibit on people's views, including strengthening the view that health care is a right. The presentation concluded by emphasizing the need for a broader viewer of evidence and taking the steps to use these diverse kinds of evidence for activism, documenting what works (and what doesn't) so that others can build on the work.

Stephanie Prejmi, a doctoral student, discussed obstacles to obtaining data on occupational hazards in relation to ethnicity in Canada. Her concern was that without these data, it is impossible to document social disparities in exposure, in recourses to address these exposures (e.g., medical care, claims), and in the impact of the resulting occupational injuries and illnesses on both workers and their families. The problem she confronted was that the main Canadian data sets with information on occupational health lack data on ethnicity, while those with data on ethnicity lack adequate occupational data for investigating occupational exposures. The solution their project found was to aggregate the data at the level of job categories (recognizing problems with misclassification), drawing on Canadian census data and Quebec worker's compensation data, and to supplement this quantitative work with qualitative investigation to understand factors leading to underreporting of claims, especially by immigrants, which would lead to underestimating the impact of ethnic disparities in occupational health problems. Emphasizing how problems are rendered invisible if there are no data to document them, the presentation concluded by encouraging academics and activists to tackle the vicious circle whereby a "lack of understanding of the issues" leads to a "lack of data collection efforts" which leads to "the problem is invisible" which leads "lack of resources" and hence back to "a lack of understanding of the issues."

Nancy Krieger, PhD, as discussant, highlighted how the different presentations, ranging from global to local, underscored both the difficulty and necessity of getting good evidence on population health, on health inequities, and on the impact of efforts to address these inequities. The point is that we need data for accountability, and we need all kinds of data for this – both quantitative and qualitative – while being fully conscious that the data never "speak for themselves." Rather, we make conscious choices, informed by theoretical perspectives, as to what data "count" – and, related, must oppose conservative efforts to discredit types of evidence that runs counter to their priorities. Also important is ensuring that appropriate data are readily available, especially via government agencies, on population health and health disparities, again for purposes of accountability. Throughout, we must ensure we work with the best data possible (recognizing that different kinds of data will be appropriate for different aspects of the problems we are tackling) precisely because the stakes are so high and because not having the data, not showing the evidence, keeps the problems invisible even as they still cause harm.

3) INTEGRATIVE SESSION

Our integrative session, drawing an audience of around 100 people (up from 90 last year), focused on a powerful example that belies the simplistic view that good evidence automatically translates to good policy: that of harm reduction, whereby the evidence strongly shows that harm reduction is effective but conservative politics and value block the enaction of harm reduction policies regardless. The line-up was as follows:

HARM REDUCTION & CONSERVATIVE ATTEMPTS TO DISCOUNT PROGRESSIVE EVIDENCE: INTEGRATING HISTORY, POLITICS OF PUBLIC HEALTH DATA, AND PROGRESSIVE PEDAGOGY

MON, DEC 12 ***4:30 PM-6:00 PM (SESSION 3385.0) * PHIL. CONV. CENTER (PCC) 114**

4:30 PM —Introduction. **Nancy Krieger, PhD**
4:35 PM —A brief history of syringe exchange in the United States. **Allan Clear**
4:55 PM —Grassroot politics plus evidence-based research: evaluating harm reduction interventions can affect federal policies. **Ricky N. Bluthenthal, PhD, Alexander H. Kral, PhD; Jennifer Lorvick, MPH**
5:15 PM —"Don't confuse me with the facts": drug and sex education in an anti-science era. **Lisa Dorothy Moore, DrPH**
5:35 PM —Discussant. **Samuel R. Friedman, PhD**
5:45 PM —Question & answer period

Nancy Krieger introduced the integrative session, intended to integrate the 3 themes of the Spirit of 1848 Caucus – the social history of public health, progressive pedagogy, and the politics of public health data – in relation to one theme, in this case, harm reduction, chosen because of what it exposes about the politics of evidence. She described three scenarios by which conservatives typically attempt to counter progressive evidence: (a) by picking on small flaws of any given study, ignoring the overall strength of the evidence from multiple studies, (b) by muddying the water with deliberately misleading data, so as to "manufacture doubt" (per an explicit strategy of the tobacco industry), and (c) by saying their values trump our evidence. Why, then, in the face of the big-P "Politics of Evidence" should we still try to generate evidence to promote progressive public health initiatives? Because, if we give a damn about the public's health, we must, since we do need to know what reduces harm, improves health, and can help eliminate health inequities. For these reasons, we do need the best evidence we can generate, even as we also need to be aware that we will be engaged in the politics of evidence as well.

Alan Clear, Executive Director of the Harm Reduction Coalition, discussed the history of syringe exchange programs in the US, spanning from 1986, when the first illegal exchange was established in NYC, up through the present, whereby 183 syringe exchange programs exist, about half with funds from Departments of Public Health and also about half with uncertain legal status. All are multi-service sites, providing counseling and referrals as well as exchanging syringes. None, however, can receive any federal funds, due to a 1998 federal ban on funding syringe exchange programs -- despite substantial evidence, even cited by major federal officials, including the Director of NIH and the Director of NIDA, that syringe exchange works (i.e., reduces harm, including incidence of HIV, and does not increase drug use). Attacks on syringe exchange chiefly have been led by conservative Republican politicians, especially Mark Souder from Indiana and Sam Browback from Kansas; their calls for congressional hearings on the topic, however, have provided proponents of syringe exchange with an opportunity to counter the conservatives' distortion of the evidence.

Ricky Bluthental, PhD, then discussed the status of research on harm reduction and syringe exchange, drawing extensively on work carried out by the Urban Health Study, a San Francisco-based project founded by John Waters in 1985 that lasted through 2005. The premise of his talk was that specific harms associated with drug use, including HIV, hepatitis and overdose, are all preventable, that harm reduction interventions can prevent them, and that ideology has trumped the evidence in preventing the funding and implementation of harm reduction programs. Among the operating principles he described for harm reduction research were: (1) a concern for the immediate as well as long-term benefits of the research to the community (per community-based participatory research guidelines), (2) hiring research staff from the community, (3) using a non-judgmental approach, and (4) conducting rigorous science, using rigorous methods. Examples of key studies included one, published in 2001 in the Lancet, showing that, with the advent of syringe exchange programs, HIV risk among injection drug users was due to their sexual risk and not injection risk; another showed the efficacy of a project training injection drug users in using naloxene and CPR to prevent deaths due to overdose. A key message was that the ideological opposition of many in US government to give resources to the people who need them was all the more reason to generate the evidence showing this ideological opposition to have no basis in fact, and thus provide some grounds to counter the lies and guide efforts to develop better policies – noting that when political will is lacking, direct action is needed.

Lisa Moore, PhD, next discussed how difficult it is to teach about harm reduction in a graduate setting when most students have already been exposed to educational programs in high school and college that present false information on sex and drugs. Noting that the problem has been getting worse over the 14 years she has been teaching harm reduction, she reported students stating they had been told such demonstrably false "facts" that, for example, HIV is spread by tears, that 100% of women who have had abortions have been traumatized by this experience, and that condoms don't work.

Related, a report compiled by Congressman Waxman in 2004 found that 11 of 13 federally funded abstinence-based programs employed medically inaccurate information (e.g., "abortions necessarily lead to tubal pregnancies," "18% of pregnancies are due to condom failure"). Moreover, the assumptions of the abstinence-based curricula are that abstinence (whether from substance use or sex) is effectively for life, such that no skills are taught about what to do to reduce risk of harm when one becomes sexually active or starts to use psychoactive substances, both licit (e.g., alcohol) or illicit. A key challenge in confronting the myths and misinformation that students have already been taught is that they will then ignore all evidence, regardless of its quality, and cynically decide everything is just a matter of opinion. Thus, teaching critical thinking skills is a necessary component of doing harm reduction education, with attention to both motives and quality (or lack thereof) of the evidence brought to bear on these issues (including that one cannot simply trust the "evidence" obtained by Googling or from the Wikipedia!). Additionally, one useful way of teaching students the importance of harm reduction is to include a community service learning component, whereby students confront their own stereotypes and misinformation by encountering and seeing the humanity of actual individuals who are in programs in which they are trying to reduce their harm (e.g., syringe exchange programs). Thus, teaching harm reduction requires teaching students how to think critically, how to question the evidence and their teachers, and how to see (and viscerally understand) the role of stereotype in perpetuating unjust policies.

Sam Friedman, PhD, the discussant, titled his comments "Why do the rulers of America oppose syringe exchange? – some thoughts in the Spirit of 1848." His basic thesis is that: (1) the science is clear on the benefit of harm reduction, such that (2) the opposition must therefore be ideological and political in nature. Citing passages from Marx and Engels, he invoked the proverbial Spirit of 1848 to analyze how the ruling class seeks to maintain power through scapegoating and "divide and rule" strategies. His central point was that to make sense of the fights over syringe exchange it is important to locate them within the broader policies of the racialized "War against Drugs," with its long history of blaming "evil races and their drugs" and stoking conservative cultural values. Thus, harm reduction efforts are opposed because they undermine the political utility of the "War on Drugs." Moreover, in the Q&A period, he affirmed that if the evidence had shown that harm reduction interventions were in fact harmful, e.g. if they had led to an increase in HIV transmission, then he would not have supported these interventions – but the facts are that these interventions did reduce harm, hence the value of the bona fide evidence in fighting ideological and harmful policies.

4) CURRICULUM/PROGRESSIVE PEDAGOGY

Our dynamic session, attended by about 70 people (down from 85 last year), was the 3rd in our series on "Teaching Activism for Public Health." The line-up initially was planned as follows:

TEACHING ACTIVISM FOR PUBLIC HEALTH, Part 3
TUES, DEC 13 * 8:30 AM-10:00 AM (SESSION 4061.0)*** PHIL. CONV. CENTER (PCC) 108A**
8:30 AM —Introduction. **Lisa D. Moore, PhD**
8:35 AM —Development of Harvard School of Public Health's Interdisciplinary Concentration in Women, Gender, and Health. **Barbara Gottlieb, MD, MPH, Corrine M. Williams, ScM**
8:50 AM —Teaching cultural competence: what does racism have to do with it? **Suzanne Selig, PhD, MPH**
9:05 AM —An integrated curriculum for teaching activism and advocacy in a pediatric residency training program. **Quimby E. McCaskill, MD, MPH, Nancy L. Winterbauer, PhD, MS, Elisa Zenni, MD, Jeff Goldhagen, MD, MPH**
9:20 AM —On our way to tomorrow: critical pedagogy for action in community-based settings. **Makani Themba-Nixon**
9:45 AM —Question & answer period

However, because the last speaker was unable to come, we reorganized slightly such that **Nancy Krieger** introduced the speakers and **Lisa Moore** served as a discussant; we have also made arrangements for materials from what would have been the last presentation to be freely available on the Spirit of 1848 website.

Barbara Gottlieb, MD, MPH, Corrine M. Williams, ScM discussed the development and content of the Interdisciplinary Concentration on Women, Gender, and Health at the Harvard School of Public Health. Key points were that this program was based on the concept of activism, the recognition of a need for gender analysis in the public health curricula (across all health outcomes and concerns, not solely reproductive health, and focused on gender in relation to men as well as women), and the need for a structure of both governance and course development that combined faculty and students in partnership. Work to develop the concentration began in 1996 and it was formally approved in 2002. The WGH concentration currently involves 4 academic departments: (in alphabetical order) Environmental Health; Epidemiology; Population and International Health; and Society, Human Development and Health (created through the merger of the prior Departments of Health and Social Behavior and of Maternal and Child Health), and also the Division

of Public Health Practice. The chair rotates every 3 months across the departments and all committees, plus the steering committee, include faculty and student representatives. All 2-year masters students and doctoral students are required to take 10 credits (5 in core WGH courses, 5 in courses with a gender or women's health content); 1-year MPH students are required to take only 7.5 credits (for the "condensed" concentration). The core courses, sponsored by all participating departments, span the academic year and include an introductory course (open to all students), a restricted more advanced level course (a seminar limited to 25 students, which involves team teaching linking gender analysis, social epidemiology, and policy across myriad case examples), a seminar on women and mental health (also recently expanded to include a service learning component), and an advanced seminar in which not only faculty but postdocs and advanced doctoral students can present their work. Work is now underway to develop a new course focused on sexuality and health. Additional exposure to gender analysis in public health is provided by a seminar series and also a brown-bag student lunch discussion group. Among the positive outcomes are students applying to HSPH because of the WGH concentration, plus increased interdepartmental contact for students and faculty alike. A challenge is administratively working interdepartmentally, with regard to funding, course conflicts, etc., and is a focus of the work underway to further strengthen the concentration's institutional basis.

Suzanne Selig, PhD, MPH, discussed a course developed as part of a CDC REACH2010 project, involving University of Michigan-Flint and community-based groups in Flint, focused on efforts to reduce racial/ethnic disparities in infant mortality. A key focus on the class, intended to address issues of cultural competency, is to tackle how dealing with racism directly is required to gain cultural competencies, conceptualized in relation to awareness, self-awareness, and skills. The underlying value of the course is social justice. The course is team-taught by an academic and a member of a community-based organization in Flint, and also involves student co-learning, with students seated in groups of 4 at tables (with enrollment capped at 30 students). The course is required for undergraduates and graduates enrolled in public health; it meets one evening per week for a 3 hour session (with refreshments). Emphasizing the fundamental importance of grappling with racism (not just "race"), course materials address: the value of diversity; stereotypes; role of media in perpetuating stereotypes; levels of racism; white privilege; cross-cultural communication; and health literacy. Students write a weekly personal journal and for the last class review their journal to discuss how their thinking has changed as a result of the course.

Quimby E. McCaskill, MD, MPH, described a new pediatric residency training program at the University of Florida in Jacksonville that is based on the core principles of social justice, equity, and advocacy. Drawing on the progressive legacy of Dr. Abraham Jacobi, who in the late 1800s founded the field of pediatrics and who was committed to social justice, the training program focuses on the social and environmental determinants of population health as they relate to pediatrics. Topics covered include: social determinants of health, population based health, community oriented health care, and community and academic partnerships; also included is a human rights approach, which encompasses learning about the Universal Declaration of Human Rights and the UN Convention on the Rights of the Child. Once a week, participants meet in a noon session to discuss the course materials, using pedagogic approaches based on adult learning theory. The residents also do a 1-month community block rotation, including "role plays" (e.g., waiting in line to apply for Medicaid). Qualitative evaluation of the program indicates that it increases the residents' empathy and compassion, understanding of the structural barriers their patients face, and sense that the residents can work effectively with their patients to improve their health and that of their families. Also underway is creating of a Florida Pediatric Advocacy Network, the first of its kind, that is working across the state, in conjunction with community-based organizations, to try to get this kind of training program in the other residency programs. The Jacksonville program is also assisted by connections with the Jacksonville Association for Legal Aid, plus also has a Jacksonville Pediatric Advocacy Network that meets once a month and encourages its members to write letters to the editor, engage with media and legislators, and otherwise advance advocacy work relevant to social justice and pediatrics. With regard to institutionalizing this type of training program, work is underway to have advocacy and activism become part of the ACGME core competencies, to get relevant questions about social justice and pediatric health on the pediatric board exams, and to have faculty review and promotion include recognition of and need for involvement in the training program.

Lisa Moore, DrPH, the discussant, summarized 6 key points that were common themes across all the presentations. These were: (1) to do good public health and public health teaching, we need to move beyond the conventional approach to one that is premised on collaborating with the community; (2) the collaboration needs to be genuine, not "rubber-stamping," and has to occur both within academic institutions, e.g., interdepartmental, student-faculty, etc., as well as with partners outside of the academy; (3) the classroom isn't the only site for teaching and community service learning is essential; (4) it is essential to teach about the social determinants of health that gets students to understand this at a deeper

level, including their own involvement as products and producers of their society; (5) a key challenge is to institutionalize these kinds of courses and integrated curricula and by doing so also transform the institutions at which they are taught; and (6) it is a privilege to train the next generation of public health professionals and to do so with new approaches, involving the continual development and transformation of public health and its teachers.

5) STUDENT POSTER SESSION

Our 4th **"STUDENT POSTER SESSION: SOCIAL JUSTICE AND PUBLIC HEALTH" (session 4093.0, Tues, Dec 13, 12:30 to 1:30 pm)** had nearly 20 submissions this year (a first!), we accepted 10 presentations, of which one had to withdraw due to the change in conference dates. The final line-up was as follows, with 1st prize this year going to Project #9 – congratulations!!

Board 1: Coalition building in African American communities: a model for reducing health disparities and achieving social justice. **Daphne Gaulden, MPH**

Board 2: Preventive care for women in prison: a qualitative community health assessment of the Pap smear and follow-up treatment process at the Central California Women's Facility. **Shelby McMillan, BA, Jennifer Hult, BA, Catherine Magee, BA, Ruby-Asuncion Turalba, BA**

Board 3: Examining the linkage between HIV/AIDS, poverty and inequality in Colombia. **Carrie Ellen Tatum, BA, Elvira Gomez, MPH, Kimberly Neroda, Marilyn Aguirre-Moline, EdD**

Board 4: Measuring prejudice and discrimination: Project STRIDE (Stress, Identity, and Mental Health). **Natasha Davis, MSW, MPH, Ilan H. Meyer, PhD**

Board 5: A world apart: AIDS and the Latino community in Reading, Pennsylvania. **Rebecca J. Incledon, BA**

Board 6: National health insurance law in Israel – universal coverage in a pluralistic society. **Dana Schwartz-Ilan, Shifra Shvarts, PhD, Revital Gross, PhD, Avishay Goldberg, PhD**

Board 7: Primary care in politically marginalized areas: community health workers developing clinical services in rural Chiapas. **Christina T. Holt, MD, MA, Michael Herce, MD, MPH, Arachu Castro, PhD, MPH, Joia Mukherjee, MD MPH**

Board 8: Native Hawaiians and health: militarization or justice? **Laurel M. Turbin, BA**

Board 9: Measuring health care provider implicit bias: using the Implicit Association Test in health care research. **Janice A. Sabin, MSW, PhC**

F) Other:

We co-sponsored & helped organize the **P. Ellen Parsons Memorial Session, on "***Social Injustice & Public Health,"* (Session 4240.0, Tues, Dec 13, 2:30 to 4:00 pm). The primary sponsor was the Medical Care Section; other co-sponsors included the Women's Caucus and the Socialist Caucus. It was attended by approximately 50 people.

The session consisted of speakers who edited and had prepared chapters for the new book on *Social Injustice & Public Health* (Oxford, 2005), edited by Barry Levy and Vic Sidel. It opened with brief statements, presented by **Ellen Shaffer** and **Nancy Krieger**, about P Ellen Parsons (who was, among other things, one of the co-founders of the Spirit of 1848 Caucus). Next, **Vic Sidel** and **Barry Levy** described the purpose of the book and its perspective on social justice and public health. Speakers included: **Norma Groce**, on disability; **Catherine Bowles**, on children; **Stephen Wallace**, on older people; **Bob Lawrence**, on public health education; **Linda Rae Murray**, on occupational health; **Jack Geiger**, on medical care; **Ellen Shaffer**, on economic globalization, trade, and health; **Jim Mercy**, on assaultive violence and war; and **Nancy Krieger,** on critical research for social justice and health, which she followed by offering closing comments on why P Ellen Parsons would have welcomed this book, in these reactionary political times, and the book's

encouragement of progressive coalition work, in the spirit of the Rainbow Coalition, to advance issues of social justice and public health.

Finally, the Spirit of 1848 co-sponsored the Occupational Health and Safety dance on the Tuesday night of APHA, which was also a benefit party for the AFL-CIO Hurricane Relief fund.

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

Onwards! ....
Spirit of 1848 Coordinating Committee

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

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

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

SPIRIT OF 1848 MISSION STATEMENT

November 2002

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

Purpose and Structure

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

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

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

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

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

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

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

Community email addresses:

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

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

NOTABLE EVENTS IN AND AROUND 1848

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

1848: World-wide cholera epidemic

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

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

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

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

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

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

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

Karl Marx and Frederick Engels publish The Communist Manifesto

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