

ATTACHMENT I. Notes from Roundtable Discussion Groups

1. Social Inequalities in Health: Defining and measuring the problem

Presenters: Paula Braveman (PB) and Edith Parker (EP)

Facilitator: Len Syme

Notetaker: Toby Citrin

PB: Context for disparities and inequalities.

Example of a health disparity?

Prevalence of HIV/AIDS in racial/ethnic minority communities.

Asthma in racial/ethnic communities

Morbidity & mortality among African American communities.

Difference in health not a disparity?

Women live longer than men

Sickle cell disease

PB: The term “health disparities” came into use in the ‘90s. What’s the difference between disparity and inequality?

I’d prefer “inequality” because it’s part of a larger societal concern about inequalities.

Syme: Implication of injustice when you state “inequity.”

What is the difference between inequality and inequity?

Syme: Inequality means it’s not the same and inequity means it isn’t right.

It’s an inequity we’re trying to capture – but isn’t it an inequity that men have a shorter life expectancy than women? In general, I wouldn’t call that an inequity.

Higher breast cancer rates among the more privileged? But women of color die more. That’s not an inequity either – it’s not the result of injustices.

The fact that there are more hog farms in poorer communities in NC is an inequity.

PB: “Differences in health perceived as avoidable, unnecessary and unfair.”

In the ‘90s I worked at WHO in Geneva to develop data on inequity in health care. A new regime came into WHO in ‘98 – the people who had championed that initiative were

out – the new people wanted to keep working on inequity. I saw they published that the traditional way we measure health inequalities was fundamentally flawed because it prejudged causation and ignored innate differences – we shouldn't be concerned about poorer health of a poor person. They decided that one should make a distribution of income and look at the amount of inequality in that indicator, not by rich vs. poor or racial/ethnic groups, because that prejudices causation and obscures individual differences. When the WHO report had just come out showing that they started having some indicators reported with comparisons between top and bottom quintile by wealth – they started to work in developing countries under the old way of measuring – but in the first year of the new regime's report, there's no comparison of rich and poor, graphs that no one could possibly understand. I spent a lot of time mounting a response. I realized that you couldn't respond on technical terms but had to talk about values.

We're talking about disparities between groups that are more or less powerful – if that's what your question is about, you need to make those comparisons.

“What question you ask” is why research isn't value-free.

With “health disparity” we're talking about (1) access to care; (2) quality of care; (3) health status. There are right wing folks who want to confuse these groups and say that none of this really exists.

PB: One of the reasons that this science vs. values dichotomy is important – it's easy to talk about this. Your values SHOULD determine the questions you direct your energies to pursuing. But once you've identified your question, you shouldn't distort your research. People who work on controversial questions typically do even more rigorous research, recognizing that the research will be challenged.

Re: *Healthy People 2010*: People within NCHS have come up with a “brilliant” way to monitor our progress. We're not going to indulge in the old habits – they're willing to categorize groups but the reference group you pick on a priori grounds will be the group that does the best on that particular health indicator. For PB, the reference group for racial disparities would be whites.

Syme: In epidemiology you usually take the group that's best and relate the others to it.

It may not be the inequities and we may not understand the factors contributing. If the factors aren't social determinants, that policies can affect, there may be no way we can do anything about it.

PB: Why do we choose a disparity or an inequity? The term inequity is charged; casting blame. Makes people feel defensive. For a lot of the disparities, if we look at what are the health disparities to focus on, for some we don't know the cause, and if we don't know the cause we can't call it unjust. The reason we call it unjust is that there's an underlying injustice in society. In human rights principles, all rights are equal to all other rights. If you don't have a decent standard of living you can't exercise your other rights.

In defining health disparities, inequalities, for the purposes of measurement, it's to find a way that (1) can be operationalized, [just because you don't know the causes of black/white disparity in pre-term birth you don't take it off the agenda] – the theory is there from highly respected ethicists and in human rights principles why we should focus on disparities among groups disadvantaged in terms of social position and placing them at further disadvantage to their health.

Health inequities – the measurement issues aren't rocket science. There's a political agenda behind those.

Edith P: I believe that what I do is about h-disparities but I'm not a health disparities researcher. In Paula's article she says that you need an indicator for health, an indicator of social position and a method to compare across different strata.

What's the role of research that doesn't include quantitative large-scale data?

Our project on environmental health looks at combined effects of indoor triggers and outdoor effects, combined with household intervention. Our partners wanted an intervention more than anything else. Exposure information came with significant implications for policy change. We started with an issue of concern – we knew there were inequalities – and our research contributes the context – pathways – fundamental to understanding causes and contributing factors. Detroit would be ripe for the other research (e.g., housing segregation). We measured social position, looked at non-medical determinants of health, looked at neighborhood-level stressors (e.g., violence) and looked at chronic and acute stressors. What we're beginning to see are things that might be useful to ask in larger populations. These give a local contextual idea that could be moved into large scale population.

Communities don't define the problem in a single discipline. In terms of the policy aspect, it's been crucial to work on the local, regional area -- often not Grosse Pointe -- working with organizations that can take the data and use it to leverage policy change.

PB: The kind of work you're doing is incredibly relevant to reducing health disparities. When I asked for examples of disparities, no one spoke of the comparison. We're not always making the comparison. We want to get the answers to what to do.

BK: Paula: What difference does it make if you're defining and measuring it your way rather than the new WHO people – for policy change?

PB: If you take the old WHO method, you'd take equity off the agenda – have no concern with justice – it's all technocratic. Where would you get the most utilitarian change? Aggregate is where it takes you. We could predict that insofar that available information gets used to drive resource allocation it could affect how the resources get allocated. If you say that whites are worse on this problem and the richest people are worst on another problem – and there's no point of reference with respect to justice – looking at who does the best – you could see big changes in resource allocation.

Looking at the results of asthma in racial and ethnic communities studies, we didn't see reduction in dust mites but did see reduction in caregiver depressive symptoms and improvement in management of kids' asthma.

Wilma: The educational piece with the parents was powerful. Some kids had been diagnosed as bronchitis. Diagnoses got changed with asthma. HMOs didn't want to buy the instruments you need to manage asthma. You empower the community.

Edith: It's better management by the parents who also learned how to deal with the health care system.

BI: We weren't changing the behavior of the physicians but we were empowering the parents.

Wilma: Also empowering the kids.

Don't underestimate the process of people learning how to deal with their health care provider. In one of our discussions, concept of kind of care you get from your physician – people want to know how to deal with their physician. Biblical text: "You have not because you ask not." This is what we're doing – consistent with what your project showed. Tells us what we need to ask policy makers and physicians.

Syme: There are two things going on. One is the ability of people to control their destiny, which has a tremendous impact on their lives and the other thing that is happening here is the ability to manage things.

What we're hearing in dialogue is that people don't feel it's even their right to challenge the physician.

Parker: depressive symptoms reduction.

PB: fascinating that there's been this quantum leap in including the science.

Syme: The link between social forces and biological consequences is opening up a new realm – "the biological embedding of social experience."

Geiger: This is why *Healthy People 2010* will fail because it emphasizes medical care and behavior.

Study of affluent middle-class African-American women living in inner city Boston looking at the incidence of hypertension showed that it didn't matter if you were an Af-Am woman with good income, high level of education, lean body mass index, good exercise; you got hypertension. The things you can't control in that environment can overwhelm the other factors.

There are lots of categories of morbidity and mortality where rates for African Americans are higher than whites. The gap between the top and low social class African Americans is bigger than the Black-White gap – but is still an inequity.

Syme: I'm excited about this program because it brings together people studying the social determinants of these inequities and people working in the community.

2. Immigrant Health: The Latino “Paradox”

Presenters: Edna Viruell-Fuentes and Mondy Mason

Facilitator: Luisa Borrell

Notetaker: Dana Thomas

Presentation Summaries

Edna Viruell-Fuentes

The Latino paradox is often defined as Latinos having low income and low access to care but also low health disparity issues therefore causing the paradox. However, Viruell-Fuentes argues that there really is no such thing as the Latino paradox because it fails to map Latino health outcomes - it applies mostly to Mexicans. We must move away from the paradox label and think about the heterogeneity of Latino population. We should think about it in critical health and think about the concepts of how we frame the questions that lead to answers. The paradox inherently leads to certain types of policy recommendations. There are several explanations for the paradox including data quality. Improving vital statistics can change the perspective.

The current sociocultural explanation proposes that healthy immigrants relate to culture and that culture provides normative health behaviors. As immigrants acculturate they lose their health. The assumption that the least acculturated will have the least social support, however, her research has found the opposite, and the second generations have stronger networks. It has more to do with the stressors of the immigrant process. What is the role of discrimination? In this idea is the assumption that the Mexican culture is static. We have to ask, what is the American culture and what is it we mean by this. Viruell-Fuentes is concerned that acculturation is overwhelmingly used for immigrant health literature but little explains what we mean by culture that justifies its predominance in the literature; whereas the discrimination literature is small when compared to culture literature. We should think about structural factors rather than focusing solely on culture. Expand how we think about the process of becoming an American and include a structure that involves racism. Larger process of becoming racialized as immigrants, how does it impact health? Take a critical look at the assumptions to see if they actually match. Immigrant health offers a unique opportunity to understand the social structure and find out what impinges on people of color. Do not focus only on the Latino paradigm, but think about ways of understanding other immigrants.

Mondy Mason

Mondi summarized her work from when she was a Scholar in North Carolina. Transportation is important to our lives, particularly among underserved populations. Working in participatory change, she worked with a group of women to develop bus stops/system for their community. The process began with identifying the real needs of the women and the community and what they knew or didn't know about transportation in their town. They worked to train the women to talk with neighbors, etc around transportation issues and conduct short surveys. Most people did not know about the transportation service that existed, especially Spanish speaking people. Over time they developed easy to read brochures and talked with city planners about a bus stop plan. A huge movement developed with people learning about their rights. It also helped gather people in interracial groups around not only transportation but other issues as well. It also had the added effect of creating relationships in the community when they did not exist prior. There are huge implications around the Latino paradox in relation to community building. Organizing opportunity that had a way to create networks and increase in community support. Through community building and the CBPR approach may have some health benefits or maintain benefits that we see in arriving immigrants.

Discussion:

Paradox does not apply to all, how to make it spread to other groups, what can we learn?

There are dangers of over generalizing the paradox.

To what extent do similar kinds of paradox exist for other immigrant groups?

Why focus on the Latino paradox? Is there evidence for other immigrant groups? We also need to be careful about who we are talking about.

People are quick to call it paradox but it's just poor methodology. Latino paradox did exist among those born in US and Puerto Rico.

How have different studies defined what it is suppose to be -- whether comparing all to whites? Look within Mexican community to find out if important differences exist, but may be due to bias, return migration effect, healthy migrant effect, cultural social buffering, or data artifact effect (born on the US side, but dies in Mexico).

Something is going on beyond the paradox hypothesis. We can begin to have better studies when we look at comparison populations.

Disaggregating data looking at Latino groups can yield different results. There is little in the literature about Latino ethnic groups. The paradox is likely to exist when you lump many groups together.

To help clarify the paradox it is important to demand as much specificity as possible. We need to go back to what are those assumptions that we have built in to the questions. Why are we defining groups? Structural factors may play a role. When naming a population there is not a fixed population. We need to have reasons from some sort of theoretical viewpoint in defining a population.

How similar are some issues for some of the immigrant communities? The immigrant experience is a natural thing to study, particularly with the changes to the immigration laws in this country.

Article: The basic principles of migration health: population mobility and gaps in disease prevalence. Emerging themes in epi. 2006 3:3

We need to understand what a migrant's health might have been like if they had not migrated. Don't forget to include community factors. Many migrants continue to be a part of the lives of their former communities and belong to multiple communities at once. Migrants are constantly going back and forth in language identity, behaviors. There are a lot of measures, but very little proof that acculturation scales work. In the black community, blacks code switch all the time.

Camara Jones - how often do you think about your race? Go to more heterogeneous community more likely to think about race.

There is frustration from an epidemiological view because acculturation captures aspects of how it relates to health, why infant mortality, etc. I would like to see more delineation -- what acculturation is delineating. There is difficulty in codifying acculturation, what decisions people make are happening in the context where they are switching codes. To the extent we are able to capture what the distinctions are, we capture contexts in different settings (medical versus home). We draw misleading conclusions when we fail to take these things into consideration. Contexts of conversations may be different in code switching.

What does this mean for policy? Acculturation, typically considered on the individual level, has implications for the types of policy that focus on individual behavior change and leads to policy recommendations that have an individual based focus.

The entire Latino Paradox is a political issue that developed when the term Hispanic was introduced into the census. Prior to that, Latinos had worse health outcomes than many groups. By lumping all Spanish speaking people together through the census [the data] creates the illusion of a paradox. By putting all the ethnicities together, the health outcomes began to look better. The Latino paradox is driven mainly by data on Mexican Americans. Since the number of Mexican Americans greatly exceeds the number of other Spanish speaking ethnic groups, and then these groups are aggregated, it hides the poorer health of many of the other subgroups. You can also see differences in those who identify as Hispanic black versus Hispanic white.

The Latino paradox in mainstream gives the impression that they are doing well.

Opportunities are at the local level when proximity is greater.

From an economic perspective Latinos are contributing to our society. It is shown by the fact that most anti-immigrant policies at the state level have not passed. We must sift through all the misconceptions.

3. Prevention of Chronic Disease Health Risk Behaviors

Presenters: Rajni Banthia and Andriette Ward

Facilitator: Karen Kim

Notetaker: Dana Thomas

Participants: Lucille Webb, Barbara Abdullah, Karen Kim, and Norman Yancey

Presentation Summaries

Andriette Ward

Obesity contributes to chronic disease. Ward is interested in the disconnect between what is designed in ivory tower and the needs of communities. Ward finds that obesity prevention and physical activity promotion designs by physicians and academics are not working because they are not designed with the community and understand the wants and needs of the community.

Ward's research from her scholar project focused on the safe school environment around nutrition issues -- How to define safe school environment with the goal of engaging kids in talking about the issues that impact them. For instance, the kids talked about how vending machines were quick because they often only had ten minutes between classes. Often academics and nutritionists stated that we should teach children how to make the right choice when it comes to nutrition. In talking with kids about what they wanted to see in the school, it was easy for them to tell what is wrong, but not so clear of what would work. For instance, vending machine companies often donate money to the schools for bands and sports teams, so it is not easy just to ban them.

Ward's current work in Los Angeles deals with lifestyle interventions for diabetes. She currently has a supplemental NIH grant based out of a larger lifestyle intervention diabetes grant with Leonard Epstein. The goal is to translate what is learned in the big study to what is really going on in the community -- trying to merge different sectors to come together to make a difference.

Community doctors often have a finger on the pulse of the community. Kids are now coming in with chronic disease, which has become a problem for health insurance companies.

Ward's goal is to create a resource manual that compile community assessments and templates for how to write letters to make their voices heard.

Rajni Banthia

Banthia focused her talk on health risk behaviors and how they impact health -- chronic illness is a spectrum that happens over a life-span. It is important to look at behavior.

Health disparity starts at the behavioral level. Are behaviors the crux of disparities? Is the number of people suffering chronic diseases really going up or is it really a result of us living longer?

Key behaviors that lead to chronic diseases are - tobacco use, substance abuse, dietary intake, physical activity, sexual behaviors, sleep, and adherence to medical regimen.

In terms of policy, what kinds of policy can help behaviors - is it taxation, zoning, creating infrastructure, crime, safety pollution. Policy can help facilitate behavior change.

When to start thinking about prevention, most prevention and promotion programs start at middle. Should it start with children?

Discussion

What role does behavior play in health disparity or how does health disparity play a role in behavior?

How to break in the cycle when socioeconomics play a role? It all goes down to economics. If this is the reality, where do we begin?

It's policy that can play a role, for example some states have passed laws eliminating vending machines in the schools.

Economics and policy is a driving force, for example, we continue to subsidize farmers who produce corn syrup. Big policies drive what happens with policies in the community, for instance, WIC gives 64oz of juice, so it gives the impression that if the parent gives more juice than it must be better. However, juice has implications on health, particularly for those already suffering from obesity or overweight issues.

What is the point of changing behaviors then if it is all about policy and economics? Policy can influence behavior. Our behaviors are legislated everyday. Changing behavior is not short term but something you have to work on to have long term affects. Resources that drive policy more than just how to get access to health care if don't have coverage.

What types of policies?

Stop subsidizing farmers to produce corn syrup and provide benefits for them to produce more fruits and vegetables. It is not going to change if we just say make better choices because it cost more to eat healthy.

Your environment has a lot to do with what happens. Grease on the streets – one street that has fast food, pawn shops, etc. this it impacts the environment and the behavior of the community.

A community can demand that no more fast food restaurants are built in their community.

Fast food tax – restaurants must pay property tax that goes to the gym memberships or building of gyms. Another option fast food has to pay taxes they would be forced to offer healthy choices at cheaper prices. Research shows that parents will choose healthy cheap choices over higher priced fast food.

You can teach children to eat healthy. Parents need the information to pass down to the children. Message must be for younger parents how to eat. Need to have structure that comes from parent. They also need to have a living environment where people can really make those choices.

Burden placed on individuals - how much can individuals be responsible for what's happening.

Sandtown in Baltimore, the community had the City invest \$200,000 in renovating a market place and encouraged the selling of fresh fruits and vegetables, now the market is 70% vacant with the remaining being fast food. The corner store is responsive to wants of the community. The best policy if no one is enforcing it is just a piece of paper. Why didn't the market work; the euphoria wore off.

Fresh fruits and vegetables

In Michigan store owners have gone to the legislator to request staggering food stamp payments to help them survive. At the beginning of each month, the stores are overwhelmed with patrons and cannot supply all the needs. For the remainder of the month, the stores have a difficult time maintaining stocks of fresh fruits and vegetables. By staggering food pay outs, it could help the stores by helping them maintain a better quality stock throughout the month.

Gas prices have helped people rethink transportation and opportunities for exercise.

Also suggested was that only healthy could be purchased with food stamps. We have to do something different. If fast food gets taxed, we will see upsurge of healthy foods.

Behavior is learned. Behavior is socialized.

4. Dismantling Racism to Reduce/Eliminate Health Disparities

Presenters: Carlotta Arthur, Derek Griffith

Facilitator: Kay Felix-Aaron

Notetaker: Toby Citrin

Present: Mercedes Rubio; Spencer; Yonas; Eng; Portia Cole; Bone; Geiger

Carlotta Arthur:

Camara Jones, CDC, "Gardener's Tale" – 3 levels of racism:

Institutional racism; personally mediated racism; internalized racism.

Research on racism is conducted in virtually every social science discipline. Each has its own focus, methodology, and way of conceptualizing the issues. One way that psych has looked at racism and health is to look at how racism contributes to the development of poor health. Psychology has been trying to understand racism – and developing measures of racism – perhaps because of their desire to not be seen as a “soft” field.

Paper published in 1999 – (distributed here) – conceptualized as a stressor for African Americans – authors conceptualized the biopsychosocial model of how racism gets “under the skin.” How racism actually makes people sick. This is more ammunition we have at our disposal to tell policy makers how important it is to address racism.

Impact of stress biologically and on mental health. Someone who may have a predisposition, stress may push them over the edge. Psychological stress – particularly chronic stress – can have an impact on physical disorder. Cardiovascular disease – pathway between psychological stress and coronary heart disease. Obesity – stress may act through hormonal pathways; behavioral pathways (overeating to cope with stress). Asthma and cancer (although pathways re: cancer is less known); Irritable bowel syndrome.

If racism is a stressor for African Americans and other underserved populations, you can see how this is of real concern to people interested in health disparities. Also, psychology looks at concept of racial identity. Some functions of racial/ethnic identity can be a buffer against racism, a protective factor. Thus, finding ways to help people develop sense of racial/ethnic identity may protect from impact of racism.

We need to merge research in various disciplines. One must show that racism is harmful not only for people of color but for society at large. This may determine the strength of the movement to eliminate racism.

How do we translate this into policy? The article distributed here is important, but how might we translate it into policy? Perhaps we don’t go to policy makers with this information, but rather go to community, show them why it’s important not to ignore or deny these issues, demand that something be done about them.

This may help make the transition from academia to community and into policy.

Discussion:

Kay: I’m a quantitative researcher. That’s my limitation. But how might one demonstrate the impact of racism on society at large?

Carlotta: How do we convince people that it IS harmful for people of color AND for society at large?

Lisa: Historically – who has racism benefited? Who has it harmed? You're saying it harms everyone.

Carlotta: If you look at the implications for society, it does harm everyone. E.g., Kawachi's work on income inequalities and health across the board.

Derek: The easiest way to support the argument you're making is starting from fundamental determinants of health (e.g., Link and Phelan) – structural factors affecting people's ability to access resources, opportunities, etc. that affect the ability to be healthy. Structured inequalities.

Why are poor people less likely to be healthy? A lot has to do not just from access to care but all the opportunities they're not aware of. One can look at institutional/structural racism – not as an individual factor but as it helps to structure people's opportunities for resources. This is a subtext of the work we did in North Carolina.

Eng: At the individual level – if individual level, if racism is harmful, is it also harmful if it is internalized superiority?

Carlotta: How do we demonstrate that racism is bad for everyone?

Geiger: There is not much evidence that having racist views is harmful, however we define harmful, to the people who hold them deeply. We're talking about power, access to resources. It is hard to demonstrate that those who benefit knowingly from a system of maldistribution of resources are harmed by that. You could make the case that it's only harmful if there are attempts being made to change it. The real question is whether it's harmful to society.

Geiger: That's better.

Carlotta: The psychologists say that racism harms the health of individuals. The challenge is demonstrating that racism is society's problem. If it's only harming African Americans, how do we get it addressed?

TC: We must look at history to answer the question whether one shows that society as a whole is harmed or the group harmed is activated to effect change.

Kay: Excellent discussion. Provocative question. Illustrates the challenges of moving across disciplines. Looking at how sociology, history, etc. can help.

Lisa: How useful would it be to look at parallels in classes and gender relations in looking at the question on a societal level? Looking at the oppression of women?

Derek: Community psych looks at oppression in context. Goal is to look within communities to figure out what's common and what are there differences.

Derek:

Dr. Rodney Clark is Assoc. Prof. at Wayne State University (died 2-3 weeks ago as relatively young man.) This work has been cited over 4-500 times. He has done a lot of work in this area.

As a Scholar in CHSP in NC, Derek worked on developing and implementing an intervention with the County Health Department . A couple of year since that time, we've been articulating the larger theory underlying this work.

Almost 50 yrs ago, ML King, talked about racism & segregation. He said there needs to be an approach both of attacking the causes and healing the effects. Intervention moves racism from looking at racism as individual factor to looking at it an environmental or institutional factor. This moves racism from a marginal perspective to the center. Look at racism as it affects health; specifically, access to care. It is a structural intervention – it does not to affect individual behavior but the context in which the behavior occurs. Systematic pattern of policies, etc., that perpetuates poor quality of care.

IOM Report *Unequal Treatment* showed the pattern was consistent.

Look at policies in health care, based on community organizing model: Assessment, research, action, reflection. Look at understanding people's perspectives on the problem. Examine what's the nature of racism in the institution.

Action – mobilizing resources to address the problem that has been identified.

Reflection – thinking about how to more effectively modify the intervention you're doing.

At the local health department, the group breaks into caucuses. Things need to be said in that group that can't be said when others are around. Whites need to say things to whites; people of color need to say things to people of color. They also meet simultaneously. And, must come back together to discuss issues they're raising – why important to consider how it affects people in the groups.

Lisa: The evaluator's color is an issue.

Derek: The process is led by a change team. It can be any constituent group. We began by asking how we'd know if the issue was being addressed. We recognized factors outside the organization.

Last part is the relationship of the organization to the larger community. The health department is a gatekeeper to health services. Lots of staff live within that particular county, and have their own perceptions of what they're bringing to the table.

Community Organizers see that people's ability to understand the structural racism – an outcome for them is not sufficient to ...how to balance the values.

The Health Director was very involved. Difficult to generalize beyond this organization on one level – 60-80 staff members – heads of the divisions were very active.

Yonas: Challenge of turnover.

Lee: Has the culture changed?

Yonas: Masters student is doing a qualitative assessment. The results are mixed. We developed a questionnaire relating to the interventions. 3 health departments are involved – trying to define an “antiracist health department” – how do we know we're making progress? The tough thing at first is realizing that these are racist health departments.

Lee: We did this in our church. Just bringing people together to talk about it.

Webb: We were put on hold by the health director – felt we were ‘beating up’ on white people. We've now watered down the project.

Geiger: There's massive polling data documenting the denial of racism.

Geiger: The prevailing opinion is that racism is dead; discrimination no longer exists. It was all fixed by the civil rights movement. If there are perceivable differences now, it's their own fault. The reconstitution of illusions of race and racism in the name of genetics also loom ahead. Multiple aspects of this – Nancy Krieger has a gift for article titles. One was “If race is the answer, what is the question?”

Derek: Are we talking about disparities, inequities or inequalities? How do we start to deal with these issues of quality of care? How productive is it to talk about racism explicitly? Putting racism in the context of the other issues (e.g., quality of care) raises issues that need to be dealt with to get people to realize the nature of the problem. What's unique in this is that they're now moving into health and health care. This is why the partnership we have in this program is important to bridge the differences.

5. Environmental Justice Breakout Session

Presenters: Mansoureh Tajik, Tamara Dubowitz

Facilitator: Alex Allen

Notetaker: Shawn Kimmel

1) Mansoureh Tajik: industrial hog production concentrated in predominantly African-American communities, without community input into how land will be used, or how it might be used for other options. Hog production produces:

--20,000 lbs. hog waste per day

- 14 billion lbs. of waste every year
- football size open pits for hog waste

The group “Concerned Citizens of Tillery” was organized to impact policy— in combination with UNC, which was already involved in looking at the community health effects of industrial hog production; this group organized a moratorium on new hog operations.

Hog production causes higher levels of odor, and raises levels of stress, asthma, and blood pressure—

This project involved in-depth interviews with rural community members on quality of life, how their lives were challenged every day, in violation of nuisance law, by industrial hog production operations. Using nuisance law as a frame, the interviews sought information on activities community members would normally pursue, but avoid because of industrial hog operations, such as cooking out, hanging out laundry, etc.

2) Tamara Dubowitz: Her dissertation looks at the neighborhood characteristics of immigrant enclaves—and discovered that women who lived in neighborhoods with higher proportion of foreign born members had a much better diet. Now looking at why this was the case. Issues of food access, etc.

She is now working on issues of obesity, social and physical activity, and the built environment.

She is also looking at how various kinds of community asset Mapping—may be used at the local and state policymaking level, to look at such things as:

- the Proportion of Green space in each neighborhood; the kinds of food stores in the neighborhood: convenience vs. grocery stores, fast-food, specialty, carry-out, etc., paired with information about:

- socioeconomic indicators, % in poverty, and median price of an owner-occupied home

- Behavior Risk Factor surveillance data

- Racial and socioeconomic segregation (sometimes hard to separate these from differences in physical features of the neighborhood)

- “Walk ability” of a neighborhood

- Safety concerns, surface amenities

Questions: A) How do all of these things shape pathways to problems with diet and lack of physical activity?

B) How do we translate this kind of neighborhoods effects research into policy?

C) How do we change these factors at the level of the built environment?

Through the law?

Responses to Break Out Session Questions

Question 1.

We should look at historical trends. Especially through use of census records for each decade, and changes related to policy changes and work of community groups in particular areas over time.

--BRFS Obesity maps data is so limited because it is based on telephone survey data.

--We could look at different kinds of use of spaces, along with shifts in income and the race composition of particular areas...

GIS mapping technology is especially good tool to help policymakers envision changes over time....

What's included in "service amenities?" *Reference USA*//

It was suggested that Tamara should look at affluent minority communities, for comparison.

Question 2. How would this research be used by the communities themselves to mobilize the communities to change policy, and to help community people run for local public offices?

What is potential of Grassroots movements to shift the mode of community response to pollutants, from one of merely reacting to pollutants by retreating from outdoor activities, to proactively doing something to redress the problems of rural pollution?

One industrial hog industry replaces 50 to 100 small farms, so that one large business ends up replacing a whole community of businesses. The one industrial operation decreases (through automation) the number of employees required for processing.

There is a tremendous use of antibiotics, which are causing many more resistant strains of disease to develop in these communities

On top of this, industrial farming started bringing in migrant workers instead of employing local community people.

--The Chavez farm workers mobilization model was mentioned, but it was noted that in order to mobilize, financial support is needed. Mobilization also requires other resources/skills that communities often lack.

But such resources can be developed over time—

Example: people got mad enough to talk to their Church, and then the local Church, with its authority, began to speak out on health impacts of the industrial farming.

Question 3. What is the obligation of researchers to keep community mobilization effort developing or keep it supported?

--Researchers should help the local community to connect to external resources at the national level for developing the capacity of local community response.

--Researchers should use academic research as basis for publications that will get important information from the research into the mainstream media.

6. Health Care Services and Access

Presenters: “Toby” Datta, Lisa Benz Scott

Facilitator: Kay Felix Aaron

Notetaker: Linda Randolph

Toby Datta:

PowerPoint handout – neighborhood characteristics and cervical cancer screening: Using multilevel techniques to assess independent effects.

Subjects recruiting from subscription list of Essence magazine, Professional organizations, and friends and family of participants

This research is secondary data analysis; subjects are not available

Methods: www.mlwin.com run by Harvey Goldstein

Discussion of methods to look at other levels of neighborhood characteristics: the use of handhelds to enter data, such as number of liquor stores, etc. to characterize neighborhoods

Discussion centered around involvement of community providers and women themselves to interpret findings; qualitative research that could accompany this type of research; the use of screening vans located in specific neighborhoods and distribution and use of cell phones to keep in contact;

Lisa Benz Scott: Telemedicine technology that was originally developed for monitoring the elderly in the home; can that technology be brought to the community setting such as a church, a food pantry.

Technology describe; digital camera; vital signs; diabetes monitoring with use of community health worker and nurse practitioner with traditional health services delivery backup; the technology company is putting in resources; Dean of the school has disclosed his consultant relationship with the technology company

Goals: increase awareness; provide information; monitoring; increasing access to care

Advantages: patients become active in managing their own health; links under- and uninsured to prevention strategies

Issues: church acceptance of technology; surveillance and HIPAA data requirements; liability concerns

7. Politics of Social Inequalities

Presenters: Dean Robinson, Ella Greene-Moton

Facilitator: Joe Gone
Notetaker: Kasey Hanson

Dr. Robinson spoke about his issues of interest -- political barriers that affect the social determinants of health.

- People don't think systematically about health (local, state, national levels)
- When does power listen to truth? It's not the more sophisticated model. It's just the truth, which may go beyond the research that's available to us.
- How is it that Great Britain so far ahead of the US, when the science is the same?
- The key issue is political power, and citizen's participation. Citizen should be able to influence policies that affect the citizens.
- What is it about US politics that short circuits' citizen participation?

Ms. Greene-Moton spoke about the politics involving the community voice

- REACH 2010 – addresses infant mortality in the African American community in Flint Michigan.
- The community decided that they wanted to talk about racism – this may be contributing to the infant mortality. Many of the barriers that exist in our society are based on racial discrimination.

Questions/Comment:

How can public health people do interventions when we don't address the risk factors that really effect health in the community? We have health messages to give, but communities have other issues that need to be addressed. We need folks who are really walking the walk and talking the talk, who are really willing to design studies that address the real issues. Some of the rules and policies from the institutions are going to have to change. We understand that folks could lose their jobs for not producing, though it takes time to address the real needs of the community.

Part of the solution is to have the right researchers talk to the right university person to communicate the changes that need to happen.

It's troublesome that we aren't more involved in health policy legislation. We should be a political force. **The CHSP are in key position to bring issues to legislatures. WE don't have to dedicate our lives to policy, but we can be a voice, and we are failing to do what seems easy to do...it's one more step.**

CBPR is where we can bring the policy work and the political motivation on the ground together. We haven't done it yet. England has been doing major work, since the Atchinson Report. This requires all of the government agencies working together to address neighborhood health renewal programs. The English have a real commitment to addressing disparities.

In terms of talking passed each other, I think that we aren't speaking the same language. Scientists are trained to be skeptics. Community members are not.

Advocacy is not always a safe thing to do. Advocacy and lobbying are seen as the same, and some believe it will jeopardize the university/organization funding.

Is healthcare a common good? Whose responsibility is it to provide access to healthcare? Other countries answer these questions differently.

It takes power to get funding to do advocacy work. The science can be there but no funding. Researchers should consider that it's good to make good science, but know how their research plays a role in policy.

Some have been told that as a public health researcher, it's not appropriate to have advocacy related to the work that public health professionals do.

There are different forms of knowledge, and power sanctions certain types of knowledge.

We know that people with more money and education have more influence on policy. Academics have both, and so it's negligent to not be involved with policy making.

Many Americans believe that we are where we are because of our own merits, so the thought of redistributing goods, means that others should contribute to someone else's success. If we change our thinking about our own accomplishments, this could help folks see that redistribution is an effort of equalizing what is necessary. Then individuals can climb as high as they can.

8. Sexual Health, HIV/AIDS, and Addiction

Presenters: Dionne Godette, Jay Chunn and Scott Rhodes

Facilitator: Carlos Zometa

Notetaker: Renee Bayer

Dionne Godette (no handouts)

Blacks' use of alcohol is low but the consequences of that use are high. She is looking at the etiology toward looking at prevention.

She has published a framework for looking at old information. The framework looks at the heterogeneity within groups. For instance, Asians are doing the best, so why do we compare to the statistics of Whites instead of Asians. We should look at the protective factors in that community that we can apply to other groups.

Policy implications:

- **Rotate our joint meetings to DC and include lobbying in the meetings.**
- **Develop relationships with program officers so that they use our research when replying to congressional staffers for inquiries.**
- **Start locally with our research and in areas where we live. Understand the epidemiology of our own communities.**

Jay Chunn (see handouts)

We are in the third wave: the first wave is the basic environmental public health interventions such as water, air, etc. The second wave is bacterial, immunizations, etc. The third wave is us and how we make ourselves sick. Behavioral change is what we look at as the key, not treatment. 96% of what the Black community dies from is preventable. We're not training our professionals to prevent disease. He developed a behavioral mapping process to look at behaviors and prevention. This is community-based.

We need to work on policymakers for more funding for prevention. We need to use social marketing.

Scott Rhodes (see handout)

This CBPR study is being reported in the JAMA Men's Health Issue. Scott's question is how do we move this research into policy.

Discussion:

People affected by these problems can really be effective in lobbying for increased funding in this area.

The issue of the brothels in Scott's research is interesting. What policies could be used to shut these down? Can you make connections for people to understand how this is impeding health?

Take Scott's findings to the city / county councils along with migrant workers and ask for a hearing. Dr. Chunn gave the example from Baltimore where the mayor became involved and set up a task force. This led to the passage of a law to create a commission. The commission is looking for funding and creating policy. Dr. Chunn would be happy to consult with Dr. Rhodes.

Use findings to develop a policy agenda. Use the findings as a tool to talk with partners about ways to move each issue into policy agenda.

Involve churches. In Flint, they just got funding from a local foundation for "YOUR Blessed Health". The ministers and their wives will be going through training and then making presentations on HIV.

9. Adolescent Health Roundtable

Presenters: Shani Harris Peterson, Portia Cole

Facilitator: Lee Bone

Notetaker: Kasey Hanson

Introductions:

Attendees: Gishawn Mance, Dionne Smith, Kacey Hanson, Dawnavan Davis, Andriette Ward, Caryn Rodgers, Abdullah, Norman Yancey, Renee Bayer, Dionne Godette, Barbara Abdullah, Norman Yancey

There were 2 presentations:

Dr. Cole's presentation addressed Adolescent Mental Health in the Context of Work/Family Policy (see handouts)

- The need for mental health for adolescents has been documented as great in several sources
- Healthy People 2010 and the National Initiative to Improve Adolescent Health address mental health at adolescent level
- Health behaviors are established during the transition time of adolescents that can affect both their current and future health
- Adolescents have many influences: family, school, media, employers, health care providers, etc.
- Lack of parental involvement due to work influences adolescent behavior
- The Family and Medical Leave Act is currently restrictive re: leave for parents who may need to take leave for family needs
- There is a need for a policy response, to help parent have more choices so that they can address their adolescents' health needs.

Dr. Peterson's presented her findings from "Project Power!" (See handout)

- The project was a media-based, sexual risk reduction program for adolescent girls.
- An after-school program was designed for girls age 11-14, and the girls valued having a place just for them.
- It was a 12 week program to tease out what things influenced their sexual decisions.
- They had an opportunity to journal about one topic each session. The topics addressed how they viewed themselves and their relationships with others (friendships)
- Based on their journal entries, they developed a script to make the interactive DVD.
- The girls efficacy increased by producing this DVD.
- Next steps: Make a professional version of the DVD; test the method; reproduce the DVD (it's cost effective), disseminate into schools

Questions:

What social and environmental determinants came up with the girls about their sexual decisions? They don't really see the determinants. But they do talk about their relationship with their mothers. Absentee parenting was not discussed. They focused more so on their relationship with friends.

Can a parent DVD be produced to let the parents know what's going on and how these girls think? In Shani's research it was difficult to get parents involved, but it's a great idea.

How could the determinants be addressed in the materials that are disseminated?

Portia, what research do you see needing to be done to address the work/family link? Focus group discussions among policy makers, parents, and workplaces would be a great start. There's an interesting connect between these two topics. Women are at work, and they have children. These children become teens, and they start having kids. Work days are missed because mothers have to leave to take care of children, but they need to work. Many mothers were teen mothers themselves.

Was there discussion in Shani's video about birth control? Yes, and we discussed the stigmas (e.g., condom use and boy breaking up with girls because she wants to use a condom).

Are there plans to replicate the program used to develop the DVD? Renee has a graduate student that may be able to help with replication

Who would use your product once you've made your final product? Shani's looking at a way to let a lot of folks know about it, as oppose to making individual contact.

How would you package what both of you have done, and make it available to policy makers? Portia would put out work/family policy literature. There's no color to this issue, yet. She would seek out data to manipulate the variable to show that this is a color issue that needs to be shared. The number of children these women have and the mental health status of these children, and the marital status of the women should also be included. Shani would seek out folks that really know how to get this into the hands of policy folks.

Overall, our work is missing social marketing. We should talk about this over the next couple of meetings. Shani's project could be taken to the city council and the school board. Portia could storm city hall as well, to make the issue seen. Bringing mothers and their children to the policy makers.

10. African American Community Research, Infrastructure and Power

Presenters: Stephen Thomas and Angela Odoms Young

Facilitator/notetaker: John Hatch

1. How do presenters hope research in this area will be used?

Reduce errors by agencies and organizations seeking to do health promotion in African American Communities.

Katrina was a wake up call for increase levels of self sufficiency and organization in African American populations in United States.

There is need to energize existing organization structures such as the church, social, civic and advocacy organizations in the community.

Professor Young has demonstrated the potential role and function of the African American church . Does this strategy have broader implications? Yes, much of the disproportions and the burden of bad health will require action by families and neighborhoods. Ways to reach the people with technical information within a supportive structure is essential.

Dr. Norge Jerome – reports must be accessible to all researchers. Writing in a style usual to one's profession is a must.

Dr. Dodds - What type of papers on social structure and organization would have been of value early in your career? Answer: More knowledge on how various elements of community function. Carol Stack's book "*All Our Kin*" was especially helpful.

Same question to Dr. Israel. Understanding of the rationale for attitudes and actions was useful.

Dr. Hatch - But what about funding agencies and unrealistic oversight. Much of the benefit of the MS health project back in the 1960s - early 70s was actions not in the project paper. It was important to respond to culture/social reality and we didn't know what that was before close interaction with the community. There is need for high quality qualitative data.