Spirit of 1848 Progressive Pedagogy Session Reportbacks (from APHA annual meetings, 1995-2019)

2019, **2018**, **2017**, **2016**, **2015**, **2014**, **2013**, **2012**, **2011**, **2010**, **2009**, **2008**, **2007**, **2006**, **2005**, **2004**, **2003**, **2002**, **2001**, **2000**, **1999**, **1998**, **1997**, **1996**, **1995**

Source: http://spiritof1848.org/apha%20reportbacks%20&%20attendance.htm

Additional resources: http://spiritof1848.org/resources.htm

And: http://spiritof1848.org/courses.htm
(with 2001 resources linked there added to the 2001 section below)

Other Syllabi

National Library of Medicine's History of Medicine: Online Syllabus Archive

2019 (p. 21-25):

● PROGRESSIVE PEDAGOGY

This session was attended by ~ 90 people.

Fighting forward: pedagogies that promote & create a radical science for health justice
(*Tues, Nov 5, 8:30- 10:00 am; Session 4066.0*; PCC Room 201A)

8:30 AM: **Introduction – *Vanessa Simonds, ScD,*** Rebekka M. Lee, ScD, Lisa Moore, DrPH

8:35 AM: **Decolonizing evidence: learnings from a multi-year partnership between the Anti-Eviction Mapping Project & San Francisco State**

University's Master of Public Health program – *Maureen Rees, MPH,* Adrienne Hall, MPH, Maria Acosta, MPH, Laura Mamo, PhD 8:50 AM: **Advancing an anti-racist agenda in local government –** Jenna Gaarde, MPH, ***Zea Malawa, MD, MPH,*** Solaire Spellen, MPH

9:05 AM: **Zine development as a pedagogical tool for critically evaluating how social justice & epidemiology relate –** Danielle Gartner, MS, PhDc, ***Jessica Islam, MPH, PhDc***, Corinna Keeler, BA, PhDc, Katherine LeMasters, MPH, Elizabeth McClure, MS, PhDc, Arbor Quist, MSPH, PhDc, Adrien Wilke, MSPH, PhDc

9:20 AM: **Disrupting public health education: a social justice pedagogy – *Keilah Jacques, MSW,*** Sophia Geffen, MPH, Julia Rocher, MPH, MSW

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

Vanessa Simonds (Spirit of 1848 Coordinating Committee; Montana State University, Bozeman, MT) introduced the session's theme and the speakers, who were selected because of how their work with pedagogy promote & create a radical science for health justice. The introduction included a Land Acknowledgment, directed to the Lenape Nation of Pennsylvania, which Vanessa, who is an enrolled member of the Crow Tribe and descendant of the Blackfeet Nation, expanded in accord with her customary traditions.

-- **Maureen Rees, MPH (San Francisco State University, SF, CA)** described the pedagogy involving an academic- activist partnership on housing evictions and health. She first became involved in this project in 2016 as an enrolled student in a qualitative methods course required for the 1st year MPH students in their 1st semester (HED 884, taught by Prof. Laura Mamo, at San Francisco State University), and then, in 2018, was one of the 3 MPH alums who participated in the project. The group with which the course partnered is the Anti-Eviction Mapping Project (AEMP): https://www.antievictionmap.com.

The pedagogic goals of the course were to promote use of a critical lens, question the content and methods of dominant knowledge production, and develop and apply skills in context, with this context explicitly defined (e.g., students who also need housing in a city with major housing shortages and rampant gentrification). An additional topic-specific aim was to gain knowledge about the individual and community effects of evictions and displacement. The activist partner group, AEMP, is a collective focused on feminist data visualization, data analysis, and storytelling. It was founded in 2013, with the goal of fighting evictions and predatory landlords. An example of one their maps was shown, for SF (noting that their website has data for cities around the US), with red dots showing where evictions have taken place, and blue dots linked to oral histories of specific individuals who had experienced evictions, so that they could tell their stories, with the interviews conducted by and transcribed by the MPH students enrolled in HED 884.

The process and strategy of the class was as follows: (1) developing a memorandum of understanding for the partnership, which included consideration of the ethics of obtaining oral histories; (2) learning about the context into which the researcher is entering (via website-based learning, via visiting different areas in person); (3) gathering data – specifically, the oral histories of persons who had been evicted and displaced; (4) listening, reflecting, and discussing – based on transcribing the interviews (N = 16); (5) coding across interviews and writing memos about the coding strategies; (6) negotiating the findings and synthesizing data themes; and (7) compiling and creating a report, to be shared with researchers, residents, and activists.

Major themes the students identified in the oral histories pertained to: (1) social isolation and root shock at dislocation; (2) structural inequalities and power imbalances driving evictions; (3) the stress, trauma, and toll of fighting for survival; (4) violent evictions and displacements – their

occurrence and the harms caused; and (5) the importance of community engagement, resistance, and activism.

Student reflections on the benefits of engaging in this project included: (a) gaining skills in critical research and critical knowledge production in their 1st semester of their MPH program, thus giving a sound basis for framing the rest of their pedagogy; (b) hands-on learning about how to do qualitative research in an ethical way; (c) the ability of qualitative methods to reveal and elevate issues not always easy to capture with quantitative methods; (d) realizing the value of community expertise; and (e) learning how to make a poster to present findings in an accessible way. Ways in which the collaboration was mutually beneficial to the students and AEMP were: (a) the students gained exposure to the design and analysis of qualitative research from an antiracist, feminist, and decolonial lens, while learning about the political economy of health and rapid displacement; (b) AEMP benefited from the students doing the time-intensive work of conducting, transcribing, and analyzing the oral histories, and discovered the value of employing a public health lens (the first time they had done so), with the oral histories also adding depth to the data-driven maps of evictions and displacements; and (c) 3 MPH students joined the AEMP collective, further pointing to the two-way value of the partnership.

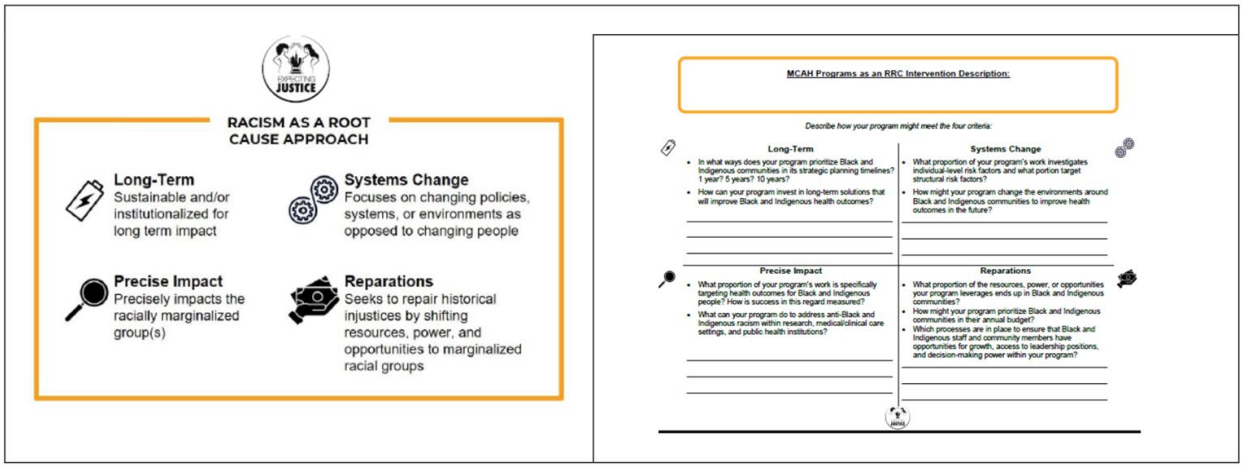
-- Zea Malawa, MD, MPH (San Francisco Dept of Public Health, SF, CA), with her colleagues **Jenna Gaarde** and **Solair Spellen,** then described their project to create pedagogical tools to advance anti-racism, including in public health programming and public health research, through the concrete work of "Expecting Justice" (see: https://www.facebook.com/expectingjustice), which is a strategic long-term initiative to improve the experiences and health outcomes of Black women and Pacific Islander women who are pregnant. A key objective is to help health departments get beyond just acknowledging racism exists and saying the word – and instead doing something real about it. In June 2019, Malawa and her "Expecting Justice" co-authors Spellen and Gaarde published "*Race Equity 101: A Series of Tools to Advance Racial Equity in the Workplace*," which draws on the Government Alliance on Race and Equity's "Normalize, Organize, Operationalize" framework from GARE and Race Forward's "Actions to Advance Racial Equity"; the book is available at: tinyurl.com/raceequity101.

The co-authors opened with a land acknowledgement that asked people to move beyond simply being "good settlers" and instead take steps to: gain awareness of Indigenous issues and share this with friends and colleagues; donate time, funds, and resources; and not homogenize Native communities, which are myriad and distinct. A related reminder was that Black women in the US who are descendants of enslaved persons brought forcibly to these lands cannot be conceptualized as being settler-colonists or immigrants.

The presentation then started with a brief recap of how public health is behind the times in addressing racism as key cause of racial/ethnic health inequities, with systemic racism still barely mentioned in the public health literature. To bring to life the issue of systemic racism for colleagues who have not grappled with this issue before, they described how they use the example of a monopoly game in which several siblings are playing. The game goes on for four

hours, during which time 1 sibling is not allowed to play, but instead is required to do chores. During the last hour, the excluded sibling is allowed to join in. It is obvious that there is no way this sibling can catch up, unless there is a redistribution of wealth and/or a change in the rules of the game.

To concretize what this means for public health, they have devised a “Racism as Root Cause” approach, with the acronym “RRC” deliberately meant as an alternative to the conventional “gold-standard” of “RCT” (randomized clinical trial). Key features of the RRC approach are shown below (as delineated in a handout provided at the session):



With regard to what the RRC looks like in terms of concrete practice, they gave an example focusing on birth outcomes and WIC (the US Government’s Special Supplemental Nutrition Program for Women, Children, and Infants; see: https://www.fns.usda.gov/wic), which is intended to be a “universal” program, but which is not reaching key communities in need – in part because the process of obtaining WIC is difficult and very undignified for Black women (see: https://www.fns.usda.gov/wic/wic-how-apply). Moreover, with regard to reducing preterm birth (PTB), deficiencies in standard health department practice were demonstrated when, in 2017, the California Public Health Department issued guidance that reduced all recommendations to the individual level, without regard to context – i.e., take a daily vitamin, go to the doctor, don’t smoke, and get healthy foods and exercise. Such an approach had no understanding of racism as a root cause, focused solely on individual behavior change, and overlooked structural barriers to good health.

In a context of worsening Black pregnancy outcomes in the SF Bay Area (e.g., PTB among Black mothers rose from 13.9% in 2010 to 16.0% in 2017), “*Expecting Justice*” is piloting a new intervention premised on an RRC approach. It is a pregnancy income supplement program which provides an unconditional cash transfer, on a monthly basis, to Black and Pacific Islander women who are pregnant up to 5 years postpartum, i.e., the age at which the child is ready for pre-school. The design qualifies as being an RRC because it is long-term, has precise impact, involves system change, and constitutes a form of reparations. Work is underway to enact policies and laws to institutionalize and fund this approach.

-- Jessica Islam, MPH (Johns Hopkins Bloomberg School of Public Health, Baltimore, MD) and colleagues next presented on challenging pedagogy about epidemiology at a major school of public health using the approach of making a zine. One of the team members, Daniel Gartner, who is Chippewa, from Michigan, opened with a land acknowledgement that recognized the Lenape of Pennsylvania and also of Oklahoma, and the histories of displacement, resilience, and sovereignty that must be acknowledged.

Different members of the team then described what a zine is and how to make one – whereby zines are self-published booklets intended to spread ideas, using words, images, and pictures. The zine they produced was created by a group of epidemiologists (mainly students, but also some faculty) and justice advocates, to address the lack of a critical lens and social justice focus in mainstream epidemiology. They solicited participation via sending an email to their respective groups, and then invited a 1-page submission per person. The students then worked collectively to organize the 28 submissions they received in relation to subtopics and themes. Key themes that emerged were: (1) the limits of epidemiology and research to address community concerns; (2) the role of "race" in epidemiologic models; (3) institutional and structural factors driving health inequities; and (4) the role of justice in epidemiology.

In Fall 2019, they published their zine: *"WAIT ... ISN'T ALL EPIDEMIOLOGY SOCIAL JUSTICE?"* --A ZINE OF COLLECTED THOUGHTS AND VISIONS ABOUT POSSIBILITIES FOR OUR DISCIPLINE -- THE UNC-CH EPIDEMIOLOGY & JUSTICE STUDENT GROUP, VOLUME 1, FALL 2019 – available online at: **bit.ly/epi-zine-online**

They used crowd-funding, obtained from alums, to cover production costs so that they could disseminate the zine widely, and they found that the zine sparked useful discussions among current students and faculty as well as alums.

Reflecting on zines as a pedagogical tool, they noted that: (1) the creative process of making a zine sparked new insights about the epidemiology and social justice; (2) zines provided an accessible format for sharing ideas both within and outside the university; (3) making a zine helped flatten some of the hierarchies in academia; and (4) having a tangible object can help promote discussion of ideas. They now are exploring the idea of making "tiny zines" (which use only a single blank sheet of paper), and encouraged people to reflect on their time at APHA by making such a tiny zine, following the approach developed by Sarah Mirk (see: https://www.mirkwork.com/year-of-zines) -- and they provided the paper for people at the session to make such a zine!

-- **Sophia Geffen, MPH (Johns Hopkins Bloomberg School of Public Health, Baltimore, MD)** next described work she and her colleagues are doing to advance social justice pedagogy

for public health education at JHU, a major US school of public health. Before beginning, however, she expressed appreciation for the land acknowledgements that preceded her presentation and said this is a practice she will now follow going forward.

Geffen started by saying a key impetus to the initiative underway was the death of Freddie Gray, a 25 year old black man who was arrested by the Baltimore police in April 2015 and who died due to injuries he experienced while in the police van. His death spurred a wave of protests against police brutality, and also triggered work at JHU to expand the pedagogy to address social justice, including via service-learning pedagogy. The aim of the initiative, SOURCE, is to affect both the training of faculty as well as what faculty teach in the classroom. The first year of work has focused on developing a strategic plan and involved all stakeholders: students, staff, faculty, and community members. Guiding theoretical frameworks include: critical consciousness, critical race theory, social cultural theory, and transformative change theory.

Current work is focused on developing a “glossary of terms,” and also a “spiral definition,” which helps delineate how learning is an iterative process. For each component of pedagogy, they are creating forms to delineate relevant axes of power & privilege, social justice identity formation, and actions for change, and are getting stakeholder feedback. It is a work in process, with backing from the new Dean at the school.

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

(1) Ways in which the anti-eviction project is including, as part of its pedagogy, how students are often part of resident displacement – these issues are explicitly addressed, and contribute to students becoming housing activists.

(2) Whether the JHU initiative will be taking on the issues of reparations – and the reply noted that the first step, now underway, is an examination of the role of JHU in Baltimore in relation to histories of racial injustice.

(3) Clarification that the “long-term perspective” for the RRC refers to sustainability for implementation of any given project over the long-term, and also that RRC, while developed for interventions, can plausibly be used to guide research.

(4) Regarding what the different presenters learned and/or found surprising while engaged in their different pedagogical projects: (a) for the zine project, how it is possible to communicate abstract ideas using drawings, and less text; (b) for the JHU project, how it is possible to take different approaches to pedagogy to ensure it addresses social justice; and (c) for the RRC

project, how hungry people are to learn about this approach and have an impact – people are ready, they just need some help and support.

(5) Whether the RRC project experienced "pushback" at the SF Department of Health and, if so, how it handled this – with the response being that despite SF's "progressive" reputation, it is the US city with the 2nd highest level of Black unemployment (the 1st is Detroit), and there was an energy among ground-level staff at the SFDH for this project, so they engaged in "ground-up" organizing to build support for this approach in the agency. A useful tactic for pushing on opposition was to phrase questions as follows: "Can you help me understand why you can be so comfortable with these persistent health inequities?" The point was to make it uncomfortable for people to be comfortable with injustice, and use this to spur change.

(6) The three sets of land acknowledgments prompted one audience member to reflect that while he typically says he personally has no conflicts of interest (COI) to report when he gives his presentation, he is now thinking he should speak to the complicity of academic institutions in producing and perpetuating health inequities when discussing COI.

(7) A public health student who is also in a police department spoke to the importance of bringing a racial equity lens to the work, and could see how an RRC approach could be the next step.

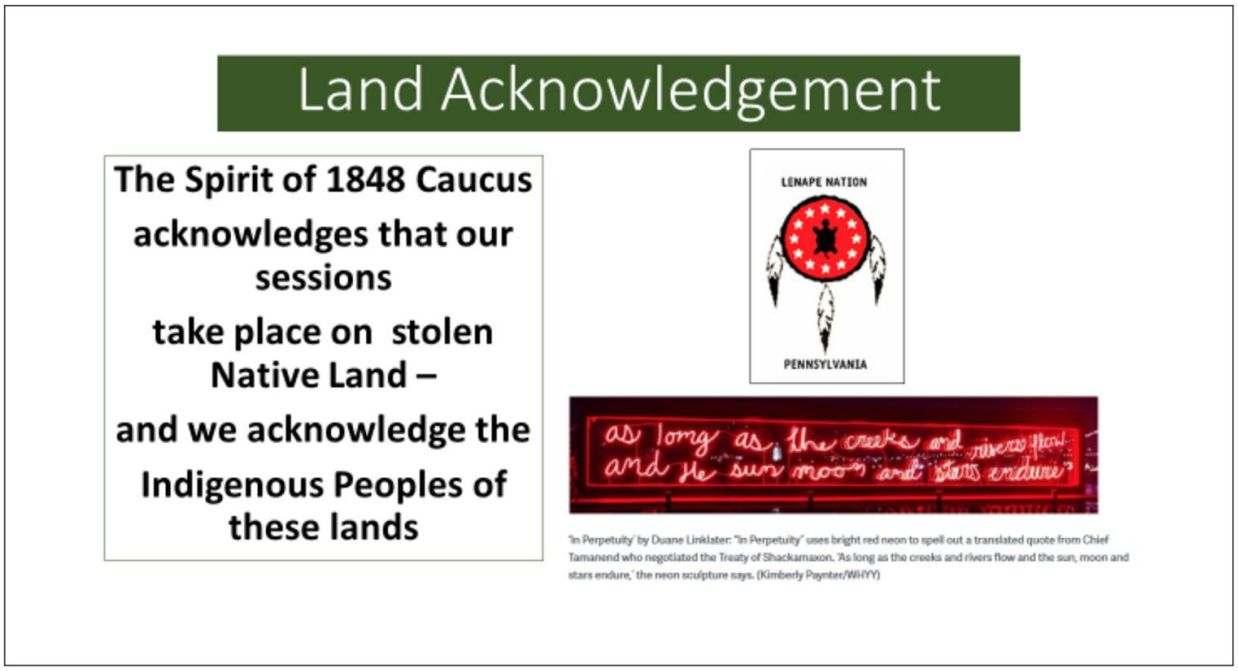
(8) The presenters were asked if they have written any papers on their work that can be cited – and the zine team said they are working on writing up a piece, and the RRC team has published a book (link provided above) and are likewise working on preparing a manuscript.

(9) A reminder that the Spirit of 1848 website lists different kinds of pedagogical resources that address many of the issues raised in this session – these include: (a) the descriptions of the sessions on progressive pedagogy we have held over the past 25 years, included in each and every annual report (see: http://www.spiritof1848.org/apha%202019.html); (b) a handful of syllabi that 1848 members have volunteered to share, plus links to relevant syllabi compiled at the National Library of Medicine (see: http://www.spiritof1848.org/courses.htm).

Also from 2019:

New Spirit of 1848 policy about Land Acknowledgement. Starting with our Spirit of 1848 sessions this year, we have begun a formal tradition of always including a Land Acknowledgement slide with the introduction to each and every one of our sessions, as a very

first step towards histories that must be acknowledged, as prelude to reparative action. The version of this slide for this year's conference, in Philadelphia, PA, is as follows:



Background information on the Lenape can be found at: https://www.lenape-nation.org/, with more background at: https://www.lenape-nation.org/2nd-project & at https://www.facebook.com/IPDphilly/?ref=py_c & also https://whyy.org/articles/neon-monument-to-phillys-indigenous-history-glows-again-at-penn-treaty-park/

We have additionally decided, based on constructive comments offered at the conference, to amend our call for abstracts so that we make clear, for each session, we invite submissions that bring a critical Indigenous lens, drawing on Indigenous theories, knowledge, and methods, to the specific topic that is the focus of each session.

2018 (p. 16-18):

This session was attended by ~ 60 people.

Making hope practical: progressive pedagogy that enhances capacity for civic engagement in the collective struggle for health (Tues, Nov 13, 8:30-10:00 am; Session 4068.0; SDCC, Room 8)
8:30 AM: Introduction –Lisa Moore, DrPH, Rebekka M. Lee, ScD and Vanessa Simonds, ScD
8:35 AM: Leaders in health community training program: building capacity for health equity – Rebekka M. Lee, ScD, Ra'Shaun Nalls, MPA, and Hila Bernstein, MPH Candidate
8:50 AM: Building local knowledge and power to advance health equity through justice reinvestment strategies in three California counties – Diana Aranda MPA, Tamisha Walker,

Noha Aboelata Dr, Danielle Mahones, and Dee Emmert MDiv
9:05 AM: Advocating for collective action to increase food security among immigrants: an online training for the public health workforce–Emilia Vignola, MSPH, Emily Franzosa MA, DrPH, Samantha Cinnick, MPH, CHES, CPH, Nicholas Freudenberg, PhD and Maria Murrman EdD MS
9:20 AM: Environmental learning for change: student connections empower action – Trina Mackie, PhD, MSPH
9:35 AM: Q&A

Vanessa Simonds (Spirit of 1848 Coordinating Committee; Montana State University, Bozeman, MT) introduced the session's theme and the speakers, who were selected because of how their work with pedagogy "makes hope practical."

-- Ra'Shaun Nalls, Rebekka Lee, and Hila Bernstein (all at the Harvard T.H. Chan School of Public Health, Boston, MA) and **Sahar Lawrence** (Roxbury, Boston, MA) described the "Leaders in Health" community training program they have designed that builds capacity for health equity (see: https://www.hsph.harvard.edu/prc/community-engagement/leaders-in-health-community-training-program/).

Ra'Shaun Nalls started by explaining that the 8-week course takes place at the Harvard T.H. Chan School of Public Health and: (1) includes a public health 101 curriculum, to familiarize participants with public health concepts and vocabulary (which is useful for the issues they care about as well as for writing grants and dealing with public health professionals); (2) builds organizational capacity; and (3) fosters community/academic partnerships. The program sessions start in mid-September and the final capstone project is presented in mid-November, after which participants receive a $200 stipend for being in the program. Thus far, the program has trained 56 Boston practitioners across 6 cohorts. These participants are drawn from diverse communities in the Boston area and must have little to no public health experience (no individuals with MPHs are enrolled); they can range from being early career to director of organizations, and must have a current project that can be used for their program assignment. The teaching team includes student technical assistants (2nd year master students) who can get course credit for an independent study for being involved with the training, in which they both teach and learn skills and become more aware of community issues and community organizing; for the independent study, the students write brief weekly reflection papers, which focus on such topics as gaining awareness of the power dynamics between them (as Harvard graduate students) and the program participants. Rebekka Lee then described the learning objectives and flow of topics addressed. The first two weeks focus on learning public health concepts and language relevant to communicating about health equity, the next two weeks focus concretely on project planning and formulating evidence-based strategies, and the remaining sessions focus on evaluation and the sharing of data, including not only how to disseminate knowledge but also how to run a meeting. Using an applied teaching approach, program participants formulate a project that can be completed in the available time, conscious of what changes they think they can make given their position in their organization. They learn how to use logic models, gain grant writing experience, and also how to give an "elevator

speech” about their organization, their role, and their project. In the final session, each participant gives a 10-minute presentation about their project to a group that includes their classmates, others at the School, and also their co-workers and loved ones.

Sahar Lawrence then described the project she did, as a staff member in a community development corporation in Roxbury (a neighborhood of Boston), which focuses on urban education and housing and works primarily with low-income populations of color. She started a partnership with a local community health center (CHC), with the goal of getting 50 new households to enroll in the CHC. By participating in the leadership training program, she learned how to approach work in a more structured way, how to plan to achieve realistic outcomes, and gained confidence and insight, as well as deeper understanding of why housing is a health issue.

-- Tamisha Walker (Executive Director, Safe Return Project, Contra Costa County, CA) then described the work she and her organization are doing to tackle the issues of mass incarceration and re-entrance of formerly incarcerated persons, such as herself, into their families and communities (see: http://www.countyhealthrankings.org/safe-return-project). She described the terrible health statistics of incarcerated persons, both when incarcerated and after they are released, including the post-incarceration high risk of mortality (especially from overdose, with risk highest in the first two weeks after release), plus their diminished sense of self-worth and chronic disenfranchisement, both of which are compounded by a sense that their society and community has changed during the period they were incarcerated. A major concern is trauma, including the trauma that led to incarceration, as well as the trauma due to arrest and incarceration. Her group, along with similar groups in two other counties, have launched a campaign to “invest in people not prisons.” In Contra Costa County, via active community education and engagement, they have defeated four county jail expansions, eliminated juvenile fines and fees, help secure reinvestment of $2 million of Prop 47 funding into services for mental health, substance use, and homelessness, such that Contra Costa County is now in the midst of building a new 350 bed facility to help people with mental health and substance use issues. Her program has created a platform to advance a proactive agenda for housing, mental health services, health access, and job opportunities. The other two counties have done similar work, with one also holding Town Halls with District Attorneys and educating community members about who the DAs are and why this matters. One of the groups also organized healing circles for their community members after the police killing of Stephen Clark. Challenges include changing the narrative from being “tough on crime” and dividing up people as being “deserving” vs. “undeserving” to one that emphasizes a public health approach to mental health and substance use and also challenges the still legal discrimination against formerly incarcerated persons. The work has shown the value of educating people about the links between criminal justice reform and its beneficial health impacts, and the power of linking criminal justice reform to health equity.

-- Emilia Vignolia (City University of New York (CUNY) Graduate School of Public Health and Health Policy) next presented the on-line training program she and her colleagues at CUNY and Columbia University have developed to address issues of food security among immigrants.

Their training is directed, via their regional Public Health Training Center, to the public health workforce in US Dept of Health and Human Services Region 2, which includes New York, New Jersey, Puerto Rico, and the US Virgin Islands; the intent is to increase their capacity to deliver services. At issue is the high level of food insecurity among immigrants in the US, which is estimated to affect 20-60% of US immigrants, depending on where, compared to the US national average of 12%. Three key programs, all of which that are threatened by the changes to the "Public Charge" policy that the Trump Administration is seeking to impose, include: (1) SNAP (food stamps); (2) WIC (food for women, infants, and children); and (3) school food (breakfast and lunch). The challenges faced by the on-line course have included: limited human and financial resources; programming in silos; limited political advocacy by public employees; and the well-known challenges of on-line, distance-based learning. Regarding technology, the platform they use is "Articulate Rise," chosen because it is intuitive, interactive, and can be run from a phone, tablet, or desktop computer. A key focus is working with existing skills to change them into transformative skills. For example, a traditional way to frame the scope of health department programs is to promote physical and mental health; the training encourages a reframing to consider factors that limit people's ability to achieve better health. Similarly, the traditional skill of assessing problems in relation to collecting and analyzing data is transformed by encouraging participants to locate the underlying causes, i.e., social and political processes, that lead to food insecurity. The participants learn to address barriers at multiple levels: (1) individual (e.g., stigma associated with use of public benefits); (2) organizational (e.g., inadequate language and cultural competency); and (3) policy (e.g., policies leading to poverty wages). A case example used in the on-line training concerns a restaurant worker who makes only $450/week and gets $180/week in SNAP benefits, but combined this is still not enough to support his partner and their two children – with the purpose of the reframing to get the course participants to see that it is not enough just to increase the SNAP benefits, but rather the wages need to be increased too, e.g., by policies for a higher minimum wage or living wage. With regard to interventions, the training expands the focus from solely addressing barriers to identifying and supporting community partnerships and social movements. Examples include involving the public health department in building coalitions, working in fair labor campaigns, and issuing public statements to foster inclusion of immigrants – with this new approach framed as making the work of health departments more effective and efficient. The case example used in the training is the one that was featured in the Spirit of 1848's 2018 activist session (see above) re the Cook County Collaborative for Health Equity. Key limitations of the training program are that: (1) it is directed toward individuals (not structures); (2) it is hard for participants to have uninterrupted time to complete the course (which requires 45 minutes); (3) it can be hard for them to identify concrete actions they can take to apply new learning from the course; and (4) training participation has been relatively low thus far. Strengths include: (1) the course is free; (2) participants get CHES and CPH credits; and (3) the training reinforces existing skills and creates new ones, including strengthening capacity for political analysis and solidarity, thus enabling moving beyond solely a crisis management mode. The link for the course training is at: https://www.train.org/main/admin/course/1077882/ -- and to boost the reach of this training, they have posted it to the Public Health Learning Navigator training database (see: https://www.phlearningnavigator.org/).

-- Trina Mackie (Touro University California, Vallejo, CA) next described an environmental science course that she teaches to MPH students and which involves their teaching middle school students, to make all of them more active in working for change and health equity. Most of the MPH students are the first in their family to get a college degree, let alone an advanced degree, and the racial/ethnic mix is reflective of the community where the school is based (50% Asian, 7% Hispanic, 7% black, 28% white, 4% multi-racial/ethnic). She teaches the class from an environmental justice standpoint, addressing such topics as ecohealth, air pollution, climate change, the built environment, water quality, food systems, food security, and citizen science. Students routinely are surprised and dismayed at how little they know about these problems, including the health inequities they produce, and they are angry they weren't previously taught about these issues and can become overwhelmed and depressed by the extent of the problems. What helps expand hope is connecting them to teaching middle school children (grades 6 through 8), to get these younger students to start thinking about purchases, consumption, and transportation, in ways they can talk about with their families, including in relation to common health problems affecting the local community (e.g., high rates of asthma) – as well as also provide an example of what they might do when they grow older. The 6th grade teaching example looks at the environmental impact of plastics, from cradle to grave; the 7th grade project looks at human biology, air pollution, and asthma; and the 8th grade project looks at climate change and ocean acidification and its impacts on the health of marine animals. Final research projects for the graduate course have included analysis of the environmental health impact of a local concrete plant, with students getting involved in going to state council meetings, writing letters to the local paper, and becoming more involved as active citizens.

During the **Q&A** period, comments and exchanges focused on:
(1) whether the Harvard team can disseminate its model to other schools – with the reply being that it was too early to do so, as it is still so new and they are still refining it (noting further that their presentation at this Spirit of 1848 session is their 1st public talk about the program!)

(2) how these pedagogic initiatives can help shift narratives to build community capacity and identify levers to lift up these community stories – with the replies emphasizing that changing narratives is necessary and is long and hard work, and one way to do this is to get people out of their offices and into the communities to hear residents' stories, as well as build up the capacity of people to do the work to get out their own stories

(3) how to realign the work of public health departments to get more engaged in such health equity work – with replies citing the example of the NYC Dept of Health and Mental Hygiene getting involved in correctional reform, and the Contra Costa County health department stepping up to be at the table about conversations about criminalization and gun violence, and engaging people at all levels in these discussions (from on the ground to top leadership)

(4) how to incorporate history, so that people understand the histories of struggle that underlie the present day, as well as gain awareness of themselves as historical actors and change agents – with replies agreeing on the need to do this.

2017 (p. 16-20):

● PROGRESSIVE PEDAGOGY

This session was attended by ~ 80 people (up from 70 last year).

PROGRESSIVE PEDAGOGY: TEACHING ABOUT LINKS BETWEEN TOXIC POLITICS AND CLIMATE/ENVIRON- MENTAL EQUITY AND PUBLIC HEALTH (Tues, Nov 7, 8:30-10:00 am; Session 4069.0; GWCC, Room B207)

8:30 AM: **Introduction – *Vanessa Simonds, ScD,*** *Lisa Dorothy Moore, DrPH*

8:35 AM: **Teaching war as a public health problem – *Amy Hagopian, PhD,*** *Evan Kanter, MD, PhD*

8:50 AM: **#CrunkPublicHealth: Decolonial Black Feminist and progressive pedagogies of cultivating liberatory learning, research, and action spaces – *LeConte Dill, DrPH, MPH***

9:05 AM: **Pedagogies for social advocacy: National Nurses United's Certificate Program in Health Inequity and Care & Women's Global Health Leadership –** *Heidi Hoechst, PhD*

9:20 AM: **Structural competency and global health pedagogy – *Michael Harvey, PhD-c,*** *Kelly Knight, PhD, Seth Holmes, MD, PhD* 9:35 AM: **Q&A**

Vanessa Simonds (Spirit of 1848 Coordinating Committee; Montana State University, Bozeman, MT) introduced the session's theme and the speakers.

-- **Amy Hagopian (University of Washington, Seattle, WA)** described the course she developed with her colleague, Evan Kanter, to teach about war as a public health problem. The motivation was to counter the emphasis of most public health war-related work that either focuses on cleaning up afterwards (e.g. Red Cross, Médicins San Frontières [MSF]), or preventing use of certain types of weapons (e.g., Physicians for Social Responsibility), or preventing adverse psychological responses to war (e.g., a National Academy of Science study for the Department of Defense on this topic, but which contained nothing about preventing exposure in the first place). A related problem is the lack of funds for public health work on preventing war.

In such a context, teaching becomes a way to introduce the material to a public health audience. Attesting to the need, analysis of papers presented at APHA in 2015 showed that among 1000 sessions, only 9 focused on war, as did an additional 7 individual presentations and posters. Research for an APHA 2012 resolution about who is teaching war found that among 6266 courses taught in public health schools, only 31 were war-related, of which only 6 focused on causes and only 4 on prevention.

To address these gaps, in 2015 Hagopian and Kanter first taught their course on "War as a Public Health Problem." It is taught at the University of Washington (Seattle, WA), where it is a 4-credit elective course that meets 3 times per week and is open to graduates and undergraduates. Students are recruited from all over campus, including those enrolled in ROTC, and students in the military have been enrolled in every course since inception.

The course focuses on how wars are instigated and uses a problem-based learning approach to address how wars could be prevented and the role of health professionals. Case examples include: Rwanda; World War II; El Salvador; and the Mexican drug war, among others. Graduate students help lead the weekly discussion groups, and the class enrollment has comprised 10 graduate students and 50 undergraduates. Topics addressed include: structural violence and how it is instigated and fueled by war; military recruiting; and the presence of the military at universities. The course also includes two panel discussions, one with refugees and one with veterans, and also includes some guest speakers. The mid-term quiz concerns the health effects of war. The final project concerns prevention and is either an activity or a quiz.

The course has experimented with using different text (e.g., books written as textbooks; novels; graphic novels) and has found that a graphic novel has worked best (Andreas J. *Addicted to War: Why the U.S. Can't Kick Militarism – A History of U.S. Foreign Wars in Comic Book Format*. Oakland, CA: AK Press, 2015); a new book that will be published this month may also be relevant (Wiist WH, White S. *Preventing War and Promoting Peace: A Guide for Health Professionals.* Cambridge, UK: Cambridge University Press, 2017).

A key emphasis is on how students can leverage the power of public health and privilege to prevent war. The course is meant to spark more courses in other institutions on this topic, and borrowing of the syllabus is encouraged! – see: (a) https://phsj.org/war-and-peace **[UPDATED LINK: https://web.archive.org/web/20160624041037/https://phsj.org/war-and-peace/**]; and (b) https://catalyst.uw.edu/workspace/hagopian/45591/329351

-- **LeConte Dill (SUNY Downstate School of Public Health, Brooklyn, NY)** described her approach to teaching, at her school in Brooklyn, NY, what she terms #Crunkpublichealth, premised on hashtag ethnography that documents processes in social and activist spaces. Framing the class are two vital questions: "Who you wit?!" (i.e., who is your work for, and whom

do you center and bring along, and why); and “Who/what do you refuse, forget, ignore, or erase?” The class also refuses the “at-risk” narrative of public health, which is not neutral, instead creating a stigmatizing narrative which focuses on individual level change to address “lifestyle” and assumes individuals have no agency to change environmental hazards. The alternative is desire-based research and teaching, inspired by Black feminist thought, which emphasizes an intersectional holistic approach that highlights agency and hope and also people’s experiences of not only illness but also wellness. The course also draws on Public Health Critical Race Praxis.

Dill recounted how she first became engaged in public health when a student at Spellman College in the late 1990s, a time when Crunk emerged as a form of music and way of being that was urban, bass heavy party music with call and response. The term referred to a state of being crazy + chronic + drunk, and inspired the formation of a crunk feminist collective of hip hop feminist urban and rural students, for whom “getting crunk” referred to declaring resistance to the hegemony of dominant and demobilizing “at risk” narratives in the field. She described how she was trained by Dr. Bill Jenkins at Morehouse, who always provided historical context when teaching epi methods, including his own role in exposing the Tuskegee syphilis study. In this context, “getting crunk” referred to a way of bringing one’s full self to class, and getting crunk in the scholarship and classroom, and also implementing radical citation practices, to bring in the work of other radical scholars of color.

Dill then described how her #Crunkpublic health course is transdisciplinary and practices a pedagogy of collegiality, in which she as teacher and her students are co-learners and co-researchers. An emphasis is on hope, wellness, and agency, not solely health inequities. The class employs art-based methods, including poetry and creative writing, music, body maps. As one example, the core course on “Urban Health Issues” starts the class with music and then focuses on gentrification as a social determinants of health, and includes use of images from the art of Jacob Lawrence, murals, and spoken word. This use of art helps students with the stress they feel about the issues discussed, since they relate so directly to their own lived experience, and the course also teaches approaches to self-care, to bolster hope, agency, and the power to make change. Dill concluded by encouraging everyone to learn more about the frameworks of Black feminism and their contribution to public health analysis and action.

-- **Heidi Hoechst (National Nurses United, Oakland, CA)** described the new certificate program developed by National Nurses United (NNU), which is the largest union and professional association of registered nurses in US history and which is dedicated to “health care justice, accessible, quality healthcare for all, as a human right” (see: http://www.nationalnursesunited.org/). The certificate program involves both Rutgers University (Rutgers, NJ) and American University (Washington, DC) and is intended to build structural competency so that nurses can better understand the context in which they work and become better advocates for social change. For example, the course on the political economy of the health care system teaches critical understanding of the health care economy, hospital restructuring, and use of technology, and how to respond to these issues, using a frame of political education that calls attention to other forces, allies, and solidarity.

Noting that it is very unusual for a union to be involved in creating a higher education program, Hoechst said that the impetus came out of the 2008 financial crisis, which lead to greater restructuring of the health care system and its financialization, plus increased use of technology, such as use of electronic medical records, in which the profit-driven priorities of health insurance companies was leading to increased overriding of nurses' clinical judgement about the needs of their patients. In a context of such activism as Occupy Wall Street and public advocacy for a "Main Street Contract" (using the slogan: "Heal America/Tax Wall St"), the program was developed to increases nurses' understanding of their economic and work context and to scale up RN advocacy, with RNs functioning as the moral center of the hospital.

The on-line certificate program with Rutgers (under their Women's Global Health Leadership program) offers 7 courses, all of which are taught by NNU faculty (all of whom have PhDs) and all of which analyze the political forces that are driving health and health inequities globally and collective response to change these conditions. The NNU courses have the most successful retention among Rutgers' on-line course. Students enroll from around the US, and include both nurses in the field and college students, thereby promoting rich interdisciplinary, transgenerational education, premised on the view that "health care is at the heart of democracy." The 14-week course teaches students how to advocate and intervene; examples of assignments include writing op-eds or speeches to present before a city council (and one student, inspired by the course, went on to become a city councilor and is now running for the state assembly!).

The two core courses are: (1) "Impact of Economic Inequality on Women's Health," and (2) "Women's Global Health Movements." Topics addressed include: inequality; debt; climate crisis; pharmakosis; food disparity; and the health care crisis. Students have also traveled, in solidarity, to such places as Texas after Hurricane Harvey, Standing Rock, and Puerto Rico after Hurricane Maria, so as to observe what is going on and have what they have learned in class inform their actions when on-site. For example, after the trip to Puerto Rico, the students wrote a report about what they observed and sent it to state legislators to advocate for the kinds of policy responses urgently needed to this disaster. The emphasis is on the connected cycle of: social advocacy – classroom analysis – organized action – evaluation, in turn informing the next steps of social advocacy, etc. Additional courses focus on: healing structural violence; science, technology & human health; health geographies; militarism and health; and neoliberal globalization and health. The emphasis is: "organize – organize – organize," and to recreate and reclaim democracy for all people.

For information on the certificate programs, see:
https://www.nationalnursesunited.org/certificate-programs

-- **Michael Harvey (San Jose State University, San Jose, CA)** presented on a framework he is developing with colleagues for "Structural Competency and Global Health Pedagogy." The emphasis is on health disparities as an outcome of structures, including contemporary and historical systems, policies, and institutions that create and maintain health inequities. Examples of such structures include systems, policies, and institutions involving taxes, health care, economics, prisons, and the judicial system, and the focus is on systems that drive health disparities in relation to class, race/ethnicity, gender, sexual orientation, and citizenship. This type of analysis is informed by the work of Metzel et al on structural competency and by the

work of the Bay Area Structural Competency for Health Care Working Group, the National Nurses Union, and the UC Berkeley Center for Social Medicine.

The framework critiques the conventional “social determinants of health” approach, which typically focuses on, say, how poverty and inequality harm health, but does not include analysis of the structures that drive the production of the types of poverty and inequality present. The five competencies developed thus far are as follows:

(1) *Articulate a language of structures in relation to health and health care disparities* (e.g., structural violence; structural vulnerability; structural racism; structural determinism), drawing on epidemiological theories that emphasize a structural analysis, include ecosocial theory, political economy of health theory, and fundamental cause theory.

(2) *Identify structural determinants of health in specific global contexts* (e.g., the case example of Guatemala, where the mainstream public health explanation for poor health among rural Indigenous populations is a lack of sanitation, poor diet, and distrust of the health care system, versus a structural analysis, which emphasizes the low per capita spending on health care in rural Indigenous regions, and how lack of resources and access to services impedes use of health services).

(3) *Recognize ways that traditional ideas and methods in the field of global health ignore structural determinants of health* (e.g., the idea of “at risk” overemphasizes individual agency, behavior, lifestyle, and culture; as an example, in Guatemala, mainstream analyses blame poor health on a “culture of death” and “fatalism,” which ignores the impact of colonialism and neo-colonial exploitation, the prohibitive costs of obtaining health care, the high debt burden of much of the population, and a reluctance to go to hospitals because people only “go to hospitals to die”).

(4) *Design structural interventions to address health and health care disparities in specific global contexts* (e.g., advocacy to increase access for HIV/AIDS medicines, as per PEPFAR and the Global Fund; or partnerships to build and support public infrastructure, such as the Partners in Health medical complex in Rwanda and the teaching hospital in Haiti).

(5) *Apply structural humility in a global health context* (e.g., be aware of one’s own privileged positioning when partnering with marginalized individuals and groups).

The reason for developing these competencies is that global public health programs are proliferating in universities and colleges, at a time when economic inequalities are increasing, and it is important to reorient the pedagogy to address the structural determinants of health, as one piece of the larger puzzle, geared to improving health equity.

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

(1) a concern there was inadequate attention to the role of corporations, in the presentations

and in the APHA conference, plus a critique of the Partners in Health Rwanda complex as solely providing 4th world health care;

(2) for #crunkpublic health: (a) when using hip hop music, how to deal with "negative lyrics," with the exchange emphasizing the need for students to "say the words" and unpack their meanings as a way to address them; and (b) use of the "body map" to identify sites of not only pain & illness, but also spaces of joy, hope, and healing;

(3) how to address the resistance of health professionals to acknowledging the existence and impact of structural racism and how to evaluate the impact of pedagogy focused on structural competency, with the exchange noting that an evaluation of pre-med students who took a course on structural competency had improved awareness of how racism harms health and the delivery of health care, and the NNU courses all including as a theme the need to end institutionalized racism as a core part of every course, using examples of redlining, militarization of police forces, and the role of social movements, such as the linkage of the fight for Medicare and civil rights;

(4) how to address in the classroom that not all students come in with the same level of awareness, with the exchange emphasizing such methods as the #crunkpublic health approach of reframing students as being co-learners and also having them go outside of the classroom to do community mappings, so as to enhance awareness of the situations being analyzed, and the NNU course aiding students to analyze their own experiences in context and hear the stories of all the students, which opens up awareness to the broader forces affecting people's lives and health;

(5) a question about key obstacles and unexpected allies encountered when creating the courses described, with the responses being: (a) for #crunkpublichealth, insights gained from Dill's invaluable experience participating in the initiative "Democratizing Knowledge" Summer Institute (inaugurated at Syracuse University in 2009 and now involving other academic institutions; see: http://democratizingknowledge.syr.edu/SummerInstitute.html); (b) for teaching about war, support from the university (which is a public university in a state with no income tax), such that support is offered for any course that draws students in (and hence their tuition fees); (c) for NNU, the ways in which the impact of economic austerity on universities led to openness to partnering to create an on-line certificate program; and (d) for structural competencies in global health: the ability to draw on disciplines outside of public health, when learning as a doctoral student, to take on the conservatism in mainstream MPH courses;

(6) approaches to bringing in the failures of public health (such as the unethical Tuskegee syphilis study) into the courses, with the responses being: (a) for teaching about war, emphasizing the abject failure of public health to focus on the prevention of war, with students

enjoying learning how to critique conventional public response to war, including how the Red Cross operates; (b) for NNU: examples of teaching about the failures of conventional public health practices in relation to the operations of Big Pharma, food policies, and global trade; (c) for #crunkpublic health, there is a section on ethical failures, using the example of J. Marion Sims (who experimented on enslaved women, yet who is canonized in the medical literature; protests against the statue of him in NYC are discussed); (d) for structural competency: one example is analysis of the racism that drives the difference in how the current opioid crisis is approached versus the prior "War on Drugs," and another example of failure is the Guatemalan secret syphilis study, in which US public health personnel injected Guatemalans (primarily prisoners and sex workers) to expose them to syphilis and study them.

2016 (p. 16-18):

PROGRESSIVE PEDAGOGY

This session was attended by ≈ 70 people (down from 100 last year, but more than the ≈ 50 in 2014).

PROGRESSIVE PEDAGOGY: HEALTH EQUITY & HUMAN RIGHTS (Tues, Nov 1, 8:30-10:00 am; Session 4069.0; CCC, Room 205)

8:30 AM: Introduction –Vanessa Simonds, ScD, Lisa Dorothy Moore, DrPH, Rebekka Lee, ScD
8:35 AM: Fixing curriculum gaps: using an advanced seminar to teach students how to develop teaching examples for public health courses lacking gender analysis – Sabra L. Katz-Wise, PhD, Jerel Calzo, PhD, Brittany Charlton, ScD, Nancy Krieger, PhD
8:50 AM: Resisting the stories "WE" tell about health: combatting the neoliberal, consumerist models of Food SystemChange in the classroom – Jason Craig, PhD-C, Sonya Jones, PhD
9:05 AM: Beyond implicit bias: a medical student course on race and racism in medicine – Charlotte Austin, Ann Crawford- Roberts, Murad Kahn, Giselle Lynch, Caroline Mirand, Lily Ostrer, Ann-Gel S. Palermo, DPH, Sharon Washington, MPHEdD
9:20 AM: Strategies for anti-racist community engagement in public health pedagogy – Miranda Vargas, MPH
9:35 AM: Q&A

Vanessa Simonds introduced the session, noting that the presentations variously focused on different types of teaching initiatives, in and outside of the classroom, that engage with rights needed for health in relation to gender, racism, and sustainable food systems and food security.

-- Brittany Charlton presented an advanced seminar designed to enable students to create teaching examples involving gender analysis that can be incorporated into public health courses that otherwise don't use a gender analysis. The seminar is a course offered by the Interdisciplinary Concentration on Women, Gender, and Health at the Harvard T.H. Chan School of Public Health (see: https://www.hsph.harvard.edu/women-gender-and-health/). It

employs active learning principles, so that students are engaged in creating (and not just critiquing) knowledge. For the assignment, students work in pairs to develop a 5-minute teaching example that can be incorporated into a classroom session (e.g., for an epidemiology course, on why it is wrong to conflate gender and sex). The assignment requires student to prepare a background statement justifying use of the specified example, an explication of the teaching methods to be used, and a list of actual courses in which the example could be used. The students present the teaching example to the course instructors, fellow students, and WGH faculty to obtain feedback prior to finalizing their assignment. The course has been taught for 3 years and has generated 19 teaching examples. In order to enable the examples to be shared outside of the classroom, WGH led the development of a new school-wide policy (which required legal clearance from University Counsel) to permit examples to be posted on a website for case-based examples, whereby the examples are freely accessible and are posted only after the class is done, with permission of the students (with a Creative Commons copyright). Selected examples have focused on gender analysis in relation to: depression and suicide risk; HIV disease progression; paid family leave; and prevalence and treatment of eating disorders; the examples will soon be available via the WGH website (provided above) and also via the HSPH case-based learning website (see: https://caseresources.hsph.harvard.edu/case-library). Lessons learned via development of this seminar include: the value of students' developing the case examples to solidify their understanding of gender analysis for public health; the value of having students appreciate the work required to generate, not simply critique, examples; the challenge of having the students keep their examples to only 5 minutes; the need for iterative feedback as students develop the examples; and the vital role of institutional policy to make it feasible for the examples to be available to others once the class is completed. The course has demonstrated that it builds students' critical capacity to develop critical pedagogy. The model employed, moreover, can be applied to other issues where classroom pedagogy is deficient (e.g., in teaching about racism and health).

-- Jason Craig presented on the course he has developed, in South Carolina, for undergraduates to gain a critical understanding of both nutrition and food system change. The course is key to a new undergraduate concentration on nutrition and health disparities. It utilizes storytelling methods to ground the students by helping them situate their own experiences, what they read about, and the community projects in which they engage to promote food equity and sustainability. The course explicitly confronts dominant neoliberal economic utopian views, which see the marketplace as the best arbiter of justice and outcomes, and does so by enabling the students to challenge the largely invisible dominant ideology with the hope of alternatives, grounded in systems thinking (as opposed to linear thinking), storytelling (using metaphors the students develop), and power analysis (e.g., parallels of Big Tobacco and Big Food). The course is designed to address background tensions between the "personal" and "systemic" that affect students' worldviews, analysis, and action, along such axes as: agent/structure, me/we, personal behavior/system change, consumer muscle/citizen muscle, competition/cooperation, and charity/solidarity. The first part of the course critically analyses the "food system" (e.g., challenging conventional "linear" models with more dynamic models, including those involving "health in all policies"). The second half is a capstone experience that involves service-based learning which partners the students and a community-based organization, which also draws on

critical work on how to communicate about systems change (see, for example: http://ecoamerica.org/ ; http://www.frameworksinstitute.org/). One classroom exercise, using a journey metaphor, is creating a "map towards nourishment," for which students identify what it feels like to be nourished, situate when they have felt this, and also obstacles that prevent such nourishment. Hopeful examples of collective action are also examined, e.g., the Coalition of Immokalee Workers (see: http://www.ciw-online.org/), plus the community organizing training approaches used by diverse organizations (e.g., the New Organizing Institute; see: http://www.wellstone.org/). A key pedagogic lesson is that students are aided in learning systems analysis when they can connect their own personal stories to the systems they are analyzing.

-- Giselle Lynch presented on a course she and fellow black and brown students at Mount Sinai Hospital (NYC) have created, called "Deconstructing race in medicine and health: our patients and ourselves." This course was designed to be grounded in the experiences they have had as students of color in medicine and in the dehumanized medical care they have witnessed being provided to patients of color. One key objective of the course is to enable the students to treat all people as sacred and truly become healers; another is to transcend the boundaries of the classroom and transform the institution, which requires understanding the context in which the course is taught, including issues of lack of racial/ethnic diversity among the faculty (approx. 80% of all senior faculty are white) and the narrow treatment of "race" as a "risk factor" for disease in virtually all other courses (with examples provided of such poorly conceived stereotypical cases used for teaching in major required courses). The course foundation is "love, compassion, respect," it is culturally inclusive, privileges knowledge of communities of color (past and present), is historically rooted, deploys critical analysis, and is action oriented. The initial course was developed by Sharon Washington when she was at Mt. Sinai (she is now at Temple University), and it is a 6 week course that most recently was led by 6 student leaders, with 19 students participating. The six sessions pertain to: (1) what is race? (including critical analysis of white supremacy and anti-blackness), (2) creation of health disparities (starting with own trauma, as well as critical analysis of common problems, such as claims that a patient is "non-compliant" without considering structural barriers that affect the ability of a patient to take medication as prescribed), (3) race & genetics (e.g., critiquing work on "pharmacoethnicity"), (4) whiteness (i.e., asking who is white and what they have in common, which ultimately is social position and political power, not a shared "ethnicity" or "culture"), (5) inclusion of a guest speaker, and (6) race & collaborative process of creating critical knowledge. It has received very positive student evaluations, and is currently being adapted for use at Baylor University, and its curriculum is being shared with WhiteCoats4BlackLives and also the American Medical Student Association (AMSA). For more information about the course, contact: RMHSinai@gmail.com

-- Miranda Vargas then described a project she has been involved in, based at the University of Washington School of Public Health, to create a Process Guide for faculty, students, and staff in academic institutions who seek to engage in health equity projects involving community-based organizations that are led by people of color. The work was premised on anti-racist principles, as articulated by the People's Institute Northwest (see: http://pinwseattle.org/). The emphasis was on the processes required for effective anti-racist practice and collaboration, and the project

was informed by a literature review and by 10 key informant interviews involving both members of community-based organizations led by people of color and also health program staff. Key themes concerned: (a) the importance of process (not just outcomes) and (b) barriers to collaborations that could genuinely be useful to the communities for which the programs are intended. Challenges include: (1) the need to shift power from the dominant institutions to the community-based organizations (especially regarding decision making power); (2) work required for undoing internalized racism; (3) the need to understand and question how white organizational culture operates; (4) the need for transforming policies and practices, to put the needs of the community-based organizations and students of color at the center; and (5) the need to build accountability, including greater transparency and more involvement of faculty, not just students, so as to build more sustainable ties between the academic institution and the community-based organizations. Limitations of the study included: (1) small number of interviews conducted (since it was a pilot study); and (2) the work was led by a white student, potentially affecting information shared and insights obtained. Next steps are to pilot use of the guide, with its emphasis on process, with more community-based organizations.

During **the Q&A period**, comments and questions focused on:
(1) role of student activism in leading to the development of these different courses;
(2) what enables which universities to address these issues, and others not, and to what extent are the university initiatives genuine (including in shifts of resources and power) vs. “public relations” and “branding”;
(3) the need for these transformative teaching & engagement initiatives to be impelled by what is right to do, in contrast to the current dominant framing of activities as needing to be “entrepreneurial” in orientation;
(4) how to deal with the lack of faculty of color and the need for resources to recruit, retain, and promote these faculty, and build critical numbers for critical thinking about social justice, public health, and medicine;
(5) how implicit vs. explicit can one be about course objectives, given funding sources? (e.g., the food systems course was funded by a grant from USDA – noting that it was “safe” to frame the course as about ethnographic methods, relevant to addressing hunger & child nutrition); and
(6) the importance of keeping a clear distinction between programs focused on pedagogy from those chasing research dollars.

2015 (p. 11-13):

PROGRESSIVE PEDAGOGY

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

PROGRESSIVE PEDAGOGY: HEALTH EQUITY IN ALL POLICIES (Tues, Nov 3, 8:30-10:00 am; Session 4074.0) MPCC Room W185bc

8:30 AM: Introduction – *Rebekka Lee, ScD*

8:35 AM: Where dialogue and action coexist: organizing leaders and building capacity to advance Health Equity in All Policies– *Lili Farhang, MPH*

8:50 AM: Role of a state health agency in expanding the understanding of what creates health – *Edward Ehlinger, MD, MSPH*

9:05 AM: Developing health leaders to champion health equity — *Harry Heiman, MD, MPH*

9:20 AM: Anti-racism in public health education: a student-driven model for changes in a Master's of Public Health Program – *Ariel Hart, MPH* 9:35 AM: Q&A

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

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

unsatisfying, and the participants face constraints on how they can apply what they learn. A key benefit is that participants gain credibility, and thus increase capacity for pushing for change within their health department and become seen as a resource, in and outside the agency.

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

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

community-based organizations.

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

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

(1) the utility (or not) of convening a national meeting to pull together public health and other health professional students working on institutional and curricula change (anti-racist and promoting health equity);

(2) the need to expose barriers encountered to creating change (e.g., faculty resistance to having students undergo a mandatory anti-racism training session; faculty lack of interest in student-led conferences and initiatives on racism and health), so as to create accountability;

(3) how to get public health practitioners to incorporate anti-racist principles in their work, recognizing that this is a multi-year endeavor, one that requires negotiation and pushing back against resistance, as well as ongoing technical support; and

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

2014 (p. 10-13):

PROGRESSIVE PEDAGOGY

This session was attended by ≈ 50 people (similar to the ≈ 60 from last year).

TWENTY YEARS OF MENTORING FOR PASSION, POLITICS, AND HEALTH (Tues, Nov 18, 8:30-10:00 am; Session 4074.0) MCC Room 206

Introduction : Rebekka Lee, DSc Moderator : Lisa D. Moore, DrPH Participants: (1) John Hatch, MD + film "Out in the Rural"

(2) Nina Wallerstein, DrPH + mentees Shannon Sanchez-Youngman (PhD Candidate), Ethel Nicdao, PhD (visiting scholar), and Sonia Bettez, PhD (postdoctoral faculty)

Rebekka Lee and Lisa Moore introduced the session and the theme of mentoring, within and across generations, as part of the social justice work of movement building. They also explained the session would have two components: one, historical, would involve looking back at the mentoring and movement building that were part and parcel of the creation of the Tufts-Delta community health center, in Mound Bayou, Mississippi, which was one of the two first community health centers in the US, both established in 1965 – and is active to this day. The second part would focus on a current work redefining mentoring as part of a multi-part program devoted to building community based participatory research, located at the University of New Mexico.

a) Historical: Tufts-Delta community health center and John Hatch, MD (by phone)

We first showed the film “Out in the Rural” (22 minutes long and freely available at: http://vimeo.com/9307557), which provides a look at the Tuft's-Delta community health center, one of the first community health centers in the nation. This health center not only provided medical services but also had the express aim of using the clinic as a lever for social change.

Community programs included starting a food cooperative, digging wells, job programs and education for children. The movie was filmed in 1969 and released in 1970, and was produced and directed by Judy Schader Rodgers (to learn more about the film, see article by Carolyn Chu that was published in Social Medicine in 2006; freely available at: http://www.socialmedicine.info/index.php/socialmedicine/article/view/33/45).

As part of her introduction to the film, Lisa Moore said she had first seen it 30 years ago, in a class taught by Meredith Minkler, who has presented at many of the Spirit of 1848 sessions on progressive pedagogy. The film affirmed to Lisa back then, and still now, that the essence of public health mentoring and pedagogy is about movement building, to enable communities to build and create conditions so that all can live the healthy lives we all deserve to enjoy.

After the film was shown, we connected by phone with John Hatch, MD, one of the key organizers of the health center who was featured in the film, and who had hoped to – but was unable to -- travel to attend the APHA conference. By way of background, Hatch (b. 1928), now retired, began teaching at the University of North Carolina at Chapel Hill's School of Public Health in 1971 and retired from UNC-CH as Kenan Professor of Health Education in 1995. In the US, Hatch worked to establish not only with the Delta Health Center but also the Community Health Education and Resources Utilization Project (Black Churches Project), an effort to train lay people to be health resources in their local communities. He also worked internationally, setting up a Practical Training in Health Education project in Cameroon, and also projects under the aegis of the Progressive Primary Health Care Network in South Africa.

In the comments Hatch shared by phone, he discussed what it was like for him, as a black man in the mid-1960s who was originally from the South but who had left to obtain professional training, to take on working with community members in rural Mississippi to create a health center like none that had ever existed before. He discussed how it required becoming familiar with the patterns of expectations of hope and dreams, to learn who was there and what their structures were for organizing themselves, so as to enhance relationships that could help people create a better life together, overcoming the bounds of poverty and creating new models of change. Key groups the health center staff realized they needed to connect with were the churches and fraternal organizations. With regard to mentoring, the primary objective was to identify people in rural Mississippi whom they could help refine their goals and objectives to maximize both their personal opportunities (e.g., by getting training to do a new kind of work, such as technical worker in the clinic) and also possibilities for social change, along with expanding the definition of what it means to provide health care. Looking back now, to the work he did 40 to 50 years ago, Hatch said that he believes the greatest accomplishment was to reach the young people and to inspire and guide them to take on new roles and create better conditions.

b) Contemporary: mentoring in the Center for Participatory Research at University of New Mexico Panelists for this component of the session included **Nina Wallerstein, DrPH** (the director of the Center) and three people with whom she has mentoring relationships: **Shannon**

Sanchez-Youngman (a doctoral student), **Ethel Nicado, PhD** (a visiting scholar), and **Sonia Bettez, PhD** (a doctoral fellow).

Nina Wallerstein began by saying she had met John Hatch at UNC, and then discussed how she has come to see the work of mentoring as creating co-mentoring, both via community based participatory research and with students. She contrasted the traditional view of mentoring, which she defined as an expert teaching a non-expert in a uni-directional approach, to her non-traditional view of mentoring, influenced both by Paolo Friere's approach of participatory listening and dialogue, and by her training by Meredith Minkler. Stating that she has come to recognize that a key component of a mentoring relationship is "who has your back," she further discussed how one of her team members, Magdelana Avila, has helped refine, through their work on community based participatory research (CBPR), a model of mentoring they term "up, down, peer/co-mentorship." A central component is to honor voice and by doing so, to strengthen people's belief that they are "bigger" than they might believe themselves to be, and call out the gifts they have to offer. Another key aspect was to learn to live with contradiction, especially the contradiction of promoting democratic ways of being within hierarchical academic and agency systems. The contrasts she posed were between: (1) operating as a democratic team vs. functioning hierarchically; (2) privileging the ideals of freedom of expression and the value of diversity vs. the actual indifference to these ideals in most academic settings; and (3) the expectation that voices will be heard vs. the common experience, especially for scholars of color and other "outsiders," not to be heard within academic institutions.

She then shared video clips of several team members' views of co-mentoring: *Julie Lucero* emphasized the importance of being aware of how one acts, practicing what one preaches, and being a role-model for others; *Magdalena Avila* stressed the importance of being part of a team where everyone is expected to contribute, which helps people to learn how to speak up and also demystifies approaches to running a research team; and *Greg Tafoya* discussed how much has learned from communities doing CBPR, and that it is vital to pay attention to context. The presentation then turned to key lessons gleaned from 7 case studies of CBPR projects. They included: (1) knowledge creation depends on who the team members are, since community members will share information differently with different kinds of persons (e.g., in a project in the deep South, it mattered to have black team members work with the black community participants) and their doing so also depends on creating relationships of mutual respect (e.g., in a project with one American Indian nation, the community members wanted the PI to be present at key meetings, to demonstrate the PI understood the importance of showing up, not just sending team members); and (2) the importance of decolonizing knowledge without misappropriating it. Ultimately, mentoring/co-mentoring involves what she termed "Deep Learning," whereby all deeply listen to each other.

Shannon Sanchez-Youngman then discussed her experience with mentoring/co-mentoring as a doctoral student and new member of the CBPR team. To her, a key part was that the team approach challenged the conventional dyadic approach to mentoring, and reframed learning as being about building capacity to promote social change. The team also offered a safe space, as compared to what she experienced in her academic department, which did not value either

applied work for social change or co-mentoring. Offering a space for both intellectual and political growth, the team and its approach to co- mentoring afforded her the capacity to work mutually with others to use CBPR to advance work to build and strengthen social movements working for social change.

Ethel Nicado next reflected on her position as a very new member (less than 2 months) in the CBPR team, in her role as visiting scholar who is mid-career and who became tenured last year. She discussed her position as insider (part of the academy) and outsider (new to the team and to CBPR), and how prior to joining the team, her model of mentorship was traditional, i.e., hierarchical and uni-directional, with the expert leading the novice. In the team, she has found new possibilities for informal and formal mentoring, with the informal being the most valuable, and the team provided a "safe space" crucial to developing everyone's capacity, including to work with communities in the work of creating social change.

Sonia Bettez then shared her perspective as someone who, though not formally on the CBPR team, nevertheless views Nina Wallerstein as "being on her team." She described how she previously had been a long-time community activist, focused on child abuse prevention, and then came back to academia as an older student to get a PhD, resulting in her "mentors" being considerably younger than her. What was key is that they all mentored her for survival, not only intellectually, but also practically (including one professor getting on the floor to show her the exercises he did to prevent back pain from extended use of the computer!), and affirmed her being there, as an older lesbian woman of color. To her, the point of the mentoring was not just for individual success (as a person), but for building capacity to work for social justice. She sees this approach as directly relevant to her work now with people who are being made obsolescent by new technologies and what needs to be done to tackle the structural issues that blight their lives; the point is to change institutions, not just individuals.

During the **Q&A** period, comments and questions focused on: (1) how conditions in parts of Mississippi now are still like those shown in the film (in terms of the power relations and current forms of poverty); (2) how another important part of mentoring is the sharing of experience that comes with having been doing the work for a long time and learning from mistakes and successes, so that people new to the work can benefit from the experience of others while they also bring in fresh ideas and new experiences; (3) how the inspiration that comes from one-on-one mentoring is critical, but not sufficient; (4) the need for taking a long-term perspective and hearing this as part of the deep listening (e.g., in one American Indian community, they traced the origins of the problems they needed to address to when the US Army invaded their community 100 years ago); (5) the tensions that can arise when different people have different understandings of what "social justice" entails and what can be done to make these tensions productive rather than destructive; (6) the importance of co-mentoring for overcoming isolation, as experienced by many people in public health departments who often feel they are the only one in their work group who has a social justice orientation, leading to the founding of a new project – the Public Health & Equity cohort – which matches up & coming people in public health departments with people in the field who are currently doing work successfully for health equity within such contexts, so as to build support for risk-taking and share ideas for how to advance the work; (7) the problems faculty can face when their time for mentoring is not adequately

compensated, since a model of assuming the rewards are what one gets in creating sustaining relationships is not enough in soft-money contexts; and (8) a view of mentoring as pouring love into others, understanding love to be a steadfast commitment to the well-being of others, with a goal of helping both people as individuals and communities as seeing themselves with more clarity than they might be able to see themselves, and engender and enhance the capacity to create communities in which all can thrive.

2013 (p. 10-12):

PROGRESSIVE PEDAGOGY

This session was attended by ≈ 60 people (similar to the ≈ 70 from last year).

PROGRESSIVE PEDAGOGY: CLIMATE CHANGE, SUSTAINABILITY AND HEALTH EQUITY (Tues, Nov 5, 8:30-10:00 am, Session 4071.0) BCEC Room 205A

8:30 AM: **Introduction – Suzanne Christopher, PhD;** *Lisa D. Moore*, DrPH

8:35 AM: **Coal blooded: Coal fired power plants spell double jeopardy for communities of color – *Jacqueline Patterson, MSW, MPH***

8:55 AM: **Bridging that gap: Using web forums to bring together champions for community change – *Carmen R. Nevarez, MD, MPH*;** C. Chan; S. Tiffany

9:15 AM: **Human health and global environmental change: A massive open online course -- *Aaron Bernstein, MD MPH***

9:35 AM: **open discussion/questions and answers**

Suzanne Christopher opened the session noting that speakers would be presenting materials about different forms of pedagogy about climate change, intended to produce action, ranging from local community-based initiatives to a Massive On-Line Course (MOOC) with global reach.

Jacqueline Patterson, Director of Climate Justice at the NAACP, presented findings of their new report on how coal fire plants pose a double-jeopardy to communities of color, by both directly harming their health due to toxic emissions, and by increasing carbon dioxide in the atmosphere, leading to global climate change. Illustrating her talk with many pictures as well as empirical data, she provided the example of Plant Jack Watson in Gulfport, Mississippi, located in a low income community where 25% of residents are of color, and which has earned an F from the American Lung Association for the number of bad ozone days it generates and been deemed “ripe for retirement” by the Union of Concerned Scientists, because the costs to fix it

are so high, with data from still another study showing excess mortality linked to the plant's pollution. Harms due to coal use, moreover, extends from its mining (mountaintop removal; harm due to coal ash spills) to its combustion, with photos showing burning stacks located across the street from playgrounds in a low income community of color, and also adjacent to rivers where people do subsistence fishing. Another photograph showed a Navajo family who lacks electricity with the coal plant stacks visible behind them, generating energy for cities. Placement of the combustion plants in neighborhoods, moreover, additionally threatens health by reducing property values and hence the tax base for public education, while also increasing risk of asthma in children, and also their exposure to metals, thereby further affecting their ability to get a good education. In still another low income African American community, the Red Cross was prohibited from helping people suffering from flooding due to an extreme storm because their community was located within 7 miles of a nuclear facility. A key conclusion was that these problems exist because of the financial and political clout of energy corporations, who expend millions of dollars in lobbying to curb threats to their profits. Solutions include educating people about the harms and inequities caused by these companies, with one example being a rousing hip-hop song (played at the end of the session) about global climate change, its causes, and solutions, written and performed by several African American youth.

Carmen Nevarez, the vice president for External Relations for the Public Health Institute, next described the web seminar series she and her team have been developing, several of which have been focused on issues of public health, climate change, and health equity. The seminars were developed to help increase education of the public health workforce (whose median age is 55) as well as draw in younger public health practitioners and professionals, plus also address the increasing fragmentation of public health workers into ever more silos. The resulting web seminar program, Dialogue4Health (see: **http://www.dialogue4health.org/**), has a low carbon footprint, preserves all seminars in its archives (now over 300, with 95 of them "open" and the rest designed for particular clients), and can reach larger and more dispersed audience than conventional educational programs; in 2012, there were 16,554 regular subscribers and over 62,000 registrants. Four of the web seminars have focused on global climate change, and have not only increased knowledge but also steps to advance policy, with post-webinar poll results showing people's increased commitment to talking about the value of policy change to reduce global climate change with local people, legislators, and local media.

Aaron Bernstein, the Associate Director for the Center for Health & the Global Environment at the Harvard School of Public Health, next described a massive on-line course (MOOC), called "Human Health & Global Environmental Change" (see: **https://www.edx.org/course/harvard-university/ph278x/human-health-and-global/573**; **UPDATED LINK: https://www.edx.org/course/the-health-effects-of-climate-change**), that he helped developed and teach, and which was first launched this past year, in Spring 2013. He opened his presentation by asking people present why they thought it was so slow and hard to address global climate change; answers included: "tragedy of the commons," denial, and the enormous political and economic power of the energy corporations (whom Bernstein noted have over 4 trillion in assets, larger than the billions of the tobacco industry). To Bernstein, all of these obstacles underscore the need to educate people around the globe about the causes and consequences of global climate change and what can be done to address it. The MOOC thus presents data on climate change, its impact on biodiversity and health, and engages students in the 3rd part of the course with what can be done, which is a section that raises many issues

involving equity, which he said was one of the least-tapped motivations that nevertheless is crucial to leading people to take action to address global climate change. A key question is: "what is fair"? – for the US to do? for China to do? for there to be a greater impact on developing countries, especially when the problem is driven by energy policies and use of the developed world? for problems created by past and present generations to harm future generations? The MOOC enrolled 45,000 students from over 100 countries; 40% were from the US, the 2nd largest number of students were from India. In the 3rd part of the course, 2 exercises brought home different understandings and realities of "sustainable" production and consumption. One concerned the example of a jacket made in a Bangladesh garment factory: whereas US students tended to focus on concrete objects (e.g., carbon footprint), the students from Bangladesh raised the issue of the abject conditions of the garment workers who made the jacket, thereby putting a human face to the issue. A second example asked students to document how easy or hard it was to get an energy-efficient light bulb, with US students discovering it was much harder and more costly for them to do so than European students, and students in other parts of the world emphasizing that they didn't have easy access to electricity, let alone light bulbs. Teaching the course in this way has helped students realize that although the scientific knowledge is important, it is not sufficient: policy change (and not just individual change) is what is needed.

During the **Q&A** period, comments addressed: (1) an additional variant of the US light bulb issue, whereby one person recounted how when he went to his hardware store to get an energy-efficient light bulb, the store staff member referred to it as a "communist light bulb"; (2) how recruitment for the MOOC was done, with the answer being that it was listed at the EdX site, with no further advertising, and this was sufficient to draw in the 45,000 students registered; (3) how to direct students to careers in environmental justice, with one approach being to engage them with the reality of the problem of global climate change and how it can be addressed through action; (4) how education and action about global climate change in low-income communities of color can create a black/green pipeline (into jobs focused on environmental sustainability) and curtail the current pipeline feeding youth of color to prisons; (5) how to get government public health workers to take action on global climate change when they are increasingly muzzled, leading to discussion about the need for inside/outside strategies, whereby outside protesters can create conditions that give inside sympathizers space to move forward more progressive actions and policies; and (6) the value of youth-oriented campaigns, talking about personal stories, and leading them to take action, as exemplified by the hip-hop song played at the end of the session.

2012 (p. 12-15):

PROGRESSIVE PEDAGOGY

This session on links between pedagogy and capacity building to promote health equity was attended by ≈ 70 (lower than the ≈ 140 last year but much higher than the ≈ 25 in 2009).

PROGRESSIVE PEDAGOGY ACROSS THE LIFESPAN (Tues, Oct 30, 8:30-10:00 am, Session 4070.0) MCC South, Esplanade Ballroom 302

8:30 AM: Introduction – Lisa D. Moore, DrPH

8:35 AM: Roots of health inequity: challenges and opportunities in developing a web-based, interactive course for the public health workforce – Mikhaila Richards, MSc

8:55 AM: Warriors for Peace: resilient young men and educating peers and their communities – David Pheng, Mike Tran, and Geoffrey Dang

9:15 AM: Engaging students and elders in social justice research and action: progressive pedagogy beyond the classroom – Meredith MInkler, DrPH, MPH 9:35 AM: open discussion/questions and answers

Lisa Moore opened the session, noting its focus was on connections between generations, with the reminder that we all carry legacies, including of our teachers and our elders, and that when we become teachers, we pass these along to our students as well. Reflecting on her own teachers and sheroes/heroes, she said what struck her most was their courage – and she gave particular thanks to Meredith Minkler, her key mentor and one of the speakers at the session.

Richard Hofrichter then presented on behalf of Mikhaila Richards, who overnight was hit by a respiratory infection that made her too ill to present, and he described the new multimedia and interactive web-based course on health equity that the National Association of County and City Health Officials (NACCHO) had created to improve capacity of health agency staff to approach their work from a health equity perspective (see: http://rootsofhealthinequity.org). NACCHO is comprised of 2800 local health departments, all of which are straining to do their work while totally underfinanced. The intent of the course is to help change the consciousness of their staff and the work that they do to keep health equity a central concern. The course accordingly focuses on making accessible the ideas, consequences, and possibilities for addressing the root causes of health inequities, defined as “class and gender oppression and structural racism,” with class conceptualized as organized power that affects the economic well-being of others (as per the kind of power Chambers of Commerce wield). The course has 5 basic units, ranging from a historical unit that introduces the progressive history of public health on through contemporary case examples. To encourage people to build up a community that collectively develops and shares a critical perspective, the course is designed to be a process of discovery, not just a conveyer of factual information, and enables participants to set up private and safe discussion groups with others taking the course, whether or not at the same institution. A goal is to help public health professionals see themselves not only as professionals but as citizen-professionals who can advance the work they do by analyzing and addressing the root causes of health inequities, even as they may be limited in some of what they can do because they are under the statutory authority of mayors and also have inadequate resources. One example of a kind of project that the course encourages is linking of health data with data on social determinants of health, such as the prevalence of foreclosures (as Alameda County has done). Another is to challenge use of language that sidesteps issues of power and injustice, cf. use of

terminology referring to “vulnerable populations” as opposed to confronting who is making whom “vulnerable” and why.

David Pheng, Mike Tran, and Geoffrey Dang then gave a collective presentation on their project “Warriors of Peace.” David first gave a brief introduction about the origins of the program, which is based at a place in Oakland called “The Spot” that was formed 5 years ago to be a safe place where youth could meet, hang out, and also learn about the health and other social service programs offered by Oakland’s myriad community-based agencies. Mike, one of the trainers for “Warriors for Peace”, then talked about how their project was focused primarily on young Asian immigrant and Asian American youth, with the deliberate intent of addressing some of the tensions between these groups. They decided to locate “The Spot” in Chinatown because the youth they talked to said it was a safe common meeting ground, noting too that the center is open to anyone who wants to hang out there and use its services. One impetus for creating the center was the murder of one teenager when she went to a different neighborhood with her friends, along with recognition that Asian youth, and especially immigrant youth, were also disproportionately being jailed, in part because the immigrant parents were unable to advocate for them (both due to language difficulties and also fear of dealing with the authorities). The key two issues identified as harming Asian youth in Oakland were: (1) violence, and (2) lack of jobs. They accordingly went about developing “Warriors of Peace” for young Asian men in Oakland. The program has 3 components: (1) team building (having fun, learning how to hang out together, including with people from different countries, backgrounds, and neighborhoods); (2) talking about violence (since it is difficult for young men to open up about violence, given stereotyped expectations that they are supposed to be tough and silent), with attention to differences between “negative” vs “positive” responses to violence (i.e., revenge and retaliation vs different approaches to healing, ranging from engaging in hip hop therapy, use of other mental health services, and learning to keep a journal); and (3) telling their own stories, including via use of video cameras, since all too often their stories are unheard and ignored. Throughout, they emphasized an inclusive perspective, informed by approaches in ethnic studies, that gave heed to connections between racism, class, gender, and sexuality; one example of a question they used to open discussion was: “who are the women you respect and why?”. The initial cohort started with 18 young men who came from a variety of areas in Alameda County. In addition to be given free snacks at every meeting, all were promised a stipend of $200, which they would be given only if they went through the full program; at the end, 12 remained, and when given the $200, many were surprised, because the project had become so valuable to them that they had forgotten all about the incentive. The first cohort created a video about Oakland which had its premiere this past June and was shown to members of the center and their parents (see weblinks below). Jeffrey, a 2nd year college student and participant in “Warriors for Peace,” then talked about his own experience in the program, and how he gained so much from meeting people he would never have otherwise met, as well as seeing parts of Oakland he had never seen before and also seeing with new eyes parts of Oakland he was regularly in. By the end, he said he not only made friends but formed brotherhood with the other participants in the program. He then showed a clip their video, called: “Where you from? Oakland – smoking!” (meaning: wonderful! – it was not an endorsement of tobacco smoking) – and was filled with interviews of friends, other youth, and adults whom they met in various parts of Oakland, expressing their delight and pride in being from Oakland (in contrast to the usual stereotypes of Oakland being a place people want to flee because of crime and violence). Showing the video to their friends and family was a highlight and he wants to remain involved with the program. To see the videos produced, see both:

http://www.youtube.com/watch?v=a2dBDo0B2Gs
http://www.youtube.com/watch?v=3D17gmNAL2c

Meredith Minkler then recounted the stories of three of the community-based participatory projects she has been engaged in for the past 30 years, all of which involve elders and all of which are premised on the critical pedagogy of Paulo Freire and its emphasis on analyzing root causes, praxis, and social action organizing informed by the lives of the participants, with the goal of base building and redressing power gaps that cause harm. Also informing the projects is work in critical gerontology, which has issues of power and privilege as central to its analyses, and which examines how the realities of aging are shaped by economic position, race/ethnicity, gender, sexual orientation, and disability, and which also stresses that elders should not just be "studied" but that projects should be designed with them as partners to enhance their capacity to make social change.

-- The first project was started 38 years ago and was called the **"Tenderloin Senior Organizing Project" (TSOP)**. Key achievements of the project were to: (1) break down distrust and overcome isolation of the residents in this economically impoverished neighborhood, one that also had very high crime rates, and (2) help seniors identify, discuss, and address issues they wanted to change. Emphasizing that the four most important words of organizing are "refreshments will be served," she described how a key gift of the students was not just the food but their desire to hear the stories of the residents, with a common theme emerging about their concern about crime (typically at the rate of 2 assaults per person per year). The community meetings in diverse buildings eventually coalesced into a large meeting with the mayor (then Diane Feinstein), who also came to visit the Tenderloin (with 16 police for protection!). As a result of this organizing, TSOP helped establish 48 safehouses, and also helped address food insecurity by setting up 4 mini-markets in 4 of the hotels, as well as creating a cookbook called "I love to cook but can't" to describe ways residents could prepare food given limited cooking facilities. The residents eventually formed 14 tenant associations and led many successful campaigns to improve their living conditions, e.g., making sure hot water was available. After 16 years, it became a non- profit organization and over the years has involved over 300 students, linking younger and older generations in the struggle for social justice.

-- The second project was called the **"Grandparent Caregiver Study"** and was started in the 1980s in Oakland at the time of the rise of arrests of young people for crack cocaine (especially young African Americans), which had far stiffer sentences than for use of "regular" cocaine used by more affluent white consumers (100:1 ratio in mandated sentencing time, an injustice only recently rectified after prolonged struggle). One consequence of these arrests was a sharp rise in the incarceration of young women, of whom ~3/4 had young children, who were then taken in by their grandparents, with yet another inequity being that grandparents who took in their own grandchildren were compensated by social programs for only 1/3 the amount they would have received had they taken in foster children to whom they were not biologically and/or legally related. One question that Meredith described was whether it was appropriate for her and her colleague, both white affluent women, to take up work on a problem that disproportionately affected more impoverished African American women and their families. They met with members of relevant black organizations in Oakland and received encouragement to join in a CBPR venture; in their ensuing grant applications, the overwhelming majority of the budget went to the community organizations. The project ultimately recruited approximately 130 grandmothers to be participants, of whom 77 remained engaged until the end. As one example of their influence on the research process, the participants helped reframe questions to make them more relevant to their lives, e.g., instead of asking "what is your income," they changed the wording to be "How much money is available to help you raise your children?" Students helped

conduct interviews, analyze and interpret data, and bring findings back to the participants and their organizations. Initiatives developed out of this project included setting up a “warm line” run by the grandmothers to offer support to other grandmother caregivers, a respite center, public rallies to improve grandparent caregiver benefits, and formation of a regional and statewide coalition, which set up a national Grandparent caregiver information center (now based in AARP).

-- The third project described is the **California Senior Leader Program**, which involves 150 seniors, nominated from across the state, and who meet in into bi-annual cohorts of ~30 people, most of whom are elders of color. Each gathering is a 2 day honoring and training event, in which each elder is paired with a graduate student who shares common interests, and this student then remains engaged with this elder over the next 15 months. Among the issues tackled by the elders in this group are: ensuring that the next generation knows about the internment camp set up for Japanese Americans by the US government during World War II, as linked to current struggles to defend civil rights and immigrant rights; American Indian struggles to prevent co-optation of their symbols and history by Big Tobacco; LGBT seniors working for marriage equality and for welcoming senior housing; and rural seniors working to improve access to transportation. The seniors involved have also produced an ongoing newsletter and website, and network together to promote advocacy in Sacramento (the state capitol), where they are increasingly seen as a group to consult by progressive legislators. Through this intergenerational project, the students gain awareness of what people are able to accomplish, and the elders gain new allies in the struggle for change. Capturing the spirit of the project is the motto of one of the elders, Frank House, who passed away this last year, was: “I don’t think outside of the box. I think outside of the warehouse.”

[NEW LINK: https://careasy.org/nonprofit/California-Senior-Leaders-Alliance]

During the **Q&A** period, comments addressed: (1) to what extent do the projects get involved with people’s lives when they become ill (with the question motivated by experiences with an project involving people with HIV/AIDS in Chicago), and for which the discussion emphasized that it is a mistake to divide the personal and political, noting that a key innovation of the TSOP project was to hold memorials for tenants who died (as opposed to tenants finding out about the death of co-residents by seeing their clothes thrown in a pile in the lobby for recycling), and that is important to find ways to help people stay in touch, including through times of illness and death; (2) what are the ways the Oakland video has been used?, with the discussion focusing on the community showing in June 2012, and also the learning experience that happened when they tried to submit it to film festivals, only to find out that because they had included copyrighted music without credits, their submissions could not be accepted – so they will keep this important lesson in mind when developing future videos; (3) ways in which county and city health departments can be creative, despite limitations on their budgets and authority, e.g., by hiring people from the local community who are committed to health equity, by actively seeking out and listening to community concerns, and by changing their view of themselves as chiefly technicians to being instead informed and engaged citizens-professionals; (4) how refreshing it was to hear the different projects together, all emphasizing the need for critical consciousness, intergenerational ties, and the need to move healing into action; (5) the emphasis of “Warriors for Peace” on the assets of the community, and learning lessons from prior movements for struggle (e.g., in San Francisco, the fight for the International Hotel in the 1960s that was key also to the development of Ethnic Studies at the University of California), with a key point being the value of listening to youth, not talking at them, and the need also to emphasize that the work

is motivated by love, not by hating the system; and (6) similarities to projects in North Carolina that since 1984 have been linking students and elders and other residents to improve access to care in rural areas in the state.

2011 (p. 10-12):

A SOCIAL JUSTICE PERSPECTIVE ON TEACHING AND CAPACITY BUILDING TO PROMOTE THE HEALTH OF COMMUNITIES

TUES, NOV 1 * 8:30 AM-10:00 AM (SESSION 4073.0)*** WASH CONV CTR (WCC) RM 101**

8:30 AM — Introduction. Cheryl Merzel

8:35 AM — THRIVE: A Toolkit for Community-Led Initiatives to Address Health Equity. Xavier Morales, Rachel Davis, Melissa Cannon

8:55 AM — From Building Capacity to Building Power: Lessons for Public Health Pedagogy. Makani Themba-Nixon, Cheryl Grills

9:15 AM — Paradox of Public Health and Social Justice: Being a Professional in the Social Change Process. David Chavis

9:35 AM — Question & answer period

PROGRESSIVE PEDAGOGY

This session on links between pedagogy and capacity building to promote health equity was attended by ≈ 140 people (attendance in 2010: ≈ 150; in 2009: ≈ 25; in 2008: ≈ 100).

Cheryl Merzel opened the session, noting its focus was on progressive pedagogy as carried out in community-based organizing and interventions (as opposed to “classroom” learning), with these efforts premised on seeking to build equitable relationships and promote health equity.

Xavier Morales, an urban planner who started out in environmental justice work and then found his niche in public health organizing, then discussed the THRIVE project, housed in the Prevention Institute. Initially funded for 2002-2004 by the Office of Minority Health, THRIVE is a “toolkit for community-led initiatives to address health equity,” that was renewed in 2010 to support the training of trainers in 20 sites over the next 5 years. According to Morales,

THRIVE's approach is to focus on resilience, not risk, in part by developing community-level measures of resilience that can be assessed. The first step is to instigate community assessments and discuss what is found; the second is to prioritize initiatives to promote a healthy community. A key component involves transforming how community members view the sources of and solutions to health issues in their community, by shifting to from individual-level to community-level thinking and action. Morales then described how, in one site, THRIVE focused on training youth, who then organized to launch a teen center and also a county-wide mentoring program; other sites launched farmers' markets in neighborhoods lacking supermarkets, and conducted health impacts of urban planning initiatives. All sites sponsored community forums, as part of a process of strengthening residents' capacity to give voice to their concerns and language to express these concerns to local government, thereby holding government more accountable.

Cheryl Grills next described the work she is doing, working with the Praxis technical assistance team, to lead evaluation of the RWJ-funded project "*Communities Creating Healthy Environments (C-CHE): Improving Access to Healthy Foods and Safe Places to Play in Communities of Color.*" This initiative began in 2008 with 10 sites and has since expanded to another 12 sites (i.e., 22 in total). As stated by Grills, their purpose is to shift from building capacity to building power. Objectives of C-CHE pertain to addressing such root causes of health inequities as land use policies, predatory marketing, and underfunded public infrastructure, whereby the process is conceptualized as challenging inequity so as to produce structural change whose impact results in food and recreational equity. The evaluation, in turn, is a dynamic process that both theorizes and operationalizes benchmarks of success in relation to base building, community leader development, and policy change – and, in doing so, not only generates information useful to those doing the organizing but is also addressing a major gap in the social science literature that Grills and her colleagues identified: the lack of tools to assess community organizing. Core components of the evaluation, premised on a social justice lens and involving both relationship building and ethnographic thick description, include a power analysis, a policy plan, and a communication plan. Noting that skill development applies as much to the evaluators as it does to the community participants, Grills described how the commitment to listening made clear that, in the case of one group, requesting written reports was inappropriate and inefficient. Instead, it was far better for the group to videotape its events and do "6 o'clock news" style interviewers of those engaged; these tapes were then sent to the evaluation team, thereby ensuring the events and views were documented (with the C-CHE team additionally transcribing the recorded interviews and conversations). Other guiding principles include: (1) people of color lead the work; (2) relationships are being built for the long-term, with an aim of creating a nationally linked movement, (3) experience as well as expertise is valued; and (4) initiatives should be intergenerational and work across race/ethnicity/class/age/native status. One example discussed concerned how one community decided to prioritize a focus on addressing structural barriers to breastfeeding, as informed by social justice and reproductive rights analyses; one action step was to challenge the promotion of breast formula by pharmaceutical companies by successfully changing local hospital policies to make them breast feeding baby friendly.

David Chavis (with: https://www.communityscience.com/) then discussed four paradoxes that he has struggled with and that repeatedly emerge when professionals engage in social justice work and community organizing, including in public health. The kind of "glass ceiling" such

professionals hit, he said, gains new names in new cycles of analysis, but the basic problems endure. He identified these 4 paradoxes as follows, illustrating each with common scenarios. First, Paradox 1: what happens when professionals promote social change & social justice from risk-adverse institutions?, and in turn raising the question: are health professionals expecting marginalized communities to make changes that we cannot ourselves make in our own institutions? Second, Paradox 2: many community residents know the problems they encounter, but rarely have access to the knowledge and literature on what does and doesn't work to solve complex public health and other problems, yet many professionals act as if they should downplay the expertise they have rather than share it in partnership to the communities. Third, Paradox 3: the greatest changes have come about through conflict and shifts in power, yet "conflict" is not seen as part of what professionals do. And fourth, Paradox 4: major structural determinants of health inequities lie outside the health system or responsibilities of public health agencies. Accordingly, for organizing work about social justice and health to be more effective, Chavis argued that public health professionals have to learn how to use power and conflict for progressive change and form true partnerships with communities, using our skills and knowledge. We likewise need to do a better job of better preparing young professionals, i.e., by teaching them that organizing is not a "technique" but rather a process of engaged social change. He concluded by saying that the renowned Highlander Research and Education Center, which played a pivotal role in training civil rights activists, taught coal workers math and reading by having them learn how to review management's finance books; they did not dummy anything down but instead built skills necessary for confronting power.

During **the Q&A period**, comments addressed: (1) how evaluation needs to be fluid, not prescriptive, so that it can provide iterative feedback to improve the work, as opposed to be graded against static standards; (2) how to handle IRB involvement, with responses noting that evaluation work as such is exempted from IRB review, but that if IRB review is needed, it is better to work with federally-approved community IRBs as compared to university-based IRBs (and many communities are starting to set up such IRBs); (3) issues of movement building, and whether what's most feasible is to start with small goals, to build relationships, then take it up to regional equity movements, and from there to national – but this depends on issues and context (as per the fast-moving morphing of the Occupy movement(s) now emerging); (4) the importance of securing funds to support this kind of organizing (e.g., the $15 million for the C-CHE project), with foundations and agencies needing to understand that for the work to be effective, it has to be open to the kinds of issues addressed in the session; and (5) whether the organizing efforts take the steps to raise consciousness about the historical and social context in which work in the US is carried out, including in relation to policies & programs created in other countries that have more progressive governments – with one response discussing how work with agencies focused on children in foster care in LA was transformed by teaching the social workers about the history of inequitable federal, state, and local policies, as well as the history of slavery and disrupted families – and the reminder that we are only one generation out from enaction of the civil rights acts of the mid-1960s; this new knowledge led to staff in these agencies gaining new insights into not only the disempowerment of the people with whom they worked but also for themselves, in their agencies, and in turn inspired new organizing efforts by the staff to realize their power as staff in the system and to start making major changes in agency policy and practices, bolstered by their power in numbers.

2010 (p. 9-10):

PROGRESSIVE PEDAGOGY

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

PROGRESSIVE PEDAGOGY FOR PUBLIC HEALTH: TEACHING AND THE CO-OPTATION OF SOCIAL JUSTICE

TUES, NOV 9 * 8:30 AM-10:00 AM (SESSION 4066.0)*** CO CONV CTR (DCC) RM 603**

8:30 AM — Introduction. Lisa Dorothy Moore, DrPH

8:35 AM — Making the invisible visible: effective learning on equity and the social determinants of health. Fran Baum, BA (hons) PhD, Angela Lawless, BSc MPHC, Gwyn Jolley BSc MSc, Michael Bentley BSc, Toby Freeman BSc Phd, Miranda Roe BSW PhD, Frank Tesoriero MWs PhD

8:55 AM — Has social justice become the new diversity? A critical examination of public health pedagogy driving community engagement. Makani Themba-Nixon

9:15 AM — Resistance to co-optation: success and failures from the field. Bonnie Duran, DrPH and Nina Wallerstein, DrPH

9:35 AM — Question & answer period

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

Fran Baum then discussed the approach she and colleagues are taking at Flinders University (in Australia), as informed also by Baum's work as a Commissioner on the WHO Commission on the Social Determinants of Health, to train the public health and medical workforce to understand the social determinants of health framework and its implications for the work of public health agencies and health service institutions. The basic logic was to point out that it did little good to treat people's ills only to send them back to the same conditions, over which they had little or no control, that made them sick in the first place. Key barriers identified included: (1) individualism (easily leading to victim-blaming); (2) the tendency to focus only on the tip of the iceberg (i.e., focus on illness and not its social determinants); (3) prior training being highly curative, with little focus on prevention; and (4) the dominance of the medical imagination, with little space for the sociological imagination. Addressing these barriers requires: (a) addressing values directly, including making the ideologies of the dominant individualistic approaches

apparent; (b) challenging behaviorism (including empirically, via research demonstrating the importance of social determinants of health, e.g., in Australia, demonstrating that two of the major determinants of smoking for members of the Aboriginal population were being incarcerated and having endured being what is termed "stolen," i.e., removed from their families by the state and missions and forced to be their wards instead); and (c) using multi-pronged strategies premised on the participation and leadership of those affected by health inequities.

Makini Themba-Nixon next asked if social justice for all, at the societal scale, is what we need, then is it already a co- optation to focus only on injustice and health inequities? Arguing that we need to move beyond problems-to-be-solved to achieving a world with social justice, she proposed shifting the analysis from "problem people" and "problem conditions" and changing distributions to transformative visions about how we share power and build democracy and co-governance, as per new work on participatory budgeting. Themba-Nixon also emphasized the importance of bringing in Indigenous knowledge, alternative visions (e.g., moving from "there is no alternative" to "another world is possible"), and advancing stories that make solutions visible. Urging creation of intersectoral, process-oriented, democratic spaces, she referred the audience to concrete examples of creating this sort of transformative action, available at the following website: http://www.transforming-communities.org **[UPDATED LINK: https://web.archive.org/web/20160304171019/http://transforming-communities.org/]** ; examples pertain to education reform, food retailing, the Blackfeet clean air resolution, and analysis of UK efforts to "mainstream equality."

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

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

2009 (p. 11-12):

PROGRESSIVE PEDAGOGY

This session on links between pedagogy and community-based participatory approaches was attended by ≈ 25 people (a smaller than usual pedagogy session, noting that in 2008, ≈ 100 attended, in 2007, ≈ 250 attended, and in 2006 ≈ 50 attended). We are unclear on the reasons for low attendance, noting that some of our prior sessions that also focused on CBPR in relation to pedagogy did draw more of an audience.

COMMUNITY PERSPECTIVES ON COMMUNITY-BASED PROGRESSIVE PEDAGOGY

TUES, NOV 10 *** 8:30 AM-10:00 AM (SESSION 4068.0)*** PHIL CONV CENTER (PCC) RM 113A

8:30 AM — Introduction. Suzanne Christopher, PhD & Lisa Dorothy Moore, DrPH

8:35 AM — "Will they really use our work?" The importance of University/Community Partnerships in creating relevant Service learning assignments. Jean M. Breny Bontempi & Chris Cole

9:00 AM — Community-based participatory research as a lens for reconceptualizing service learning: diverse urban students bridging campus and community. Ester R. Shapiro, PhD & Michelle Rogers, BA, Asi Yahola Somburu, BA, Genita Johnson, MD, MPH, Brian K. Gibbs, MPA, PhD, Naomi Bitow, MPH, Roland Smart, BA, K.T. Craddock, EdM, PhD, V. Kumarpeli, MB, BS, MSc, MD, S. Walker, BA, Felton Earls, MD

9:25 AM — Question & answer period

Suzanne Christopher opened up the session, introducing the speakers and also the genesis of the session – which is that having previously included some courses that emphasized the importance of community-based service and learning, we thought it would be useful to get community perspectives on this approach to pedagogy.

Jean M. Breny Bontempi described the partnership between her academic institution (South Connecticut State University) and AIDS Project New Haven in a course focused on community-based service learning. Opportunities included the chance for students to work on projects that get used by the community and to learn critical skills regarding collaboration and group dynamics; challenges included the difficulties of conducting such a class in a student body that is largely part-time/commuter students and the attendant difficulties of work schedules, commuter schedules, and family responsibilities. One solution to these problems was to have students divide up into workgroups that matched with both their academic interests (in relation to skills they already had and new skills they wanted to learn) and their time constraints. One workgroup accordingly focused on administrative/management aspects of the project, another on secondary data analysis (including literature reviews), and the third on primary data collection (e.g., conducting a client and staff satisfaction/needs survey, on-site observation, and a client focus group). The University's IRB approved the work of the class, conditional on informed consent being obtained from all participants and also prohibiting the publication of any content data on the project's findings (although discussion of the process of the class can be shared). Staff from AIDS Project New Haven were actively involved in designing the project goals (including methods used), provided advice throughout the project, and at the end came to the final class in which students presented their findings and recommendations – and then took this information back to their board, thereby initiating some potentially useful changes in their practices. Positive aspects for the community agency of being involved in the class included: (1) getting fresh views on their work from an "outsider" perspective; (2) receiving the product of quality focused work provided as a free service; (3) the reward of introducing developing professionals to service work; (4) attracting subsequent interns and volunteers from students who took the course; and (5) strengthening the agency's ties to the University. The two major challenges concerned: (1) ensuring client confidentiality, and (2) allocating the staff resources to provide adequate supervision of the students. The overall sense was that the benefits far exceeded the challenges for all concerned.

Ester Shapiro next presented on models, methods, and challenges in service learning, drawing on experiences from what had started out as a joint collaboration between two institutions, but was now a course based only at her institution (since the relevant unit at the other institution no longer existed, following the departure of its head for another position). Noting that most service-based learning has been premised on the assumption that it is for white middle-class students who have not experienced poverty or social exclusion so that they can benefit from learning about conditions in marginalized communities, she countered that the urban commuter students who take her course are in fact from the very communities targeted for being served by the service-based courses. Consequently, course objectives need to address pathways by which these urban commuter lower income students can convert their community-based knowledge into professional pathways for personal and community development. The approach of community-based participatory research, as used in the course, offers one bridge for helping

students see the relevance of research to further these twin goals, and also for understanding how research can be a tool for accountability. The theme of the importance of learning in order to “give back” was then emphasized by Special, one of the graduate students who took the course and who now is mentoring undergraduates to get them involved in community-based research that can address community needs.

During the **Q&A**, one set of questions focused on the difficulty of addressing curriculum content versus getting the actual work done; one solution discussed was using classroom time (and also “laboratory time”) for both teaching content AND holding the discussions needed to move the project along. Another set of questions focused on issues of students’ diverse skill levels (ranging from practically illiterate to very skilled students) and time demands (given jobs, commuting, and families), with discussion emphasizing the importance of the course for putting these challenges in context and also the necessity of structuring the course so that students can participate at (and extend) their relevant skill levels, and work collaboratively in teams, with opportunities provided for them to mentor each other (as opposed to viewing all mentoring as solely the faculty member’s job). An alternative suggestion, based on approaches currently used in New Zealand, is to recruit students from relevant community services (e.g., Maori health providers) that see the value of research and data and who are eager to have members of their staff brought into the University to learn helpful skills, which they can then bring back to their organizations. The overall emphasis in the discussion was on the need for inclusive methods, drawing on what the students, academic institutions, and community groups can each best offer.

2008 (p. 8-10):

PROGRESSIVE PEDAGOGY

This engaging session was attended by ≈ 100 people (twice the ≈ 50 in 2006, but down from the ≈ 250 in 2007, which drew in many who wanted to know how to teach the content of “Unnatural Causes”).

TEACHING CRITICAL HISTORY OF PUBLIC HEALTH AND HEALTH POLICY: PROGRESSIVE PEDAGOGY IN ACTION

TUES, OCT 28 *** 8:30 AM-10:00 AM (SESSION 4063.0)*** SD CONV. CENTER (SDCC) RM 2

8:30 AM — Introduction. Lisa Dorothy Moore, DrPH and Suzanne Christopher, PhD

8:35 AM — A role for exhibitions: “Making a Difference in Global Health.” Manon Parry, MA MSc

8:50 AM — Literacy, access to information, and social power – 1848 and 2008. Sherry Spence, MD

9:05 AM — Necessity of teaching the history of public health from a critical perspective. John P. Elia, PhD

9:20 AM — University of Toronto's history of international health course. Anne-Emanuelle Birn, MA, ScD

9:35 AM — Question & answer period

Lisa Moore introduced the session with comments on how the lack of critical teaching about public health history in most US schools of public health was the impetus for the session, since a knowledge of history is part of what enables us not only to better understand the past and how we got to where we are today but also to see ourselves as historical actors who create history in the present by what we do. She also announced that all **syllabi discussed in the session will be available at the Spirit of 1848 website**, at: http://www.Spiritof1848.org.

Manon Parry described the exhibition the National Library of Medicine launched in April 2008, titled "Against the Odds: Making a Difference in Global Health." Geared especially to a younger audience and to overcome the widespread views that "global health is about them, not us (in the US)," that "the US provides answers, as opposed to solutions coming from elsewhere," and that "the problems are so overwhelming that nothing can be done," the exhibition focuses on "missing stories" about the impact of poverty on health and well-being, the connection between health and human rights, the shared values that promote a decent quality of life, the link of the US to the rest of the world, and concrete examples of individuals, organizations, communities, and societies that have made a difference. Using historical and contemporary examples, the themes of the exhibit pertain to: clean water; nutritious food; access to affordable health care; protection from violence; and safe housing. Other "missing stories" addressed pertain to discrimination and HIV/AIDs, to the spending on monies on conflict and war, rather than health needs. The exhibition goals are to: (1) broaden perception of the causes of illness, i.e., not just viruses but poverty, hunger, and other social determinants of health; (2) challenge assumptions about who is at most risk, looking at inequities within as well as between countries; (3) encourage collaboration based on shared values, e.g., human rights; and (4) encourage people to get involved, especially youth activism. Each week, a new question is placed on a comment board at the end of the exhibition, asking "What's Your Perspective" and, suggesting the exhibit is meeting its goals, when the question on the board asked "can one person make a difference," one reply from a student concisely stated: "Hell yeah!" The traveling version of the exhibit is intended to be shown at schools of public health, with the only cost being that of covering its shipment by fed-ex, and the encouraging news is that it is already booked up through summer 2010. If you are interested in having your school host the exhibit, contact Manon Parry at: parrym@mail.nlm.nih.gov; to see more about the exhibit on-line, visit: http://apps.nlm.nih.gov/againsttheodds/index.cfm

Sherry Spence then gave a presentation looking at health literacy and the dissemination of public health information in historical context, with attention to the implications of literacy and health literacy for power relations and health inequities. Examples pertained to the invention and dissemination of use of the printing press in Europe during the Renaissance and Reformation, the rise of slave literacy in the US in the mid-19th century, and the current use of the internet and the importance of e-health literacy. Common themes were the link between literacy and power and the need to build capacity for health literacy, including e-literacy. For more discussion of these issues, and also the 50-page bibliography informing the presentation, see: http://sandbox.wikispaces.com/health-literacy-community **[N/A]**

John Elias next presented on a new course at San Francisco State University on the critical history of public health in the United States. Geared to undergraduates, the course's impetus was the lack of any public health courses focused on history, coupled with the lack of any courses in the history of science department that were focused on either medicine or public health. Approximately 75% of the enrolled students were from public health, the other 25% from history, with one discovery being the utility of pairing up students from these two different disciplines, since the public health students could teach the history students about health, and the history students could teach the public health students about both history and analyzing primary as well as secondary source materials. Key to the course was its inclusion of critical, revisionist history, with an emphasis on the intersections between class, race/ethnicity, gender, and sexuality. Each session includes a 30-35 mini-lecture; other components include: (a) students working in groups to critique, from a critical intersectional standpoint, a particular article, with each student writing a 3-4 page analysis that s/he shares with the other students in the group, as the basis for a joint critique developed by the full group; and (b) engaging the students in critiques of different films, regarding what they cover and what they omit, e.g., a film on the "History of Sex in America in the 20th century," which, when discussing Margaret Sanger, made no mention of her support for eugenics. There is also a mid-term exam and a final 8-10 page paper. Two aspects of student resistance, both the result of prior educational experiences, that needed to be addressed were: (1) their expectation of being "fed" education rather than be engaged in critical education, and (2) their questioning of the legitimacy of studying history from a historical perspective; by going through the course, students came to appreciate the value of a critical stance.

Anne-Emanuelle Birn described the graduated level course she teaches, a seminar on the History of International Health at the University of Toronto. This course looks at the ideologies, institutions and practices of the field of international health, from its imperial origins to the present-day, including in relation to colonialism, class, racism, and gender. Focusing on the political, scientific, and social underpinnings of the principles and activities of the international health field and its embedded cultural values as well as both its continuities and discontinuities, the course relies on both primary sources (e.g., printed documents, whether text, correspondence, or poems, and also photographs and films) and secondary sources (e.g., scholarly research, both books and articles). Each session uses films and documentaries and draws especially on the visual resources available at the National Library of Medicine (with Anne-Emanuelle also acknowledging the work of Elizabeth Fee, who was present in the audience, for her essential work in making more visible and available critical work on the history of public health). The two assignments are: (1) from the perspective of a late 19th or early 20th century medical officer, justify the importance of a particular international health activity or policy, and (2) write a 2050 paper, analyzing early 21st century work in international health, so as to learn how to contextualize the on- going work in one's own era. Examples of themes of particular sessions are: (a) Colonial vs International vs Global Health: what's the difference?; (b) Mind, Body, Race, and the Building of Empire; (c) Missionaries and Health; (d) Industry, Research, and "Tropical" Medicine; and (e) Sex, Sickness, and Security: Metropole and Outpost. Examples of two contrasting films, whose use sparks lots of conversation among the students, are an mid-20th century American Medical Association film titled "MD International" (1958), featuring then Vice-President Richard Nixon extolling US efforts to help others abroad, versus a very different, sponsored by the World Health Organization, on "Health for All" (1978), made after the Alma Ata conference, and showing footage of, among other things, a Frelimo rally in Mozambique, making clear how the fight for national liberation was essential for health, with health campaigns to fight disease, conducted in the midst of armed struggle, portrayed as

part of a strategy to ensure people would be strong enough to build their nation – and with contemporary students amazed that WHO would ever have included such material in a film, noting how in the current era, prevailing ideologies and power relations have precluded such a critical stance.

Suzanne Christopher then opened up the session for **Q&A,** noting how the presentations had made vividly clear how many "missing stories" there were and why a critical historical perspective is needed. From the floor, **Elizabeth Fee** underscored the many resources that are available at the National Library of Medicine, including not only films but also syllabi of courses taught world-wide about the history of public health and medicine, and noted that the NLH is currently producing a DVD-series to make the films more widely available. For these and related resources, see:

-- for films: http://www.celebratingresearch.org/libraries/nlm/healthfilms.shtml

[UPDATED LINK: https://web.archive.org/web/20160804062024/http://www.celebratingresearch.org/libraries/nlm/healthfilms.shtml ; and a more recent link: https://www.nlm.nih.gov/hmd/collections/films.html]

-- for syllabi: http://www.nlm.nih.gov/hmd/collections/digital/syllabi/index.html

An additional resource mentioned by **Walter Lear** is the US Left Health Historical Center, based in the Institute of Social Medicine and Community Health (in Philadelphia) which he directs and whose website is in construction. The Center has available archival documents (e.g., pamphlets, photographs, political pins) and scholarly publications and also produces a news letter; for further information, contact Walter Lear at: ISMCH, 206 N. 35th St, Philadelphia, PA 19104 (phone: 215- 386-5327; email: wjlear@critpath.org). Other issues raised during the Q&A period included how to ensure these sorts of courses are taught, or materials are at least included in required introductory courses, given how many other requirements students face, and also how to ensure that whatever is included as session in other courses is presented in a critical way (e.g., simply including photographs of the Broad Street pump and mentioning John Snow is not adequate for critical history of epidemiology) and how to address the problem that most students need remedial education in general history so as to put the public health history in context – with the only way to address this being that there is no short cut around the fact that students do have to read to gain this context ...

UPDATED LINK re: Walter Lear's archives:

https://www.library.upenn.edu/collections/special-notable/groups/u-s-health-activism-history-collection-walter-j-lear-us-health

2007 (p. 11-13):

CURRICULUM/PROGRESSIVE PEDAGOGY

Our pedagogy session, attended by ~ 225 people (a huge jump from last year's count of 50!), was as follows:

BROADENING TEACHING ABOUT HEALTH INEQUITIES AND SOCIAL JUSTICE

TUES, NOV 6 *** 8:30 AM-10:00 AM (SESSION 4070.0)*** WA CONV. CENTER (WCC) 144C

8:30 AM — Session introduction. Suzanne Christopher, PhD, Lisa Dorothy Moore, DrPH

8:35 AM — Social justice as the organize theme in undergraduate education. Mary Beth Love, PhD, Vicki Legion, MPH, Amanda R. Goldberg, MPH, Ingrid Ochoa, MPH, Savi Malik, BA, Rachel Poulain, MPH, Cathy Rath, MA, Sarah Rodriguez

8:50 AM — Alameda County Public Health Department's pedagogy for social justice. Mia Luluquisen, DrPH, Sandra Witt, DrPH, Katherine Schaff, BA, Sandi Galvez, MSW

9:05 AM — Linking health inequities and social justice: teaching the social determinants of health. C. Linn Gould, MS, MPH

9:20 AM — Using "Unnatural Causes" to educate and advocate for health equity. Rachel Poulain, MPH 9:35 AM — Question & answer period

Note: all speakers for this session have agreed to have their powerpoint presentations posted on the Spirit of 1848 website; be on the look out for them, at: http://www.spiritof1848.org/

Suzanne Christopher introduced the session & speakers, noting the range of types of teaching issues that would be addressed.

Mary Beth Love began by describing the Community Health Certificate program for frontline community health workers, informed by a social justice perspective, that San Francisco State University (SFSU) has developed, in collaboration with the City College of San Francisco. Certificates currently are offered for: Community Health Workers; Drug and Alcohol Studies (a public health approach to addiction and harm reduction); Health Care Interpreter; HIV/AIDS Prevention Education; and Trauma Prevention and Recovery; more are being developed (e.g., re mental health, youth, and post-incarceration re-entry workers). Their new initiative, Metropolitan Health Academies, is intended to address the under-preparation of many people who want to get a higher education and be leaders in public health. It contextualizes public health issues by using a social justice framework, and has four components: critical thinking, oral communication, quantitative skills, and writing. She also described an introductory film-based course on social justice and public health, and also an advanced course in which students learn to make films focusing on the links between social justice and public health. Also

mentioned was the Katrina Teach-In at SFSU and their Masters of Public Health program, requiring community involvement. Among lessons learned, she emphasized: (1) courses should start with case studies, then work their way to more theoretical material about racism, class, gender, and health; and (2) four different lenses are needed to engage students in active learning: emotional engagement, vision (i.e. there is an alternative), analysis (about developing historical consciousness and recognition that policies have been made and can be un-made and re-made), and strategy (about power analysis and both long-term and short-term plans to combat health inequities). Major teaching challenges include: (a) overcoming the feeling that this is all too depressing; (b) spending too much time on the problems, rather than the solutions; and (c) having too much content crowd out interactive pedagogy. The best approach for addressing these challenges is to increase the time span for teaching and engaging the students with the course materials. All of the programs described are summarized in a handout that will be posted on the Spirit of 1848 website. See also:

-- for the Community Health Certificate program:
https://www.ccsf.edu/Departments/HealthScience

[UPDATED: https://www.ccsf.edu/degrees-certificates/community-health-worker]

-- for the Metropolitan Health Academies: http://www.sfsu.edu/~hed/faculty/grants.htm
[UPDATED: https://metro.sfsu.edu/about-metro-academies]

-- for two film-based health & social justice courses:
http://www.communityhealthworks.org/film_series.html

[UPDATED:
https://web.archive.org/web/20080420062728/http://www.communityhealthworks.org/film_series.html]

-- for the MPH program in Community Health Education at San Francisco State University:

http://www.sfsu.edu/~hed/masters/glance.htm

[UPDATED / REDIRECT LINK: https://healthed.sfsu.edu/]

Mia Luluquisen next described the work she is doing in the Alameda County Health Department to train its workers in pedagogy for social justice and public health, with a particular emphasis on institutional racism. One critical problem is that most staff at most US health departments lack training in either public health or social justice. Her program uses a Frierian popular education approach to engage the students so that they develop a deep understanding of – and are motivated to address – the health inequities in their communities. The approach involves: emotional connection with what is being addressed; critical reflection; praxis; and a liberatory approach to education. The goal is to move through a 2-year planning process to develop a strategic orientation and plan, throughout the health department, to address health inequities. The course components include: an overview of public health; cultural competency and cultural humility; health inequities; undoing racism; and social justice dialogues. The discussions can be very charged, so experienced facilitators are needed, and it is important to be flexible, so that it becomes possible for all participants to deal with the difficult material presented and to generate ownership of the decisions about the direction of strategic planning

for the health department.

C. Linn Gould then described the Population Health Project in Seattle, WA, which takes a population health approach to teaching students in elementary and high school, and also health department staff, about population health and the social determinants of health. They have offered their program in diverse venues: the Seattle Girls School, the Puget Sound Early College program, University of Washington, and SeaMar Community Clinic. Their emphasis is on critical health literacy, which includes functional literacy (to understand factual information), interactive literacy (to develop personal skills based on the information learned), and critical literacy (to develop the capacity to understand and change social determinants of health). The six modules they have prepared (with others in the works) focus on: "introduction to population health" (what it is, how measured, what are health inequities, and what are their causes); "civic engagement/advocacy" (what is social change, what is activism, what is civic engagement); "food security" (designed to complement traditional nutrition courses, including material on food security, malnutrition, over-nutrition, and local and global data on food production and distribution); "environmental justice" (whose voices are heard, what is the precautionary principle, who are the stakeholders and what are their debates, plus a trip to a superfund site); and "global health and art activism" (with the teens who have taken this course focusing their project on issues of teen violence and teen crime, which they did by doing a public play on this topic, performed at a major transit center). Pre- and post-test evaluations show that participants do gain in their knowledge about social determinants of health, health inequities and their root causes, and what kinds of action are needed to change them. Challenges include: (a) the originators of the program were all white women, so they co-teach their courses with people of color, and (b) they have encountered some resistance about getting into the public health system, since many staff at the health department do not see links between social justice and public health.

Rachel Poulain next presented a brief overview of *Unnatural Causes* (see details in the "integrative session," above) and described the public health impact tools that California Newsreel and its collaborators have developed. These are available at the *Unnatural Causes* website (see above, and also: **http://www.unnaturalcauses.org/**) and include: (1) a Tool Kit on how to host a screening (developed with the Praxis Project); (2) a discussion guide for each episode; (3) a handout & fact sheet on health inequities; (4) a viral marketing "myth-buster" set of video clips for dissemination on-line; (5) a press kit; (6) Extension Tools (e.g., an on-line course for which one can get credit); (7) a "getting connected" data base (to link people organizing around the series and health inequities); and (8) a companion website, which will be officially launched in March 2008, and which will feature "self-directed learning, engaging interactivities, audio and video clips, discussion guides, teaching tools, and a valuable archive of research materials" to enable people to learn about "the social conditions that underlie our health" and encourage people to "take action to create better health outcomes for everyone" (see description of what the final website will contain at: http://www.unnaturalcauses.org/site-description.html ; **UPDATED LINK: https://unnaturalcauses.org/about_the_series.php**). To date, *Unnatural Causes* has commitments from over 100 outreach partners to do screenings, with the diverse objectives of these screenings including: (1) building leadership within health departments to tackle health inequities, (2) reframing the public debate about health disparities (e.g., the town forums that the National Association of County and City Health Officers [NACCHO] is planning with over 100 local health departments), (3) spurring investigation of

community conditions and health inequities, and (4) building strategic alliances across “silos” (e.g., SEIU adding a focus on health inequities to its current work on health care). Additional uses of the series include: (a) organizing events to increase participation and democratic accountability around issues of health inequities; (b) mobilizing constituencies (per the October 2007 screening organized by the Harvard Center for Society & Health); (c) dialoguing about health inequities with journalists and bloggers; and (d) encouraging implementation of health impact assessments (HIA) regarding the health impacts of social policies.

Lisa Moore then moderated the Q&A period, which focused on such issues as: (1) how to handle the resistance to addressing health inequities, whether by individual students or organizations; (2) how to address the anger of people who feel they have been trying to raise these issues for years, especially in communities of color, with recognition of health inequities only given when academics (and especially white academics) focus on these issues; (3) the need to distinguish between civic action (based on a social justice perspective) from the “civic engagement” fostered by Bush et al (which favors volunteerism and no analysis of power inequities); (4) the challenge of doing creative teaching when students and teachers are increasingly forced to teach towards an exam; (5) how to forestall a slide from raising demands for fundamental change to being focused on short-term “fixes”; (6) how to teach about who is benefiting from the status quo; (7) the ways the series can be used in a health department (e.g., the San Francisco Department of Health is planning to: screen each of the episodes, with community residents acting as facilitators; host a town meeting; and also use the series to train members of the health department); and (8) whether Unnatural Causes will be available in languages other than English (the answer was: yes, it will be dubbed and sub-titled in Spanish, and they are seeking funds now to have it be sub-titled in several different Asian languages).

2006 (p. 12-13):

CURRICULUM/PROGRESSIVE PEDAGOGY

Our pedagogy session, attended by about 50 people (down from 70 last year), included the following speakers:
HEALTH & HUMAN RIGHTS: TEACHING IN THE COMMUNITY AND THE CLASSROOM
TUES,NOV 7***8:30AM-10:00AM(SESSION 4066.0)***BOSTON CONV.CENTER (BCEC)50

8:30 AM — Introduction. Suzanne Christopher, PhD
8:35 AM — Teaching of health and human rights: approaches, challenges, & opportunities. Sofia Gruskin, JD MIA, Daniel Tarantola,Prof
8:50 AM — Integrating human rights principles across health curricula. Silvia Amesty, MD, MPH, MSEd, Alicia Gurdian, PhD
9:05 AM — Popular education: moving beyond the dialogue session. Jessica Henry, MS, Matt Griffith, MPH, Doug Taylor, PhD, Connie Tucker, Estelle Archibold
9:20 AM — Valuing, vetting, and visioning: advance health and human rights in professional health programs. Wael Noor El-Nachef, Jonathan Chevrier, MSc, L. Emily Cotter, MPH, Lisa Rahandale, MD, MPH, Rodhan Radhakrishna, Sheri Weiser, MD, MPH, Vince Iacopino, MD,

PhD
9:45 AM — Question & answer period

Suzanne Christopher introduced the session & speakers, noting the range of types of teaching issues that would be addressed.

Daniel Tarantola opened by noting that higher education about health and human rights began only in the 1990s, first focusing on HIV/AIDS (per courses led by him, Jonathan Mann and Sofia Gruskin), then expanding to a broader concern with health overall. He then described a conference convened at Harvard the previous Friday, which included 22 participants (chiefly but not only from the US), whose objective was to bring together key people involved in University-level education around health and human rights, so as to share experiences and discuss how they constructed courses and responded to student needs. Common themes included: (a) growing student interest in the topic; (b) students' wanting courses to provide advocacy tools; (c) different emphases in different types of schools (e.g., law school focus on international legal human rights context and normative value of human rights, vs. public health school focus on advocacy tools); (d) importance of treating the US as both a case study and a global actor; (e) the importance of linking research and teaching, and (f) the need to teach about human rights & health in historical context, including countering the Cold War emphasis on the split of human rights into two different sets of rights (political & civil versus social, economic, & cultural) and instead emphasize their original conception as all interdependent. Course formats varied from seminars to case studies to field studies; undergraduates tended to be more interested in reading and writing than graduate students (especially those in medical school); and all courses needed to provide a safe space for students to confront difficult material (e.g., about torture), to express fears, and to disagree with the teachers about human rights principles. Soon two websites related to the meeting will be available: one with the syllabi that were shared (http://www.iphhr.hsph.harvard.edu; **N/A**), the other for donations to support development of these curricula (http://ihhr.unsw.edu.au; **UPDATED LINK: https://web.archive.org/web/20090126025241/http://ihhr.unsw.edu.au/**).

Silvia Amesty then discussed a course on health and human rights she has developed with her colleague Alicia Gurdian, at the University of Costa Rica Medical school. The emphasis was on engaging students in a dynamic process to help them become agents of change and be responsive to their society and its needs, and hence in contrast to the usual more passive learning that occurs in medical school. Its intellectual content and methodology were intended to help students analyze how social and political processes create health disparities and also to put individuals and patients in social, political, and historical context. Another objective was to promote self-analysis, referring to how the students, as physicians, fit into the political to personal processes studied in the course. They have developed three versions of the course: (a) 12 hours of didactics included in a "health and society" course, (b) a 12 hour course for practicing health professionals, and (c) a 12 hour course for university professors. Students in each of these versions wanted more, so they are working on how to develop a required (rather than elective) module that can be included in the medical curriculum and also are working to increase discussion of health and human rights throughout the University context.

Jessica Henry next presented the South East Community Research Center's approach to popular education, based on Friere's model and used in conjunction with community-based participatory research, with the aim of ensuring that such research incorporates a social justice perspective. The presentation reviewed key principles of community-based participatory research and its attention to power dynamics.

Emily Cotter and Rodhan Radhakrishna then discussed a survey they have sent to Deans of Schools of Public Health and Schools of Medicine regarding the extent to which their schools offer and support teaching on health and human rights. The survey itself is the outgrowth of a class project for a health and human rights course they and their co-authors participated in last year. They sent the survey to all 36 accredited US public health schools and all 125 accredited US medical schools. Currently, the response rate is 58% and they are working on raising it to 70%. Preliminary results, shared at the session, indicated that: (a) slightly over half of the schools of public health and one third of the medical schools offered at least a course in health and human rights; (b) the health and human rights course(s) tended to be elective, not required; and (c) key barriers included competition for time (given all else required in the curriculum), a lack of qualified instructors, a lack of faculty interested in teaching about health and human rights, and a lack of funding to support the development and teaching of such courses. Despite these obstacles, most of the Deans expressed support for health and human rights to be taught at their schools. Next steps will be to develop recommendations on what these schools can do to increase their course offerings on health and human rights.

During **the Q&A**, discussion items included:
(a) how to address controversial topics in the courses, e.g., conflicts between universal human rights and "traditional values" -- with the suggestion being that it is best to engage with these conflicts and use them as teaching opportunities, rather than try to gloss over them;
(b) the importance of teaching that human rights are indivisible (rather than teaching about "positive" versus "negative" rights);
(c) the need to translate English-language articles about health and human rights into other languages (since most of the literature is published in English); and
(d) the need to be aware that faculty from different disciplines may use the "same" word or term differently, hence the need to work on improving transdiciplinary communication and teaching about health and human rights. Also discussed was how the desire to have core courses and also modules included in other courses was common to other related efforts to improve public health and medical curricula, e.g., in relation to health disparities, gender and health, etc.

2005 (p. 13-15):

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***8:30AM-10:00AM(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.

2004 (p. 13-15):

CURRICULUM/PROGRESSIVE PEDAGOGY

Our dynamic session, attended by about 85 people, was on "TEACHING ACTIVISM FOR PUBLIC HEALTH, PART 2" (session 4082.0, Tues, Nov 9, 8:30 to 10:00 am); of note, this session ended up being at the same time as the APHA rally & walk on Capitol Hill, i.e., activism in practice, which understandably likely cut into attendance (especially for a session on activism!).

The line-up was as follows:
8:30 AM Introduction. Elise Papke
8:35 AM Teaching engage scholarship through community based participatory research. Meredith Minkler, DrPH
8:50 AM Teaching students to be health activists. Ashwini Sehgal, MD
9:05 AM Teaching participatory health promotion as leadership development for social change. Ester R. Shapiro, PhD
9:20 AM Pedagogy of collegiality: teaching community-based public health. Vivian Chavez, DrPH
9:35AM Question & answer period

Meredith Minkler presented on pedagogy based on the principles of – and to promote --

community based participatory research (CBPR) and action to improve community health, per a relationship diagrammed as: Participation in education ↔ Research ↔ Action. Noting that CBPR is among the 8 new competencies listed for schools of public health to address in the new IOM report on public health, she briefly described the history of CBPR as rooted in both the "action research" of Kurt Lewin in the 1940s and the revolutionary approaches advocated by popular movements in the 1970s, as especially articulated by Paolo Friere in Brazil. Using case examples in her course, she described approaches to assist students in gaining skills to identify natural community leaders, to do community risk + asset mapping, use photo voice (a method by which community residents are given cameras to document their surroundings & concerns), and engage with concepts of validity and reliability as appropriate for CBPR. As a final project, students prepare a detailed retrospective analysis of an CBPR in which they were involved, in terms of both what worked and what didn't work, which they share in class. Ultimately, CBPR stands as an important counter to Alinsky's assertion that "the word `academic' is a synonym for irrelevant," and instead provides an approach for academics to create useful knowledge with communities for social change and social justice.

Ash Sehgal then presented on a medical school course elective he has taught for 5 years to approximately 100 students; the website for the class is: www.home.case.edu/activism (and similar kinds of classes can be found at: www.citzien.org). The goals of this course are for students to understand social, political and economic factors affecting health; to learn from practicing activists; and to prepare for future activism. The seminar meets once a week (2 hour session) for 6 weeks, in which students engage with the invited activists to learn about their motivations, obstacles, specific projects, and future plans, plus also design an activist project. Speakers have included Khassan Baiev, a surgeon from Chechneya; David Himmelstein & Steffie Woolhandler on universal health care; & Sidney Wolfe & Peter Lurie on drug safety. Student projects resulting in publications include: Alexander, JAMA 1998 on racial/ethnic, gender, and class disparities in kidney transplants; Landers, Arch Int Med 2000 on how physicians lobby members of Congress; Tsai, Am J Med 2002 on internet sales of ciprofloxene after the anthrax outbreak; and Goyal, JAMA, on economic & health consequences of selling kidneys in India (health & economic resources of the donors gets worse, not better). In the course, students usually make a 1-step change, building on where they are in the following sequence: don't think about activism; think about activism; consider activist projects; complete activist projects. Challenges to the course include: limited funding (e.g., costs $1000 to bring in outside speaker), competing demands on students' time, short duration of course. Given declining enrollment (25 in year 1, but only 10 in year 5), may be worth trying to include topic in main required medical course or possibly expand to a full semester.

Ester Shapiro next discussed the kind of teaching she does to promote social change & address health disparities in an under-resourced urban university in which most students are working class, low-income, & ethnic minorities (US-born & immigrants) typically scraping by and too busy to be activists on top of working, taking care of their families, and going to school to get a undergraduate college or masters degree. Describing herself as a clinical psychologist "in recovery," her teaching focuses on how to understand links between personal experiences and social structures. Recognizing that working class students typically do not have a sense of

intellectual entitlement, she seeks to assist students in realizing their ability to make a difference. Her aim is to open students up to the wide word of public health and health disparities and to see that there are options other than solely private psychological counseling; instead, students can draw on their own unfair experiences with health care systems to make a change in how these systems operate – including by training for a career in public health or health services administration. Her teaching is based on a Frierian approach plus also uses ecological and developmental approaches emphasizing resiliency.

Vivian Chavez then discussed her framework and approach of the "pedagogy of collegiality," involving mutual learning, with students as colleagues of the teacher and both as co-learners, also based on a Frierian & CBPR approach, emphasizing imagination, diversity, bringing one's own context to the classroom, and reinventing knowledge in each session. The class is premised on the principles of health & human rights plus social justice, has multicultural learning objectives, and examines community health through a community organizing lens. The 14 sessions of the class are organized as follows: first 4 sessions are on listening & building relationships, then 8 sessions on problems & solutions, including activism & its challenges, followed by 2 sessions on evaluation (how the course worked) and reflection (what the students' own experiences were), ending with a celebration (with food, music, & cultural symbols, all to promote festivity & celebrate completion of the course). The "dyad" is an essential teaching tool, so that students' voices can be heard; the hardest of the "dyad" exercises is one conducted in silence, based only on "eye experiences" & using body language; people attending the session participated in a brief (and very lively) dyad exchange on essential aspects of learning (stated to include curiosity, openness, respect, and common ground, premised on trust). Writing is also a key component, since teaching typically has privileged speaking over listening and reading more than writing, so writing is used to stimulate dialogue. The overall goal is to raise students' consciousness about social justice, plus awareness of context in which teachers teach (e.g. university rules), and hence the role of teachers' authority and need for transparency about this.

During the **question & answer period** (which continued well after the session was officially over!!), exchanges concerned: how to incorporate these approaches into more conventional classes; the Schweitzer fellowship (which teaches activism to 30 students/year and renders the students fellows for life); how to bring in historical context, to help students understand the context of their own experiences; the importance of recognizing the histories & context teachers bring into our classes; the importance of avoiding teaching solely by lecturing and needing more student participation; and the importance of building trust by dealing honestly with conflict, given that students & faculty together bring their worldviews into the classroom.

2003 (p. 10-11):

CURRICULUM/PROGRESSIVE PEDAGOGY

Our session, attended by about 200 people (the highest by far for this "early bird" session!), was

on “TEACHING ACTIVISM FOR PUBLIC HEALTH” (session 4085.0, Tues, Nov 18, 8:30 to 10:00 am).

The line-up was as follows:
8:30 AM Introduction. Lisa D. Moore, PhD, Babette J. Neuberger, JD, MPH
8:35 AM Community Action Model: Working with advocates to change the place they live. Christine Carpenter, Isabel Auerbach, MPH; Buffy Bunting, MPH; et al.
8:50 AM Using Literature to Teach Activism for Public Health. Martin T. Donohoe, MD, FACP
9:05 AM Unlocking students' activist spirits: Experiential learning and leadership in the San Jose State University MPH program. Kris Friewald, Emalie Huriaux, MPH(c)
9:20 AM Media Advocacy: Using news as a pressure tool for social change. Sonja Herbert, MPH, Lori Dorfman, DrPH
9:35 AM Discussant. Meredith Minkler, DrPH
9:45 AM Question & answer period

Christine Carpenter presented the Community Action Model she and her colleagues are using, based on a Frierian approach, to build community capacity via participatory action to address public health problems. The concrete example was a youth campaign to address smoking of bidis (an Indian cigarette), where the youth involved in the campaign did research on the internet, plus conducted key informant surveys and surveyed sales and purchase of bidis. Their work resulted in the FDC placing warning labels on bidis, increasing local enforcement of laws about sales of bidis, and lessening the appeal of bidis among their peers by documenting how bidis are produced by child labor in India.

Martin Donahoe next described how he has included use of short stories, with accompanying scientific articles, to engage students more deeply in learning about the realities of disease and social injustice as a cause of ill health. Using the twin strategies of getting stories included in already existing curricula and also development of new training programs linking medical students with English literature students, he emphasized the importance of this approach especially when training students whose lives have been privileged. He provided numerous examples of short stories that he uses; his reading list will be posted on the Spirit of 1848 website, and he can also be reached directly at: martin.donohoe@verizon.net

Kris Friewald then described the innovative learning program involving MPH students, with faculty support, at San Jose State University. Based on the principles of praxis, community, and love – for which the students offered definitions reflecting the complexity of each construct -- the program encourages students to become engaged and reflexive learners who take on the commitment and responsibility of working for social justice and public health. The program involves seminars, work on concrete projects, mentoring of students by each other, and advocacy within the university to address issues of discrimination. It is also making links with the undergraduate student groups as well as making ties with public health student organizations at other campuses.

Sonja Herbert then described the importance of linking concerns with social justice with media

advocacy to promote public health prevention policies that keep the focus on structural and policy determinants of health. Noting that individual stories tend to be interpreted in relation to individual-level solutions, the Berkeley Media Group has developed a variety of training programs to help make sure an effective and engaging public health message gets across to policy makers via the media. Her 7 key recommendations were: (1) develop an overall strategy before the interview for key points to emphasize; (2) talk more about the solution and less about the problem; (3) talk about why the issue matters, from a social justice perspective, as that is what is engaging; (4) identify who has accountability for the problem or can help facilitate the solution (e.g., in a mid-western state, the voices able to reach policymakers re a problem affecting youth were those of the football coaches); (5) train a variety of spokespersons, as different kinds of voices are needed to get a particular story across; (6) build a news story, not a scientific journal article, so use media bites, visual, and humor (e.g., the message: “having a non-smoking section in a restaurant is like having a non-peeing section in a swimming pool”); and (7) present data in an accessible way (e.g., risk is 1in 5, rather than the number of people affected; make contrast without even using data, e.g., students in college spend more on alcohol than they do on textbooks).

Meredith Minkler, as discussant, emphasized how these courses are key are essential for training public health advocates. Common themes were: the importance of participatory approaches, an emphasis on lived experience, and an explicit focus on social justice. She recommended that training in media advocacy be a core requirement for any degree in public health.

2002 (p. 9-10):

Curriculum/progressive pedagogy

Our session, attended by about 30 people, was called “DISTANCE EDUCATION - PROMISE OR PERIL?” (Session4078.0; Tuesday, November 12, 8:30 to 10 am). The purpose was to learn about the context & content, plus promise & pitfalls, of web-based education for progressive public health education.

The line-up was as follows:
TUES, NOV 12 *** 8:30 AM-10:00 AM (SESSION 4078.0)*** PCC 108B
8:30 AM Introductory remarks: Cheryl Merzel
8:40 AM The turn to technopedagogy: a contextual appraisal—Janice A. Newson
9:00 AM Activist pedagogy in cyber-space—Lisa D. Moore, Maria Chavez
9:20 AM Distance learning: promises, opportunities, constraints, and threats: sorting it all out—Babette J. Neuberger
9:40 AM Discussion

--Janice Newson, Associate Professor of Sociology, York University, Toronto, Canada, focused

chiefly on the perils,noting that the use of technology for distance-learning represents a decision, not just an inevitable outcome (per technological determinism), as linked to the commodification of education. Key contextual factors included a drive to managerialism in academia, due to cuts in public funding, leading to an emphasis on market-oriented notions of“efficiency,” “productivity,” and “accountability,” coupled with an opening of academia to the “private sector” (to peddle their wares) and a market-oriented redefinition of students as “consumers” and of universities as “service providers” in the “knowledge business.” Noting that one can only get to the promise of distance-based technologies if one acknowledges their perils, she discussed 4: (a) the view that embracing technology is key, thereby losing sight of the purpose of academic activity: teaching and learning; (b) choosing teaching technologies based on comparisons to conventional methods (“chalk and talk”) without recognizing their degradation due to underfunding; (c) accepting“efficiency,” “productivity,” and “accountability,” as pedagogical criteria (rather than as budgetary criteria); and (d) a narrow assessment of the benefits of these technologies, without considering their toll (e.g., long hours on email,ergonomic problems, etc.).

--Lisa Moore, Assistant Professor, San Francisco State University, then discussed her ambivalent embrace of distance-learning, in the context of a community partnership intended to teach activists as well as students about matters pertaining to harm reduction (i.e., reduction of drug-related harms). She underscored that her teaching took place in a CA state university in a context of state putting more money into prisons than schools, and where an explicit goal is to find ways to teach more people without having to build more facilities—and where fewer and fewer working class students can afford to go to college full-time and instead have to work multiple jobs to meet their rent. The course she and her colleagues developed consisted of readings, threaded discussions (on-line), and required volunteer work in communities. They found it was more popular than any of the other courses on drugs and harm reduction that were taught face-to-face, that some students found it easier to share their thoughts on-line than in the classroom, but that it was harder to get completed course evaluations. Important concerns pertained to a lack of an interactive learning community (partly mitigated by the required 40 hours of community service), an inability to read body-language and other non-text forms of “dissent” when presenting controversial material, a reliance on teaching by text (rather than by interpersonal engagement), and the greater likelihood of less motivated students to get lost in cyberspace. Hence, pluses and minuses: it has the promise of opening up possibilities of education for people who cannot afford to be at college, but also many drawbacks, some of which may be countered, but will require concerted attention.

--Babette Neuberger then offered her perspectives as both Associate Dean for Academic Affairs and as a faculty member who has taught the “same” session of a course on environmental law and policy both in-class and on-line. She first offered a definition of progressive pedagogy as “education that provides students with the skills they need to critically assess and understand the world about them within a framework that envisions a just and humane; and that takes that knowledge from theory to action.” She then offered an analysis of distance learning at 3 levels: (a) the instructor: does the methodology work?, (b) institutional: does a systemic shift to this technology impede or advance progressive pedagogy; and (c)

social/economic/political context: as exemplified by the use of distance-learning at a university in Palestine, when regular teaching at the school was rendered impossible by the militarized crisis. On the plus side, she found that teaching her environmental law session on-line improved use of case-oriented material, enabled her to bring in students—and experts—from around the world, reduced time constraints of the classroom, and allowed multiple layers of material to be provided (via hyperlinks) assisting students needing remedial or more advanced instruction. On the negative side, she found it took much more work to engage students, including in on-line discussion,and could never generate the kind of excitement that occurred in real-time live classrooms as students presented their experiences and debated ideas. She also noted that the institutional drive to use web-based classes to recoup more money for universities and even individual departments may end up countering the promise of reaching students with fewer economic resources, if the courses are priced out of their range.

2001 (p. 8):

Curriculum

Our session was called **"CRITICAL CLASSROOMS, GLOBAL PERSPECTIVES: PROGRESSIVE CURRICULA FOR TEACHING ABOUT DETERMINANTS OF GLOBAL HEALTH"** (Session 4077.0; Tuesday, Oct 23, 8:30 to 10 am). About 50 people attended (at 8:30 in the morning!—and in conflict with a session on the latest updates re bioterrorism ...). The focus was on different ways to teach progressive public health classes about how global & local politics shapes global & local health. The lively discussion after the presentation focused on the extent to which any of the courses used or avoided web-based learning and also whether there was any way of evaluating the ways in which students and community-based organizations actually benefit (or not) from being participants in courses taught from a community-based participatory research or action framework; these topics will likely be addressed in next year's curriculum session. The line-up for our session was:

TUESDAY, OCTOBER 23 * 8:30 AM-10:00 AM (SESSION 4077.0)*** GEORGIA WORLD CONGRESS CENTER, ROOM 202E**

8:30 AM Introductory remarks: **Cheryl Merzel, Marion Field Fass, Babette Neuberger**

8:40 AM Infusing social justice throughout the curriculum: The University of New Mexico MPH Program Experience--**Nina B. Wallerstein, Bonnie Duran, Lorraine Halinka Malcoe, Cynthia Lopez, Howard Waitzkin, Jo Fairbanks, Deborah Helitzer, Marianna Kennedy;** *available at:*

"Infusing Social Justice throughout the Curriculum: the University of New Mexico MPH Program Experience" - Nina Wallerstein, Bonnie Duran, Lorraine Halinka Malcoe, Cynthia Lopez, Howard Waitzkin, Jo Fairbanks, Deborah Helitzer, Marianna Kennedy, University of New Mexico.

8:52 AM Changes in Health and Health Care in Post-apartheid South Africa--**Sally J Guttmacher**

9:04 AM Fostering Critical Perspectives in Health: A Community Organizing Course for Public Health Students— **Jesus Ramirez-Valles;** *available at:*

"Fostering Critical Perspectives in Health: A Community Organizing Course for Public Health Students" - Jesus Ramirez-Valles, University of Illinois, Chicago

9:16 AM Building and Retaining Public Health Capacity in Developing Countries: Challenges & Opportunities--**Yogan Pillay, Claire Botha {CANCELLED}**

9:28 AM Engaging activists: Teaching global perspectives on health and social inequalities at the undergraduate level—**Marion Field Fass**

9:40 AM Discussion

2000 (p. 4-5):

Curriculum

Our session was called **"TEACHING SOCIAL JUSTICE IN PUBLIC HEALTH: PROGRESSIVE**

PEDAGOGY IN ACTION" (SESSION 4082.0; Tuesday, Nov 14, 8:30 to 10 am). Over 120 people attended (at 8:30 in the morning!)—with many staying long after the session to continue their discussions. Some members of the audience also raised the question as to whether we could sponsor a progressive pedagogy workshop, teaching ideas and applications based on some of the presented courses, on a Saturday or Sunday before APHA, a suggestion the Spirit of 1848 coordinating committee is considering.

The line-up for our session was:

TUESDAY, NOVEMBER 14 * 8:30 AM-10:00 AM *** HYNES CC, 306 *** (SESSION 4082.0)**

8:30 AM Introductory remarks: **Cheryl Merzel, Marion Field Fass**

8:35 AM An interdisciplinary graduate certificate program in human rights and social justice -- **Sherlina S. Nageer, Barbara S. Keary, Jeremy Hess**

8:48 AM Promoting Diversity and Teaching Cultural Competence: Notes from the Field -- **Marian Clarke McDonald, Ted Chen, Carolyn Lebrane Tilton**

9:01 AM Teaching social justice in schools of public health through community fieldwork – **Belinda Reininger, Molly Greaney, Kim Nichols**

9:14 AM History, politics, and public health: Theories of disease distribution across time

and culture – **Nancy Krieger**

9:27 AM StandingTogether Program: A Curriculum for Future Leaders of Color – **B. Cecilia Zapata**

9:40 AM Discussion

1999 (p. 6):

Curriculum

Our session was called **"From classroom to community: approaches for teaching social determinants of health"** (Session 2084; Tuesday, Nov 9, 8:30 to 10 am). About 100 people attended (at 8:30 in the morning!) to join in a session about creatively integrating classroom- and community-based learning to deepen ties between public health & social justice. The line-up was:

* Introduction--**Cheryl Merzel, Marion Fass**

* An integrated curriculum to teach, learn, and practice social justice in public health—**AM Vilaneuva, H Rubenstein, K Pham, P Blumberg, NA Bartle**

* Teaching social determinants through community assessment—**Pyser Edelsack, Len Rodberg, H Jack Geiger, MR Gold**

* Using service-learning experiences to enhance understandings of social inequalities in health in a rural university setting—**SE Christopher**

* Participatory Action Research: Research for the sake of social justice—**Jaime Delgado**

NOTE: if you want copies of any of the syllabi or related materials handed out at this session, contact Cheryl Merzel (cm449@columbia.edu) and she will send you the presenter's email address. You can find abstracts for all the presentations in the APHA abstract book.

1998 (p. 1-2):

Curriculum

Our session was on **"PEDAGOGY WITHIN CONTEXT: BROADENING PUBLIC HEALTH CURRICULA TO ACKNOWLEDGE THE POLITICAL, ECONOMIC, AND SOCIAL DETERMINANTS OF HEALTH".** Over 120 people attended and engaged in lively dialogue--starting at 8:30 in the morning! The line-up was:

*Introductory Remarks--**Babette J. Neuberger (Presider)**

*Teaching community organizing for health: integrating perspectives from political economy, community building, and Friere's pedagogy--**Meredith Minkler**

*Teaching public health within a political, economic, social, and historical context: a critical and interdisciplinary approach to health policy--**Carole Schroeder**

*Teaching undergraduates about social class, racism, and other social determinants of health--**Martha Livingston**

*Course evaluation tool to measure whether the influence of social position on health is adequately covered within the School's curriculum--**Andrea Acevedo, Shalini Ahuja, Hannah Cooper, Melissa Dimond, Rochelle Tucker, Phuong Vo, and Connie Young**

NOTE: if you want copies of any of the syllabi or related materials handed out at this session, contact Babette Neuberger and she will send them to you.

1997 (p. 3-4):

Curriculum

Our session was on **"Curricula in social inequalities in health: critical epidemiology and public health advocacy."** It was attended by over 40 people, at 8:30 in the morning! The line-up was:

*Presider--Carles Muntaner

***Issues in Health Advocacy**--Ramon Castellblanch

***Controversies in Epidemiology: Teaching Causality in Context**--Donna L. Armstrong

***Maternal and Child Health in the Urban Environment**--Robert Aronson, Patricia O'Campo

***The Use of Allegory in Teaching about Race and Racism**--Camara Jones

1996:

The Curriculum Committee (Spirit of 1848 Coordinating Committee representative: Michelle Murrain). This committee has mainly directed its efforts to organizing a session at APHA ("Curricula in social inequalities in health: teaching in different settings"; Tues, Nov 19, 8:30 to 10 am, Hilton, Sutton South, Session 2074). **The committee also undertook the task of conducting a curriculum survey of schools of public health. During the coming APHA

meeting in New York, they will discuss the survey and further define their work plan for the coming year. For further information, contact Michelle Murrain at (mpmNS@hamp.hampshire.edu).

1995:

Curriculum (chaired by Michelle Murrain)

Persons attending: Jaqueline Bartelt, Arthur Himmelman, Karyn Pomerantz, Ramon Castellblanch, Carles Muntaner, Barbara Gottlieb, Joel Swartz, Bonnie Duran, Arlene Eisen, Jean Forster, Naomi Kistin

Project(s) planned: **We plan to begin to design a questionnaire about curricular issues,** either to be sent to schools of public health, or to individuals at the next APHA meeting. As well, we plan to begin to accumulate syllabi of courses. APHA sessions/activities planned: We plan to have one session at the next meeting to present issues around teaching courses in public health schools or in other settings such as undergraduate institutions, which incorporate content in social inequalities in health. Michelle Murrain, Barbara Gottlieb and Ramon Castellblanch will work on organizing this session.