Federal/State Partnership Meeting

General Session

October 25-27, 2009

MICHELE LAWLER: Good afternoon, everyone. Welcome, everyone. It's wonderful on a Sunday afternoon to hear so many people so excited about being here. So it's my pleasure to walking you to this year's Federal State Title V MCH Partnership Meeting. I'm Michele Lawler. I am the deputy director in the Division of State and Community Health, which I think most of you know by now, is the division within the Maternal and Child Health Bureau that oversees the administration of the Title V MCH Block Grant Program. We see many friends and colleagues in the audience. It's wonderful to have you here. I know it's time to get started, so I'm not going to take very long. But I would like to take this opportunity to introduce Cassie Lauver to you, who I think is no stranger to any of you. As you know, she is the director of the Division of State and Community Health. And she came to the bureau about nine years or so from the state of Kansas where she was the Title V MCH director of -- in Kansas. We are a little late starting. Cassie, of course, ran the marathon this morning and had to -- and had to, you know, catch her breath a little bit afterwards so she could be here. Actually, I'm kidding, but we encourage health and wellness, but marathon runners we're not. But, anyway, without further ado, Cassie, let me turn it over to you. Thank you.

CASSIE LAUVER: Thank you, Michele. I wasn't quite sure how to handle that until she said I really didn't run the marathon. The only marathon I ran was trying to get here through the race today, as probably many of you trying to get to the hotel today may have found it a little difficult getting here because of the Marine Marathon. In fact, I saw lots of people in the hotel wrapped up in their silver warmers. So we'll find out tomorrow who the winners were, and fortunately I can tell you right now it wasn't me. But thank you for being here. And I'm glad we actually are starting this a little later in the day because it was an absolutely gorgeous day in Washington today, one that we love so much in the fall. Unlike yesterday, for many of you who came here early, that it poured rain, and I mean really poured rain. So we appreciate everybody coming in this evening and being here for our session.

And we're really very excited about this year's partnership meeting for a variety of reasons. And one is that we have, and you will see wonderful support not only from HRSA but from the department. And so, tomorrow, we'll have Dr. Mary Wakefield here, who is the associate -- oh, not the associate -- who is the administrator of HRSA, and as well as on Tuesday, Secretary Kathleen Sebelius will also be here. And so, we're very pleased. In the nine years that I've been here, we have not had a secretary of the department join us, and so we're very pleased with that.

This year, we're redefining our acronym MCH a little bit. And Maternal and Child Health -- MCH, we know, stands for Maternal and Child Health. And this year, as you see in the title, it also reflects, "make change happen." And there is a lot of change going on in the world that we live in right now, with healthcare reform and with the way that we do business. And one of the things that we're looking at in the bureau that we've talked about and that we know that there is a lot of work going on in the field as you're going to hear from this evening with experts in the field, is looking at doing business in a little different way than we have done it in the past. We still have a responsibility to the populations that we serve. But maybe it's time to look at the populations a little bit differently.

So I looked up before I came, just some of the – some -- Google is wonderful, and if you wanted to look at how other people look at change, because change in how we do our day-to-day business is an opportunity that we have that we can look at. And some of the quotes that I looked at -- that I found, included, "progress is impossible without change." And so we do want to progress, and so we need to look at change. "The one unchangeable certainty is nothing is certain or unchangeable, " President John F. Kennedy. "He who could not change the very fabric of his thoughts will never be able to change reality," Anwar Sadat. And finally, "change is the watchword of progression." When we're tired of well-worn ways, we seek for new. And I think -- not that I feel that the way that we've been working are well-worn, but certainly it's an opportunity to look at new ways and to look at change.

So this year, the Federal/State Partnership Meeting will examine health research models that explore the impact of social determinants, life course and health equity on the health of the nation's women, children and family, and the intersectional nature of these models, their translation from research to practice, and the opportunities they provide for the development of improved healthcare delivery systems that will enhance the health and well-being of the populations that we serve across their lifespan. And we're going to have particular emphasis given to the influence that women have not only on their own health but their children's health, their family health and the health of the community in total.

We're going to hear from programs which offer potential for enhanced MCH outcome in their states, and we're going to hear from the experts who have experience with these research models. And this year's meeting will offer -- showcase the unique role the Title V MCH Programs to make change happen in a transforming healthcare system through investments that will build and sustain family -- healthy families, again, across the lifespan. And the focus will not only carry throughout this meeting but will set the stage for a new framework for Maternal and Child Health Bureau as we carry on our business in the coming years.

Tomorrow, you're going to hear from Dr. Peter Van Dyke in the opening plenary, who will be sharing the direction for the bureau and the bureau's strategic

planning efforts that will take into consideration the framework that we're going to hear about, not only tonight, but throughout the sessions tomorrow, and that you're going to hear about at this point. So, what we have in this evening session is a wonderful opportunity to hear from the experts in the field. And we have a keynote presenter which will be followed by a panel presentation and then an opportunity for response from the audience in terms of questions, comments and share that opportunity.

So, what I want to do first, and perhaps as I always say, being left-handed, I tend to do things backwards, and that is I want to introduce the panel first and then introduce our keynote presenter. And I'm going to be brief on the introductions because we have five people, but I do want to point out that everybody's full bio is under tab four and refer you to that, because most of our panelists are prolific writers. They've published, they've received numerous awards and don't want to overlook those.

But first, I want to introduce Dr. Milton Kotelchuck. And he is going to moderate the panel discussion after the keynote. And he's currently professor of community health sciences, pediatrics and obstetrics and gynecology and chairman emeritus in the department of maternal and child health, Boston University School of Public Health. He has extensive experience evaluating public health programs to improve birth outcomes and child health status. His research interests include examination of adequacy and content of prenatal and

intranatal care, racial disparities in birth outcomes, maternal morbidity, immigrant health, child health services, child nutrition and health policy. And you all recognize the name, if you haven't met Dr. Kotelchuck before, from the Kotelchuck index that you all report on in your Block Grant application every year. So, he's written extensively on racial disparities and perinatal and child health services and he's also senior and founding editor of the Maternal and Child Health Journal.

Also on the panel, is Diana Autin, and she is the executive director of the Statewide Parent Advocacy Network, New Jersey's Parent Training and Information Center, Family to Family Health Information Resource Center, Family Voices and Federation of Families for Children's Mental Health Chapters and Statewide Parent to Parent Program. She's a member of the National Center for Cultural Competence, workgroup on assessing cultural and linguistic competency in family organizations and technical assistance partnership to child and family mental health consultant pool. She received her Bachelors Degree with honors from the University of Michigan and graduated from the University of Michigan Law School in 1977. She's the mother of multi-racial adopted children and young adults with and without special healthcare needs, ranging in age from 17 to 33 and the grandmother of a two-year-old.

Debbie Allen, and for many of you -- she is one of the family, one of the past family, and she is the director of the Bureau of Child and Adolescent Family

Health at the Boston -- at Boston Public Health Commission, Boston's public health agency. She's responsible for a broad array of maternal and child health programs addressing birth outcomes and early childhood well-being, youth health and development, women's health and prevention of violence among and affecting children, youth and families. And her work has a strong focus on disparities in the impact of racism on health. Before coming to the Boston Public Health Commission, she was faculty at the Boston University School of Public Health, Department of Maternal and Child Health and was formally the Title V Children with Special Needs Director in Massachusetts. And then, our final member on the panel is Dr. Myrtis Sullivan. And Dr. Sullivan is the associate director of the Office of Family Health at the Louisiana Department of Human Service a.k.a. the --

UNKNOWN SPEAKER: [inaudible]

CASSIE LAUVER: -- I'm sorry, Illinois, a.k.a. the Illinois Title V Director. I've moved you. She earned her medical degree and master's degree in public health from the University of Illinois at Chicago. In addition to her role as the state Title V director, she is adjunct clinical associate professor and clinical assistant professor, division of community health sciences, maternal and child health at the University of Illinois at Chicago School of Public Health, as well as the clinical assistant professor, department of pediatrics UIC College of Medicine. And she's also published extensively and has received numerous honors including the

National Medical Association pediatrics section, Grace James Award for Academic Leadership.

So, at this time, I want to introduce our keynote presenter. And again, all of these individuals here on the panel tonight have a great deal of experience in the models that we're looking at to frame the meeting around in terms of social determinants, life course, health equity. And the keynote presenter is Dr. Vijaya Hogan. And Dr. Hogan is a clinical associate professor at the department of maternal and child health in the School of Public Health, adjunct assistant professor in the department of obstetrics and gynecology and a research fellow at the Sheps Center for Health Services Research at the University of North Carolina, Chapel Hill.

She is also the co-director of their certificate program in health disparities. Dr. Hogan has worked in state and national level public health agencies in North Carolina Office of Rural Health and the Michigan Department of Public Health and for Centers for Disease Control and Prevention, focusing on maternal health programs designed to reduce premature health. Her major public health interest is in defining effective strategies for eliminating health equities in maternal and child health outcome. She studies the impact of social factors on maternal and infant health outcomes and the goals of establishing evidence-based strategies that effectively address social determinants. So at this time, please join me in welcoming Dr. Hogan.

VIJAYA HOGAN: Thank you, Cassie. And thank you all for having me here. It's a pleasure to be able to talk about some of the work that I'm doing and to talk about this issue of health disparities which I think is one of the more important issues of our time. I'm trying to find where my presentation is and I will – let's see, okay, there we go. All right. So, what I was asked to talk about today is basically three issues: health disparities or health inequities, social determinants of health and life course. And I know a lot of you know much more about these issues than I probably know a lot more about the basics of these. So, you'd have to pardon me if I talk in very general, simplistic terms because what I'm trying to do today is really just lay the foundation of ideas to build upon, because the real meat of what I want to talk about are the intersection of those three things: social determinants, life course, health disparities, and adding a fourth dimension, which is the interventions that we apply to address some of those things. So that's the third thing that I'll talk about. And then, fourth, I'll just briefly talk about implications for infant mortality reduction and policy, and the panel and you all will continue that discussion after.

Now, one caveat before I start. This presentation, as you can see from the slides in your packet, is pretty data heavy. There are a lot tables and charts and so on. Don't get lost in the charts because this is not a numbers presentation. It's a conceptual presentation. I want you to understand ideas. So, what's more important than the numbers themselves are the interrelationships between the

trends in different race/ethnicity groups. So, don’t worry if you can’t see the numbers or if I don’t spend much time on the graphs. And I’ll try to be sure to point to out what the critical issues are for you to see in the pictures that we’re going to be looking at. So, let’s get started.

The main issue that we’re talking about today is the issue of health disparities. Now, it's a challenge that has been pretty resilient to all of our efforts to try to eliminate them. And I think there’s a reason for that. We’ve approached it from a way that may not be entirely scientific. And I think after today, hopefully, you’ll be able to understand my premise for this. We’ve tried to use the same tools and approaches that we use for reducing disease rates, for example, which may not be effective. There’s also an assumption in the field broadly that we have a toolbox or we have an evidence base of what works to reduce disparities. But the truth is, we don’t. Such a bible of what works for disparity reduction, particularly in maternal and child health does not exist. And so, I would contend that we really need to go back to the basics and begin to develop that evidence base.

So, today, I’m going to try to put this in the proper perspective or a different perspective, I should say. This -- what you’re seeing up here is the -- one of the official definitions of what a disparity is. The first one is from a community perspective. The second one is the NIH definition.

We, however, at Chapel Hill developed a little bit of a different definition. And ours is inequities in disease and well-being that come from discrimination and unequal access to society's benefits such as quality education, good jobs, decent and affordable housing, safe neighborhoods and environments, nutritious foods and adequate healthcare. These inequities result from disproportionately higher rates of -- result in disproportionately higher rates of disease, disability and adverse consequences on physical, mental, spiritual and social well-being of population groups who historically and currently don't experience equivalent social advantage. And there are specific subpopulations in the U.S. that generally fall into those categories.

So, we can look at disparities across a number of health outcomes from life expectancy. Whites generally have a 10-year advantage over African-Americans; death rates, where African-Americans have higher rates of death than other populations of people. We can look at self-rated health status where people tell you whether they have good, fair, poor health. And we see that African-Americans and Hispanics tend to rate their health as poor more highly than White populations. And more closer to home for us, we can look at infant mortality and see the differences in rates between African-Americans, Native Americans and other populations of people. The same holds true for neonatal mortality, which is the case. The top line, the red line is the rate. The trend and the rate in neonatal mortality for African-Americans, the bottom line for Whites. So again, you can see the degree of the disparity and how it changes over time.

And finally, we have disparities in premature birth. With the top line, again, being Blacks. The red line is Black Americans; yellow, Native Americans; green, Hispanic. The blue is Asian-Pacific Islanders -- and the line that didn't show up. Who would be for the White population, which is slightly above or below the Asian-Pacific Islander rate. But again, the point is to see the degree of the disparity and to see that I could go and on and on and on for the rest of the night going through different disease outcomes and risk factors, and you would see basically the same trend that some populations have higher rates. So that's the issue that we're facing and that's the problem that we're trying to resolve.

But when we look at this data, there are actually two problems. One is that there's no change in the rate itself. The line is pretty flat. So we're not making much progress in reducing the rate of the disease overall, but there's also not much change in the rate of the disparity. So we have two problems: why is there no sustained decline in the rates and why is there no sustained decline in the disparity?

So we have tools for looking at that. We basically take infant mortality because it's really not one disease. There are many diseases that lead to the death of an infant. And we look at our birth certificate data and identify the underlying contributors to infant mortality, and we find there are three top causes: birth defects, preterm birth and sudden infant death syndrome. And so, in our

generalized risk approach to disease prevention, what we then do is put all of our resources into those three top causes of infant mortality, because addressing them would give us more bang for the buck. That makes sense.

The problem is, when we look at disparities, the top three causes or the top cause of the disease isn't necessarily the same as the top contributor to the disparity. So if we look at this chart, birth defects, for example, was the leading contributor to infant mortality. But if you look at the degree of difference between the black and the white bars representing the African-Americans and White populations, there isn't that much of a disparity. There are still some, but it's not as great as it is, for example, for SIDS or for preterm birth. So the biggest contributor to the disparity is not necessarily the same as the biggest contributor to overall infant mortality.

So, we know preterm birth and SIDS and birth defects are some of the biggest contributors to infant mortality. And preterm birth is the biggest contributor to the disparity. The thing that we've done, though, is to focus on prenatal care as the mechanism of choice for addressing some of these issues. However, when we look at the practice of prenatal care, if you look across the timing of entry of care for different groups of women, there isn't that much of a difference in improvement and outcome over time. So, for example, just look -- forget about the none and the unknown, that's a totally different issue for now. We look at

women who come into prenatal care in the first, second and third trimester. And I'm afraid I can't point backwards, so you have to kind of bear with me.

So, the black bar represents African-American women. And if you look from first to second to third trimester, there really isn't a lot of difference in the rates of preterm birth. So, what you can sort of conclude from that is prenatal care isn't really having much of an impact. So, coming in early doesn't necessarily buy you much in terms of improved outcomes. And the same pattern holds for other groups as well, but we also can see that for African-American women who do come in in the first trimester, their rates of preterm birth are still higher than any other group of women who comes in in the second or the third trimester. So something is not quite happening in prenatal care.

For SIDS, however, we have a little bit of a different situation, and that is because we do have an intervention that helps to reduce the rates of SIDS, we do see some decline in the rates, so we don't see the same flat line that we see and in preterm birth. So, the top line, the green line is the SIDS rates and the trends for African-Americans. The red line is for Whites. And the one in between -- the one on the bottom is the overall rate.

So, what you see is, after the introduction of the Back to Sleep Campaign, there is a slight discontinuity in the trend where it's starting to come down. So it appears as if there's some impact of this evidence-based intervention on the

rates of SIDS, but it’s occurring equally in all populations. So it’s good, we’re having an impact in reducing the rates of SIDS. But if you look at the degree of the disparity from the beginning of this time measurement to the end, there isn’t much change in the disparity. So the point that I’m trying to make with the slide is even with the existence in the delivery of an evidence-based practice, it doesn’t necessarily guarantee that you’re going to reduce the disparity. So it’s unnecessary, but it’s not a sufficient quantity or not a sufficient effort to reduce disparities.

The problem is, we have the disease and we also have the contributors to the disparity and they’re often two separate things. Excuse me. If you look at this some list of factors -- this is from a study by Raynard Kington, who is the -- was the acting director of the NIH, and Herb Nickens. They did a very extensive review of the literature up to this day in 2000, looking at what does the literature say about what factors actually contribute specifically to the disparity. And these are the factors that they came up with. Now you notice many of them are social factors or environmental factors. I put an asterisk next to behavior and genetic factors because they don’t always explain the disparity. It really depends on the specific disease in question. And there were basically two criteria: Is it related to the disease? And is it differentially distributed with the higher rate among African-Americans, and it wasn’t always the case for those two. So the point is, there are whole separate set of factors that contribute to the disparity that we don’t generally include in our interventions.

The other thing to consider -- I am going to go back to the SIDS graph for a second -- is that when you think about how we actually intervene in relation to a lot of the risk factors for SIDS and for a lot of other infant mortality contributors, the thing that we do is we provide education. We tell women what they should be doing, go home, put your baby to sleep on the bed, go home, eat fresh fruits and vegetables, go home and exercise. But the point is, the initial part of the intervention happens in the clinical setting, but it has to be actually carried out in the community. We count the number of encounters we have where we handed that information to someone. But for the intervention to be complete, she actually has to go into her community and to her family, her social setting, and fulfill what education you asked her to do. So we have to stop thinking about the intervention as just what we did in the clinic, what we gave to her. We have to begin to think of it in a bigger sense of what happened when she went home. Was she able to follow through with that intervention? So, I think it becomes clear that the social environment that she lives in and her family environment plays a big role in whether that intervention actually gets completed, whether she's able to put that baby to sleep on its back. So, again, the social context plays a huge role in actually completing the interventions that we start in the clinical setting.

Okay. So, not only do we need an evidence-based intervention but we have to specifically address the contributors to the disparity, and these often lie in the social context. Now, any treatment or intervention that we provide will have pretty

much a fixed effect on the outcome so it's going to change that slope like you saw with the Back to Sleep Campaign. It changed the slope a specific degree in both populations. But we have to recognize is that in order to affect the disparity, the slope actually has to change faster in the vulnerable groups. So it has to go down faster among African American women.

And so, how do you make that happen? That's the question that we have to begin to address. But I say that -- but it's only partially true and the reason is because there's a study that Cindy Berg and others conducted where they looked at risk contributing to infant mortality and low birth weight, and they found that there really are different degrees of contribution of specific risk factors for Black versus White woman. So, say, for example, income might have a greater impact among African American women as compared to White women.

So what that tells you is that there may be -- you may need a different set of interventions to address the same types of risks or the same types of diseases in two different populations. So, what that means then is the slope representing a decline in the rates from a given intervention might actually be larger for one group compared to another depending on how prevalent that risk factor is in the population.

And to understand this better, I think we can turn to the perinatal period of risk analysis to sort of demonstrate how that might work. So, most of you have done

perinatal periods of risks, so I'm not going to go into exhaustive detail about it. But, basically, this was developed by World Health Organization to analyze infant mortality and it was adopted by CitymatCH or adapted by CitymatCH in the United States to get a better sense of what specifically we should be doing differently with respect to infant mortality interventions in different populations. And so, basically, what this analysis does is segment all infant death into six categories based on the weight at birth and the timing of death. And then it overlays on top of that the periods of risks, so at what point did the idealogic pathway really begin and where do you have the best opportunity to reduce the risk of that particular death.

So, when you overlay the interventions, the top three boxes are perinatal health or preconception health -- excuse me. So, if we provided preconception health, we more likely prevent the births that occur in those three categories. The fourth one, maternity care -- so prenatal care would be in the fourth category, the pink. Newborn care would most likely prevent the deaths that occur in that category, in infant health, in the last category.

So each one of those opportunities for intervention are attached to specific types of intervention that we conduct. So when you talk about infant health, when you provide those interventions, you're going to have an impact on the births that appear in that category and the deaths that appear in that category and not some of the ones that appear in the other risk categories. So, basically, what it tells us

is infant mortality, again, is a lot of different diseases and we have different ways of getting to the different aspects of infant mortality. And so, what does this look like in a specific population? Is it the same across all populations? So, it's supposed to give us some sense of what we should be doing to address the excess deaths that we see.

So let’s look at Wisconsin -- and thank you, Wisconsin, for the data -- as an example. So, you take a reference population, and usually it’s a population that has the best rates of infant mortality or the lowest rates of infant mortality. In this case, I believe, it was White women, 18 to 25 or something, high education, so they had the lowest rates in the state. And you segment all the infant deaths hat occur in that group. In this case, there are 477 deaths. And you segment them into each one of those six categories and, again, overlaying the period where the opportunity for prevention on top of it. And what you see on the -- I guess it’s your right side of the screen -- is the actual rates segmented into each one of those categories.

So, for the infant mortality rate of 4.7, you can see which categories or which opportunities for prevention contribute the most to that infant mortality rate. In this case, it’s the preconception types of interventions. So this is the reference category. So this becomes the comparison group that we look at other segments of the population with to understand where is the excess coming from, where are

we seeing the excess deaths and what period of intervention should we focus on to get at those excess deaths.

So, the first comparison is with the White population in Wisconsin. And if you look at the right side of the screen, it shows the distribution of the excess deaths. So you can see most of them, 46 percent, come from or could have been prevented during the prenatal period, 26 percent could have been prevented by the -- by interconceptional care, and another 22 percent infant healthcare. So, you can sort of see the distribution of those excess deaths compared to the reference population with the major part of them, the opportunity for prevention would have been during prenatal care.

Let’s look at the difference when we look at African American populations. When you look at the excess, 50 percent come from or could be prevented by preconception care. And that again, compare it to the 26 percent among White populations. A very small part would be affected by prenatal care, another large part by the infant health interventions, that’s the greenish, bluish, proportion. So it’s a very different picture when you compare Whites and African Americans in this population of what opportunities for prevention would help us get at those excess deaths.

And if we look at the Latino population, it’s quite a different picture again, where we see 57 percent of those deaths could have been prevented by improved

quality or access to prenatal care, and 39 percent to improved interconceptional care. So for each one of these populations, there's slightly different opportunities for prevention. So if we put all of our resources and our investment into prenatal care, then we're implicitly choosing which population is going to have a disproportionate benefit. In this case, it's not African American women.

So, what it does is -- what this PPOR does, to me, is demonstrate that we really have to look at different types and systems of intervention for different population groups. So if we make decisions whether they're economically based, politically based to provide resources for prenatal care over, say, interconceptional care, then again, we're inadvertently choosing which population will differentially benefit. So we have to really be considerate about the choices we make about where the -- where our resources go.

So, just to summarize this section, SIDS trends demonstrate that African Americans need something more than evidence-based practice to reduce disparities. We also have to reduce some of the underlying social risks that contribute to the disparities above and beyond that evidence-based practice. And the PPOR shows how different subgroups differentially benefit from different types of intervention. African American women would benefit from quality preconception care more so than quality improvements in prenatal care.

Okay, so let’s move on to the next section, which is the social determinants of health. So, as you can see, social factors can’t be ignored. Just from the previous section, if we expect to eliminate disparities -- so, let’s look a little bit more closely at what these are and how they impact on health in a general sense. So what you’re looking at here are just some of the social factors that are considered to have an impact on health.

This figure is sort of the conceptual model of how these additional factors that are outside of our physical body can have an impact on health. This is an ecological model, and basically a posit that the individual and their impact -- their physiology and their behaviors are impacted by a variety of influences that encircle them. And there is interaction among all of these. So, for example, social and economic policies affect environmental exposures, which affect someone’s health.

And if you think about smoking as an example, you can see how an environmental intervention, for example, to eliminate smoking in public places, for an example, which would be in the outer ring, could influence something closer to home, to the women in her health. So this sort of gives you a sense of the rings of influence that social factors have on health and on health behavior.

We also know that there’s a dose response between level of income and health. The more money you make, the less likely you are to be sick. And despite the fact that we haven’t acted to address social determinants of health, at least not

aggressively, it's pretty well accepted in the public health world that social determinants are one of the biggest contributors to the disparity in infant mortality. This is not a new fact. It's not a revolutionary revelation that I'm making to you today. It's been known. And this, for example, is something that former acting director of the NIH said in a congressional testimony, she said, "The causes of health disparities are multiple. They include poverty, education, inadequate access to care, lack of insurance, discrimination, et cetera."

And most of you will be familiar with the IOM report on unequal treatment. But you probably didn't read the part at the beginning of the report where they noted that even though they're just dealing with one small piece of the pie of what causes or what contributes to disparities, the medical care portion, they were very careful to put it into the bigger context and recognize that racial and ethnic disparities reflect differences in social, socioeconomic, behavioral risk factors and environmental conditions. Healthcare is necessary but insufficient in and of itself to redress racial and ethnic disparities in health. So, again, we're not talking about a new piece of knowledge. We've known for a long time and in a widespread way that social determinants are a major contributor to the disparities.

On an international level, it's also been discussed for a very long time and recently the World Health Organization convened the social determinants of health workgroup that essentially tried to model how those relationships happen,

how do social factors and environmental factors impact on health. And, again, this is a slide that you should have in your packet. I'm not going to go into it in detail. But I wanted to show -- I wanted to present it because then you can have it to study later on. But also to bring up the point that it's not just the level of income that's important. One of the things that this slide demonstrates and this conceptual model demonstrates is that if there are inequalities in any of these levels of any of these factors, then you're going to see inequalities in health. So, it's the inequalities that lead to poor health and to the disparities in health. And so that's a concept that we haven't really discussed before.

So inequalities in the social conditions have a big impact on health. In fact, in some cases, you'll see, if you look at data, you'll see lower-income countries might have better health outcomes than higher-income counties. But if you look at the disparity in income, the wealth distribution, the smaller the disparity in wealth, the better health there's going to be. So in some cases, it's the inequality in wealth that has a bigger impact on health outcomes than the actual level of wealth in the country.

And so, again, the inequalities in those social conditions that you saw in that map are some of the things that we want to examine because we want to look to see whether there are inequalities by race or ethnic group, et cetera, in this country on those factors. And what you have in the next couple of slides is a

demonstration that, yes, we do have unequal distribution of social condition in this country defined by race and ethnicity.

So, for example, if we look at poverty, we see Black and Hispanics have higher rates of poverty and it's persisted over time compared to Whites. Again, we see higher rates of childhood poverty for Black and Hispanics compared to Whites. We see higher exposure to toxic facilities in the whole neighborhood for Blacks and Hispanics compared to Whites. So, again, these are some of the factors that you saw in that World Health Organization model. And these demonstrate that we do actually see disparate distribution of these exposures for African Americans compared to Whites.

And finally, if we look at social hardships specifically during pregnancy, these are from Paula Braverman's data, and she looked at specific social hardships during pregnancy and who experiences them. What she found basically is that all women experience them as you can see from the data, even among Anglo women, there are non-zero numbers. But the numbers, the percentage of women who experience these hardships was much higher for African Americans compared to other women. And if you look at the number of women who experience more than one of these hardships during pregnancy, you can see it's much more likely to be a Black woman than an Anglo woman.

So, again, you see the disparate distribution of social hardships and social -- experiences of social hardship in the United States. So you might say, “Well, wait a minute. All women experience hardships. It’s not race or ethnicity. It’s income that makes the difference.” But if we look at preterm birth, for example, by maternal education and race and ethnicity, you can again see that even the second set of bars, the blue line, is African American women who have greater than 12 years of education. You can see that even those women have higher rates of preterm birth than any other level of education for any other group of women. So income alone, for which education is a proxy for in this case, doesn’t undermine the risk that you have due to race.

Now, I say race but I used that word with caution. It’s not the word that I prefer to use, because we’re not saying that there’s something inherently risky or something inherently wrong with Black people because of their race, or with Hispanic people because of their ethnicity. That’s not the case. The point is, and as you saw in the slides that I just showed, we see social inequalities based on these characteristics. So what we’re seeing actually is the differential effect of how people are treated in this country. So the risk factor that we should be looking at and the way we should be calling it is racism, and not race.

So this is kind of a good segue to move on to the life course. Life course, social factors, historical factors, they’re intimately related. So, what are they? Basically, they gain prominence -- life course gained prominence in the late '70s, mid to late

'70s, when Barker published his theory. And I'm sure many of you are familiar with the term the Barker Hypothesis.

So the way the theory emerged was they looked at geographic analyses where they looked at where infant mortality was occurring and overlaid it with other chronic diseases that occurred later in life. And they found direct relationships between these rates of infant – high rates of infant mortality or preterm birth in some cases and child – adult diseases in later life. So, this is just an ecological analysis but it was enough information to prompt him to ask the question and to develop the theory about whether what happens in utero can influence health later in life. So, later, those studies lead to several retrospective studies where people looked at childhood experience to see if it actually had an impact on health later in life.

And so there are several studies that looked at low SCS in childhood and found that it resulted in worst health later in life, with diabetes, increased rates of diabetes, experience of violence was associated with depression and dissociation later in life, et cetera. So there are a number of studies across a variety of health outcomes that are beginning to emerge that track what happens during childhood with adult outcomes. And some of these are hypothesized to operate through different mechanisms.

So there’s the theory of developmental plasticity, which is more in line with the Barker Hypothesis, that it’s actually physiologic changes that are occurring, where he's hypothesizing that when the fetus is subjected to stress in utero, the short-term adaptations that it has to do to adapt to those, to protect itself from those stressors, actually change the physiology in such a way that it protects it at that point but it becomes a risk later on.

So, for example, the brain, he suggests, might be hardwired to secrete high levels of stress hormones leading to high blood pressure and heart disease in adulthood. So at that immediate moment, it’s a protective mechanism but it sets the stage later for something that could be potentially harmful. So that’s one hypothesized mechanism that life course effects might have.

The other hypothesis that people argue would be epi-genetics, that it’s the environment that the child is exposed to in childhood and the same environment in adulthood that has these physiologic or stimulates these physiologic changes. Others argue that it’s inherited social disadvantage, that it’s not anything physiologic that’s passed from one point in time to another, but just that the child is exposed to the same physical and social environment in adulthood as they had in childhood, and thus they’re going to have the same outcomes.

And then the last theory is that it’s a pure genetic inheritance, that the expression of those genes are passed from mother to child. Now, none of these are mutually

exclusive and I think there shouldn't be an argument about whether it's either or because it probably depends on the disease status. And I think over time we're going to get a little bit more clear about which mechanism is operating in which case. But I think we should suffice to say that all of these are potential mechanisms that lead to life course effects for the child into adulthood.

So life course and historical factors which you heard me connect, it's very important to understand it from a historical perspective and to understand that we are talking about what happened in the past having influence later on in the future. And it becomes tricky because when the risk factor is something that happened before, how do you address that in the present time? So I think that's going to be one of the challenges that we have to face.

But I find that sometimes people have a hard time conceptualizing what that means exactly. And so I would like to just present a metaphor to give you some imagery to attach to this so that it will help you to understand how life course effects operate. So here's the metaphor. So just imagine that there's a relay race or a marathon. And let's imagine further that each generation – it's an intergeneration marathon and every generation passes the baton at a certain point to the next generation. And let's further imagine that one group of people was systemically forced to run the marathon with a 500-pound weight attached to their leg. And then imagine further that his went on for four or five generations.

So, if you haven’t gotten the metaphor, the 500-pound weight represents slavery and Jim Crow and other forms of discrimination that African Americans and other populations have faced. So think about it. After four generations, would it be surprising to find that African Americans were behind in the race? Would anybody be surprised? Okay. So, I’m sure you see by now that the marathon represents social and economic wealth generation.

So now let’s imagine that after, say, 400 years and many iterations and generations of the race, somebody stood up and said, "Wait a minute, this is not fair. It’s not fair for some people to have to wear the weight and other people to not wear it." And so they were able to gain the political will to end this unfair advantage and remove the weight from that group of people’s legs. But after this emancipation, nothing else was done to undo the unfair advantage. You already had one group who’s way ahead, the other behind. And so even though everything is equal at this point in time, nobody has the disadvantage of that weight. There's still some catch up to be done, and there's still one group that’s behind.

So when you look at – go back and look at all of those social disparity variables that I just presented and then you begin to understand why African Americans are consistently worst off than other populations of people. So this is an example of how history, things that happened in the past, can affect the present. And it’s important to understand it plays a huge role in the existence of disparities. So not

only do we have to engage the social determinants in addition to the disease determinants, but we also have to address how past disadvantage created by the social history of populations impacts on these disparities. And again, understanding how to undo the challenges of past discrimination, of past history is going to be one of the challenges that you all will have to face, that we all have to face.

So now, you've gotten an overview of disparities, causations, social determinants and life course. And again, I apologize it's all been very basic. So what I really want to do is explicitly illustrate how these all fit together and where we as public health people and the interventions that we plan and deliver fit into this equation. Now, I reiterate that one reason that – excuse me – public health has not adequately or consistently addressed social determinants is because we don't really know where we fit in the equation and we don't know how to influence these things. So we don't have this book of evidence-based practices for undoing past ills or undoing social injustice, et cetera. And so what we generally do is say, "It's too big. We're just going to deal with the things that are closer to home, that are easy to deal with that we can report on the indicators that, say, we're having -- making progress on them," but we continue to sweep them under the rug. We acknowledge them, but then we say, "Well, we're little S society. We don't have power to change a big S society has to undo racism or undo social inequalities." And so it doesn't get done because nobody [inaudible] to being part of big S society. The problem is that social context and life course are intricately tied. And

they're tied into each other and also to the effectiveness in our intervention effectiveness and our ability to eliminate disparities.

So I'd like to illustrate why this is and how that works and thus this section is called the intersection. So what I want to do is take you back to algebra 101. So don't get nervous. But if you remember -- well, first, this is just a typical illustration of disparities and what they look like and the trends over time. And, you know, Black versus White worse off among Black folks. But I want you to go back to algebra 101 and remember some of the constructs, some of the formulas of a line that you use to describe a line. There's the intercept. Do you remember the intercept? Okay, and there's the slope. The intercept is the point at which you start measuring. It's the point at which it's at the zero axis. So you have a common place, a common starting point for comparing the two groups of people that you're comparing and the two lines that you're comparing. So, the intercept is a very important part of the equation, of the description of the line. It's the starting point. So it represents the state of things at the time you first decided to measure it. So when you look at Black-White trends and disparities, you're essentially looking at the fact that African-Americans traditionally start out worse off whenever we do these measurements. So the intercept for African-Americans is always going to be higher. And that's one of the characteristics of the line. The slope is the measure of how much improvement in the outcome you gain for every input or intervention that you provide to that woman.

So the slope really depends in large part on the effectiveness on our -- of our interventions and on whether we intervene correctly. So generally, given some evidence-based intervention, it has a fixed effect and it will produce a predictable slope. And we essentially know from our Epi studies of how much a particular intervention is going to reduce that line or have an impact on outcomes in a particular population. But recall from the SIDS trends that I showed earlier that we have a fixed slope for both Black and White women. And we do same things presumably to both groups and both populations, then the outcomes are going to improve at about the same rate. That's basically how we expect it to work. They have the same slope. But if they continue the same slope forever, those lines are never going to converge. So even though the rates are going down, which is good, our goal is to reduce and eliminate the disparity. So in order for that to happen, we have to change the degree of the slope in one group relative to the other, bearing in mind that the intercept is where you started off.

So, the intercept, just to summarize, is the starting point. It's what -- it's determined by history. It's what happened before the type of measurement. This could be 10 minutes before the woman comes into your care of 10 years, 25 years, 100 years. So when you do things like mark down reproductive history or previous preterm birth et cetera, these are all factors that go into that intercept. And income and other social factors also factor into where that intercept is. So if we think about disparities, we may be able to eventually or to potentially change the slope by intervening, but we can never change the intercept. It's what it is. It

doesn’t mean that’s impossible for these lines to converge, though. It doesn’t. What it simply means is that we have to make sure the slope declines more rapidly among Black women compared to other women, other groups. And this is the only way to eliminate disparities. It’s the only way to undo the effects that we see inherent in that intercept. And you say, “Well, impossible. We can’t do it.”

But if you look at this -- I don’t have a pointer so I can’t point -- but where it says, slope, at that point, if you compare the slopes of the two lines for Black women versus White women, it is declining a little bit more sharply among Black women. And if you look at preterm birth, there are periods of time in the ‘90s, for example, where the slope declined a lot faster among Black women than Whites. One of the things that we never do is step back and ask ourselves, “Why? What did we do right? What was going on that would factor into our ability to change the speed of that slope and undo some of the effects that are inherent in that intercept?” So again, what do we do to undo the effects of the intercept, is the $10 million question, and one of the things that you’re going to have to grapple with today and over the course of the week and for a long period. So, maybe, it’s not the same intervention in all populations. And maybe we have to do additional things, like, address those social factors in addition to the medical ones to be able to impact on the slope.

So let’s look again at the slope. The slope, again, are the inputs. So your interventions factor into what happens with that slope. The trajectory is basically

the direction that the line is going. Is it moving towards your goal? If your goal is at lower rate, is it going down or not? Is that flat? Whatever, that's the trajectory of the line. And your intervention is designed to move a person or a group of people towards that goal. So the questions you have to ask is, "is it moving in the right direction? Is the trajectory going in the right way? "How fast is it moving?" And the force -- the slope is the force that takes it along that trajectory. So now I want you to stretch your imagination again. And imagine that this line represents one woman's journey towards a good outcome during pregnancy. So this could be nine months of pregnancy. And further, imagine that this line exist in 3D space because a woman lives and works and operates in a social context. It's not unobstructed. So, there's an environment around her that has some power over what happens to her on a day-to-day basis over the course of that nine months. So, you have to interact with her through your interventions but she also has to interact with her social environment.

So, again we want women to travel a specific trajectory towards a specific outcome, so we intervene with our programs and treatment trying to nudge them in the right direction. So, you know, sometimes we get confused because we do all the right things. But women don't always do what we want them to do or their outcomes don't always come out the way we expect them to and we wonder why. Well, just imagine for a moment that the substrate or the social context of one group of women in this 3D space was air. So, it's just filled with air. All she has to travel through is air over the course of her pregnancy. So, you provide your

intervention, you interact with her, and she moves pretty smoothly along that trajectory towards a good outcome. So, her substrate is pretty supportive. It's not hurting her in any way. So, that's one set of women.

Let's take another set, and let's just imagine that that substrate or her context is filled with water. So, water, you know, you can still maneuver through water. It takes a little more effort but you can basically do it. So if you nudge her in a certain direction with a little more effort than the women who is existing in the air environment, she can still get to that outcome. But it takes a little bit more effort on her part and a lot more energy on her part.

So then the final case is imagine if that substrate were filled with landmines instead of air and water. So the substrate is a little bit different. And imagine what it takes for the woman who has to navigate through that context, through that substrate. So here you are trying to nudge her along the trajectory but she keeps bumping into things in her social environment that are pretty adverse and either they push back against what you're trying to do or they're so dangerous that she has to put out effort to navigate around that landmine. So it takes her a lot longer and a lot more energy to do what you want her to do over the course of that nine months. Naturally, it's a lot harder for her, it takes a lot longer, if at all, for her to do what you want her to do. So for each intervention you do pushing her forward, there's something in her environment that may be pushing her in the opposite direction.

Now, this is among the fantasy I constructed. I know it's causing you to have to stretch your imagination, but this exactly represents the differential experiences that women have as they interact with the public health and the medical system and the social service system, I might add. And one of the reasons why I know this is because I participated and actually conducted a study to try to better understand why -- what's happening? Why does this happen? And I'll give you the context of the study. The parent project was a thing called the Preterm Prevention Project, Jennifer Collins, the PI. And this was a randomized trial that was trying to test a certain set of interconceptional interventions. So women, after they had a previous preterm birth, they were led into the program and they were screened first for specific risk and then they were enrolled into the interventions for those risks and the -- and the interconceptional period. Now, what was unique about this randomized trial was, they took everything we know about various prenatal care and addressed them. So there was child care provided, transportation was provided, and all the services were free. Social support was provided, flexible hours and I could name probably six other things. Extensive training of staff and interpersonal communication et cetera. Despite all of this, some women still didn't come. You'd expect 100% participation but it didn't happen.

And so we designed this qualitative study to try to understand what exactly is going on in the social context that's preventing women under these

circumstances from participating in care, in this case, an interconceptional care. So, my study was a sub-study of that parent study. And what we found -- one of the things we found was that this study was just looking at African-American women, but there was great variation in the quality of their generalized substrate or social environment. So even just among Black women, there were some who had that air substrate. They had very few barriers in their way and they can do everything as you ask them to do over the course of the nine months, all the way to the other extreme where there are women who literally had to navigate landmines every day of their existence. And in fact, some of the other data collectors there, anthropologists and I who where in the field, we were actually surprised that some of these women ever got out of bed some days because when we looked at some of the things that they have to navigate in the course of a day or a week, it was extraordinary. We just couldn't understand how they could do it.

The other thing we found was that actually all women at some point along that nine-month trajectory will have to negotiate some landmines. So, even if they exist in a high income, very nice environment, their social support is intact and so on, at some point along that nine months there's going to be a landmine that they have to navigate around. So, it's something that everybody experiences. It's just a matter of degree that you see it over the course of the pregnancy and over different women. Let see.

The other thing we found is that the position and the existence of these landmines are generally not predictable, and this is the hard thing to deal with because if you could predict them, you could figure out a way to systematically maneuver around them, but they're not predictable at all. They arise from factors in the social and physical environment that any individual woman has no control over. And in many cases, again, she can't predict when they're going to come or protect herself from it.

So, this is only a small bit of our findings, but we found that many of the landmines are actually created or exacerbated by our own health services. Sometimes our attempts to structure institution so that we can deliver efficient services to whole populations end up creating more stressors and more disadvantage for some women. And sometimes our attempts to address variants may actually create other landmines for women.

Okay. And one example is -- this study took place in Philadelphia, and one of the things we found that women told us was that there was this sort of two-strikes-and-you're-out rule for some health providers, that if you missed two appointments, they won't reschedule you and they say, "Go find another provider."

Now, you know, there are two sides to every story, and these healthcare institutions are businesses. And you can understand that to get reimbursement

and to keep the flow, they have to have a steady stream of patients. If people consistently don't show, they don't get the revenues they need to keep their doors open. So, you know, there are very real business reasons why you would have a rule like that. But the point is, or the reality is, that rule is based on a business decision. It’s not based on a decision related to equity or based on the conditions or the characteristics of that population, and there are consequences to that.

So, we may not intend to discriminate based on class or social condition for specific groups of vulnerable women but that’s what ends up being the effect. Intent has no impact here. Intent is meaningless. You can intend or not intend, the effect is still the same, women are shed out of the system. And we may not want to admit it, but our decisions to use metrics that are other than social equality and instead make business decisions in public health services unfairly disadvantages poor, vulnerable and usually African American women disproportionately. So, we really need to examine the impact of our institutional rules because many of them offer very little flexibility for women who have to negotiate these landmines to deal with the systems that we set up.

I'm going to actually skip this part because of time and just go to the end. So, where do we go from here? Now, this is not something I have the definitive answers for. This is where the field is. This is where the state and the sciences. So together, this is the type of thing we have to begin to evolve and unfold and

discover. But, basically, this is one tool that you can potentially use to help in your discussions. So, I presented here just for discussion purposes.

This is, again, from that same World Health Organization social determinants of health work group. And what they did was they focused on the causation part, which was the model I presented before, but also on the intervention part. So, this graphic sort of gives you a structure for what needs to be done at what level to address these social determinants of health. And I think what the challenge to us is, is to figure out how as maternal and child health agencies or public health agents, how do we fit in to this big picture? Where are the places where we can have influence in this big picture and find a role for ourselves and actually be committed to making the change that we want to see?

So, what we have to do is specifically address the disparity contributors. We have to prevent or buffer the effects of these historical or life course conditions that we see factoring in to that intercept and ask the questions: Do our interventions change the slope in outcome? If they don't, what do we need to do to make that happen? What counter-veiling forces act on women to undo the effects of effective interventions? Which of these do our agencies create? Which are -- which of them are health services mediated? Which are socially mediated? Which are environmentally mediated? And what are we, as public health people, doing to change these?

And I say that because we as public health people have been given the responsibility to eliminate health disparities. It wasn’t given to the Department of Justice. It wasn’t given to the Department of Education. It wasn’t given to the Congress. It was given to us in public health. So, we have to be scientific. We have to look at the big picture and deal with all of the issues that contribute to health disparities and not just the ones we feel comfortable with. And if we don't, then we should give up our role and give the responsibility and all the money for health disparities to someone else to take the lead on.

Now, I don't want to see that happen, and I'm sure none of you want to see that happen. So, we have to ask ourselves, what is our role in this bigger picture? Again, we say, we’re little S society and there’s big S society that has to deal with the issues of racism and poverty and so on. But you have to realize that all of our institutions are part of that bigger society. We make up the fabric of that bigger society. So, if we can't change what happens and how it happens within our own institutions, then that bigger society is never going to change. So, we have to begin to ask ourselves some of the really tough questions in our own backyard and address them there before we can address them in the bigger society. So, I end there and thank you.

MILTON KOTELCHUCK: Thank you. Is this mic on? I want to thank Vijaya, that was a really fine presentation. And we have in store for everybody three panelists and myself giving a little bit of comments. We’ll take questions and everything at

the end of the presentation of the commenters. So, we organized the commenters. So, we started with families, cities, nation, and God knows what I'm supposed to be after that. But -- so, our first speaker -- ‘cause we like to move right in to it -- is Diana Autin, who will give a little -- who will talk to us from a parent and family perspective.

DIANA AUTIN: Hi, everybody. I'm actually representing National Family Voices here today, which is a national organization that speaks on behalf of families of children with special healthcare needs. And the motto of Family Voices is keeping families at the center of children’s healthcare, and my organization’s motto is Empowered Parents: educated, engaged, effective. And there’s a reason I'm telling you my organization’s motto because it relates to some of my comments today.

I think the keynote presentation today that talked about the social determinants and characteristics that directly impact health outcomes makes it pretty clear that what works for one culture, ethnicity or family may not work for another. And I direct you to a wonderful book by Dr. Beth Harry called Using Cultural Reciprocity with Families. And what she talks about is that, really, anytime we’re working with families, it’s all about relationships. And we’ll never be able to know everybody’s culture, everybody’s ethnicity, what -- and what works for me as a Cajun who didn’t grow up in the bayou of Louisiana is not the same thing as probably going to work for a Cajun who did grow up in the bayou of Louisiana.

Because even though I'm from the same culture, Cajun and I'm also Native American, it’s different than someone else’s culture who’s a Cajun or maybe who grew up on a reservation when I grew up in urban communities.

As parents, we have a lifelong interest in and commitment to our children. And I think this is especially true for children with special healthcare needs because children with special healthcare needs are more likely to need to have that support of the family even as they get older. I have a 33-year-old son with mental health challenges who does live independently with his wife and child, but we talk to him three or four times a week because of his continuing needs.

My presentation is in your binder but because of time, I'm not going to go through the PowerPoint. I want to talk a little bit about the Platinum Rule. Everybody knows the Golden Rule, “Do onto others as you would have them do unto you”? But, really, that’s not very effective, because what we really want to do is the Platinum Rule, which is do onto others as they would have us to do onto them. And that really speaks to this idea that we have to do different things for different cultures and ethnicities and family compositions because different things work for people.

If you want to do what’s effective, we can't just do the same thing with everybody or the thing that would work for us. I also like what Steven Covey says, which is, “seek first to understand and then to be understood”. And I think that as a family

organization, that’s something that we spend a lot of time doing, trying to understand where the families who were coming to us for help are coming from as opposed to trying to get them to understand what we can offer, which may not be what they need.

One of the most important things, I think, as parents is that -- of people who -- you know, as parents and families who come from different cultures is that we have networks of support that we rely on. And those networks of support often are not the formal networks of support like maternal and child health programs. And, in fact, from many of the families we worked with, they’re not going to access maternal and child health program because it’s a government program, and a government program is seen as someone who’s going to report them to the immigration service or someone who is going to conduct research on them that may lead to their children being taken away, for example, which are things that we’ve actually seen happen to many of the families that we worked with.

So, we work a lot and we think -- maternal and child health programs in order to address health disparities need to work with cultural liaisons or cultural brokers. And I'm sure many of you are familiar with the National Center for Cultural Competence guide on cultural brokers and in healthcare. But you also have to understand that family organizations and culturally based -- community-based organization are the most under-resourced organizations out there. So, when we’re asked to come to the table to help you address health disparities without

any money or other kinds of resources being put on the table, it's very difficult for us to be able to do that because we're already stretched to a point beyond no return.

Another thing as families is that when you think of health disparities, a lot of times people think just of race, which clearly is an important thing. But there are other kinds of health disparities: language, immigrant status, religion, geography, north, south, central, urban, rural, suburban, family composition, whether or not you have kids with special healthcare needs, education status, you know, economic class. And I think one of the most important things about -- in addressing health disparities that we have found is that we have to engage people who are our target from the beginning in our effort.

So, we identify and work with families from the targeted community to understand what their needs are, to design the goals and objectives and activities we're going to implement, to actually implement them, to evaluate them and to do improvement planning. And that's the only way we've had any effectiveness is by actually working with the target population from the very beginning of the process and all the way through the process.

One of the most important things I think to understand is that families do feel more comfortable getting information and support from other families, especially those who have similar experiences. But again, what is perceived as a similar

experience often varies based on race and ethnicity. So, when we did focus groups of families in New Jersey, we found that for Spanish-speaking immigrant families, they wanted to be getting information from other Spanish-speaking immigrant families. It didn't matter whether that person had a child that had the same kind of needs as their child. They really -- the language and immigrant status was the thing that was most important, because those were the barriers they had to face most in their lives.

For African American parents, we found that it was speaking with another African American parent. But if they were an urban parent, they want to speak to another African American urban parent, and if it was suburban they wanted to speak to somebody from the suburbs because that experience is different, being an African American parent in the suburb versus an urban community. And for White parents, it often was, especially White middle class parents, somebody who had the same kind of special need their child had.

So, again, our intervention in terms of addressing the needs of families couldn't just be we're going to match you with your child's, you know, special need. It had to be we're going to be able to connect you to parents who have the experience and expertise that you're looking for and not what we think you want to have.

I encourage all of you to look to organizations like Family Voices and Family-to-Family Health Information Centers, there's now one in every state, Federation of

Families for Children’s Mental Health, because one of the other things that family organizations do that really feeds into what our keynote presenter talked about is advocacy to change systems to make them more fair. And that really is maternal and child health’s role, is also advocating to change systems, and not just health systems but other systems that have an impact on health. And I think that’s what our keynote presenter was encouraging us to do. We want to be a catalyst for change. We want to engage parents in that catalyst for change. And we -- our vision is empowering parents not just dealing with your healthcare. And that’s one of the big things that has -- that we’ve had a tremendous success with is using this empowerment approach.

For several years, we’ve worked with immigrant families of kids with very significant special healthcare needs, undocumented immigrants mostly who speak no English. And one of the most powerful things to see is what happens when working with those families and having them focus on becoming leaders, that every parent is a leader. They may be a leader in their family; they may be a leader in the community. They can be a leader in systems change. But that is -- that's something that really changes people’s approach to life and makes, in our experience, they’re more likely to take care of themselves because they see themselves as having a bigger purpose in life and having a larger goal that they can aim for.

One family, for example, we're working with, who was an immigrant mother, who was suicidal before we started working with her, hadn't gone to the doctor in seven years. She -- and she had a cancer diagnosis and hadn't gone to the doctor in seven years. But now, she's a parent leader in immigrant communities in New Jersey working with other families and helping them advocate for their children and for systems change.

One of the most important things, I think, is the idea of -- that the keynote didn't really go a lot into details, is the idea of kind of that cultural and racial self-assessment, cultural and racial linguistic competence, self-assessment -- and for family organizations -- I worked with the National Center for Cultural Competence in developing something for family organizations to assess our own culture and linguistics competence in the work that we do. And I think that's one of the most important things, because if we don't really look at what's going on, what are we doing well and what aren't we doing well, we can't develop a plan to make it better.

So I just want to end with a couple of quick thoughts to address health disparities, identify partners that have legitimacy in the communities you're trying to work with, be prepare to reach out beyond your existing databases to do that, make sure that you are working with people who are representative of the communities that you -- when I -- when we started to work with immigrant families, we used immigrant families in order to do that, to develop that

legitimacy. Ask families what they need and what works for them and listen to what they say and be responsive to that, be flexible and determined. Written materials for most of the families that we worked with, even middle-class families, written materials -- people are so saturated with written information. It’s not very effective.

Also, be flexible with the kinds of things you’re recommending. When we worked with Spanish-speaking immigrant families, they said, “We can't tell our husbands not to smoke inside. We can't do it. Culturally, we can't tell our husbands not to smoke inside.” So if the only message you’ve given those families is don't let anybody smoke inside, you’re not going to have any improvement because they can't tell that to their husbands. So you have to have something else, like maybe there’s a room with an open window, which is where they ask their husbands, please, to smoke, right? So, getting those kinds of -- that kind of information from families themselves is important.

Or telling urban parents, “Oh, you've got to let your kids go outside to play,” when there’s no place for their children to go outside to play that’s safe or that even exist. Or telling single working parents, “Don't let your children spend all that time with the TV or at the computer.” Well, you know, you’re working and you have to make dinner, what are you going to do in terms of dealing with screening time?

So you have to really listen to families and help develop strategies that start with where they are. Be prepared to change many times along the way. And I think really focus on families as leaders, and then conduct ongoing evaluation of your efforts and their impact and learn from your mistakes, and be willing to admit that we make mistakes because, boy, we've made lots of them.

I just want to end with a quote, which is people say, what is the sense of our small effort? They cannot see that we must lay one brick at a time, take one step at a time. A pebble cast into a pond causes ripples that spread in all directions. Each one of our thoughts, words and deeds is like that. No one has a right to sit down and feel hopeless. There's too much work to do. And I know that family organizations all over the country and families all over the country are willing to work with you to address health disparities. Thank you.

MILTON KOTELCHUCK: Moving along. Debbie Allen. Deborah Allen.

DEBORAH ALLEN: Hi. I'm a bit -- I'm speaking to you from my new perspective as the essentially MCH director for the city of Boston. And I do that with some humility. I'm new in my position and I'm really learning about what it means to address things at a city level. And I want to acknowledge a couple of people: Cheri Pies and Mario Drummonds who are here, and hope that people will find them because I think they are the masters of addressing disparities at a city level. I've learned an enormous amount from them both in my short tenure. And

perhaps, my novice status makes me -- I'm not entirely an appropriate speaker because I'm really struggling to think this through as I go along. So I hope this will be a discussion rather than a speech.

Let me tell you -- I want to sort of focus on a couple of things. One is my own -- the evolution of my own thinking about disparity, and the other is a few sort of tied to some philosophical notions about what we're doing in Boston, we're trying to do that might serve to provide concrete example.

So, first, I think it's very, very clear and it has been throughout my life -- you know, I was brought up in a very progressive household -- that there are material differences between people, and clearly that has a lot to do. I mean, as Vijaya said, as Diane said, that clearly is an important part of this reality. But, you know, the World Health Organization report, which I think is superb -- people should get hold of it -- makes the point that a Black man in Harlem has about the same life expectancy as a poor man in India, and the material differences between them are vast. The Black man in Harlem has much more stuff available to him on the whole than the poor man in India. And so, clearly, there is more than material issues at stake.

Second was I was exposed to the life course perspective and found absolutely profound the notion it offers us that racism serves as a social stressor that interferes with every single social interaction that people of color have in this

society, that that stress has a physiological correlate in terms of allostatic load, and that you have to add on to the Black man's experience in Harlem that added burden that may sort of equalize his experience with the poor man in India.

But then the World Health Organization tells us, "Ah. But if you look at men who look exactly alike in two different neighborhoods in Glasgow, which apparently is a city with very wide disparities in income and social standing, which is also true in Boston -- as you might know, it's a city with a lot of very rich people and some very poor people -- you find the same level of disparity as you do between the Black man in Harlem and the poor man in India," which I think is a sort of fascinating concept, that disparity alone has some effect.

And so, I've been thinking a lot about what does disparity do. And the best I've come up with -- and I invite you to think about this, too -- is that when there are wide disparities in social standing, whether it's based on race or income or disability status, whatever it's based on, or sex, the world is set up for the people at the high end. And the people at the low end are forced to live on the edge. And that's -- so everything they do in life becomes hard. And that's made me think about an aspect of Black culture in the United States that I haven't before thought much about.

I come from a very secular Jewish family, so I haven't spent a lot of my life thinking about religious music. But, you know, family ties got me into the Catholic

Church, not as a member of it, but, you know, going to it, you know, for Christmas and other major holidays and listening to the music. And, you know, I've certainly been aware of gospel music. And it suddenly struck me that there's this huge theme in gospel music about burden, about picking up my burden. Nobody knows the trouble I've seen. There's actually a gospel group called Willis somebody & The Burden Lifters, which I think is utterly amazing.

Now, when you listen to Catholic Church music, it's not about burden. I mean, it's about sin and it's about God and it's about joy, but it is not about burden. And, you know, I never really thought about what that meant. And I think it means something very deep about this idea people being asked to live at the bottom of the disparity, of people being asked to live in world that's set up for the people who have means and access that they don't have systematically.

So, my -- I feel as if my own understanding of disparity is sort of evolving and growing. And this last insight, which, again, I invite you to help me become clearer about from this World Health Organization finding about the two men in Glasgow and my appreciation of religious music, not my own, has really added something to my understanding. So, what then do we do about it?

Well, first, I think from a city perspective -- and admittedly, this is harder from a state perspective -- I think we need to target our programs, and I know that's a word that's in disfavor. I just haven't come up with the better one. But we need to

sort of try to focus on the populations that are most clearly at the bottom end of that disparity and level the playing field. And I think Vijaya spoke to that a great deal. Second is giving a life course understanding of that disparity. And the fact that it’s cumulative, we need to start upstream.

And I want to say something that I think is a little controversial in MCH circles here, which is that I don't think that means exclusively starting in early childhood. I love little children. I have grandchildren. They, of course, came from my having children, and I love them all when they were small. So it’s not that I don't care about little children. It's that I think there is absolutely no way of addressing the needs of early childhood without recognizing the burdens on the families that are bringing them up. And unless we're prepared to take children out of their families right and left, which is not proven to be a winning strategy so far, we have got to recognize that upstream means the parents, and fundamentally, I think it mostly means the mom. Now, I think it means the father, too -- I know that’s controversial, too. But I think there are different ways those burdens are born and that the most immediate way to effect outcomes for children has a lot to do with recognizing burdens on the mom.

Third is I think it doesn’t mean we need to address material needs. And here, I will begin to be concrete. This is something I think Cheri is doing something wonderful from which we are stealing flagrantly, which is helping families come up -- we run in my city the Healthy Start Program and Cheri runs the Healthy

Start Program. And the idea we've stolen is to come up -- for each family we're working with through Healthy Start and some other programs we run -- with a plan about how to achieve sort of that family's maximum financial stability. So, how to do things like help families get a bank account.

I mean, I challenged Cheri at one point saying, "Well, families don't have enough resources to plan economically. They are living from hand to mouth. And then I realized if we had been in a position to educate families about mortgages, for example, many families who are in very sort of on the edge but have a relative who had a house who could have taken them in when they became homeless no longer have the relative with the house who can take them in because nobody was educating poor people about how to think about money and how to understand what's a fare mortgage and what's not. And those of us who can afford a financial plan, of course, didn't fall into those traps. It's people who don't have the material resources we do who did.

So, I think address material needs -- in Boston's Healthy Start Program, we're trying to do the same thing that has come up with an individualized plan also around food security and around housing security. And I'll come back to that because I know you're all thinking those are impossible. We can't assure those things. We've systematically decimated some of the support system we built. So we can't promise those things to people. So hold that thought. I'll come back to it in just a second. So address material needs.

Next, I think we have to learn as public health to take on racism. And I don't just mean the outcomes of racism, I mean, racism. I mean, the fact that when a murder happens in a Black community in Boston, the Boston Globe blogs where the leaders communicate with each other, talk in terms about the people who killed and the people who got killed that are vile, that are outrageous, and public health doesn't say anything about that. We need to learn how to take on racist attitudes that allow White people, who are the majority in the country, to tolerate the horrendous conditions in which Black people often live, including conditions in which murder is more prevalent.

I also think we need to be able to address racism as it affects Black people. There we do have one, I think, nice small idea which is running a group of what we've called Women Circles where we encourage women whether of childbearing age, whether they are currently pregnant or not to get together to have conversations around the issues in their lives including explicitly racism. And I know there are other people who have tried things like graphic stories where women, I forgot the name of the --

UNKNOWN SPEAKER: [inaudible]. I can't remember.

DEBORAH ALLEN: We'll come up with it -- but where women are really encouraged to examine their lives and think through how oppression has affected

them. And I think in Public Health we have to get much, much better at that. And then the final thing I think is this question of thinking about being -- people being at the bottom end of a disparity. And the fact that -- I mean, I think the two previous speakers, Vijaya and Diane, both did a really good job of talking about the fact that, you know, people are asked to do dozens of impossible things a day like feed their kids, make sure they're able to pay their bills, make sure the gas is on, make sure the electricity is on, that there's a phone working, that the car has gas, and all of those things are sort of demonstrably impossible if your income is, you know, at or near the poverty level in the United States. And none of us, no matter how many degrees we have, could possibly do that. Those things are undoable.

So, what does it mean to address that? One thing that we are trying, and it's not a perfect solution – I mean, first, I think it means advocacy, as Diane said, if saying this is outrageous, we need, you know, more support for housing, more support for, you know, for food programs and so on as opposed to cutting those things. But the other thing that we're proposing is to have what we're calling a problem forum. And the idea is that when our case managers, who work for Healthy Start or other programs, encounter a problem that a client has that they can't solve, instead of doing what they've done historically which is say, "I've tried Section 8," you know, "I've tried the projects, I haven't succeeded, sorry."

What they are supposed to do is fill out a form that they send to us and we are then supposed to try to figure out whether in fact they've done everything that they can do as the system is currently constituted. And if we can't come up with anything, we've gotten an agreement from city hall that we can take it to a group called the Human Services Sub-Cabinet. It's all the agencies in the city that address peoples' social needs. And the sub-cabinet is going to have to think about it. It's going to have to think about why is it that there's no housing resource for this woman and what could we do, how could we reallocate resources or how could we at least document the case and try to get new resources made available so that this becomes dissolvable problem.

And at a minimum, we want to make the point to that woman that if that problem is insoluble for her, it's not because she's dumb or lazy or inefficient, it's because the entire city has been unable to solve that, and it's a real problem and we're there with her. And I think that changes the landmines from being unpredictable, which they of course are in an individual level, to being completely predictable because when you look at women as a whole, when you look at a city as a whole, you know exactly where the things are going to go wrong, whether it's for woman A or for woman B. And it's time for us in Public Health to acknowledge that and take that on

MYRTIS SULLIVAN: Well, it's very difficult to follow such excellent presentations by Dr. Hogan and the other members of the panel. But I just want to give a few of

my reflections as the Title V director in Illinois and some of the observations that I've made and build on some of the reflections that Vijaya Hogan shared with us. I must admit, too, that for the lecture this morning -- this afternoon, gave raised more questions with me than answers. You know, I started thinking how those things began to grapple with these health and healthcare inequities as social determinants across the life course. What do we do in a state -- in a nation where the healthcare is fragmented and not integrated across the life course? It doesn't ensure healthcare access for all the citizens regardless of their ability to pay. And then, what policies and resources are needed to end these historical and deeply rooted complex structural inequities? So, with all these questions, you wonder where to start. In reading through the literature and reading Dr. Hogan's presentation, I wanted to underscore what she said about the work of the WHO commission on social determinants.

They really give a very good blueprint for states and any local government to build upon to start somewhere to address these inequities. They gave three short, brief but very helpful principles. I won't go into all of them, but I do want to stress two of those principles. The first one is to improve the conditions of daily life, and we've talked extensively about this and how we have to intervene across the life course. And we talked about the social ecological motto and how that's helpful in directing our interventions, especially if you add the fourth ecosystem like the author said in a recent publication in the MCH Journal there at the University of South Florida. And they talk about adding to that another ecosystem

which is the historical context that was discussed in detail earlier. And I think that's what was AMCHP and its partners had in mind when they got funding from the Kellogg Foundation to establish a six-state action learning collaborative, which formed the partnership to eliminate health disparities and infant mortality.

And so, this begins the dialogue. This is how states and local governments can organize themselves to reach, go out the state -- throughout the state to reach the populations there, to engage in dialogue and start building policies to benefit everybody. Also, in joining this collaborative, we also had plans to show film -- the film on natural causes to a host of state and local and not-for-profit organizations to again to promote awareness and dialogue about racism and its effect on health and well-being. And one thing that really was impressed upon me when I first started few years ago as the state Title V director is when I came to a forum like this here in Washington, D.C., where the keynote speaker asked us about where we are with the political will of our states of our Federal government and then I find myself three years later addressing that same question.

And so, I set up working with advocates and other partners within our state to do what -- to work with policymakers and convene together like what AMCHP has done to bring the state policy directors and the state Title V directors and other policy makers together to begin to really take action about policies to address inequities. Another thing I wanted to focus on with the WHO commission report is

the second principle. And that principle was to tackle the inequitable distribution of power, money and resources which are the structural drivers of those conditions in daily lives.

And I know we talked a lot about the social context of these problems but then I don't want us to lose sight of what it takes beyond the – of examining the social context. We're often reminded by constituents and advocates that real challenge of Public Health is to address these social determinants which scares public health doctors. The report also said that in any country, economic inequality, including inequality of public finance, needs to be addressed to make progress towards health equity. So where are we with funding? We have to have consistent policies and funding in our respective budgets to address these health equities or we will go nowhere. And so, we have to begin to not only engage our other partners in discussing housing, to build environment, food security, all these things that we talked about today. How do we address them? How do we go forward? And how do we get the political will and the public health dollars to preserve these successes and build upon our public health interventions and address inequities in the matter they should be addressed.

And then, finally, I want to say, too, that with the second principle is that another critical player that we keep hearing over and over is the health sector itself, which should provide benefits beyond just treating illness. This is why universal health coverage in broader social policies such as public finance are so important. And

while the talk here this afternoon argues in some ways for more specific tailored interventions to decrease disparities because of varying in social context, we are reminded again that the universal approaches are the best way to make social change. The idea is that when an intervention or benefit is universal, it is no longer -- it no longer targets or stigmatizes vulnerable groups and becomes a desirable intervention. Therefore, if we had universal social structures such as guaranteed minimal income, children's allowances, universal access, maternity and paternity leaves, the sick leaves, et cetera, what then will be the role of targeted interventions?

Finally, the third principle is to measure. This is something we can really grab as Public Health professionals. Measure the problem, evaluate action, expand the knowledge base and develop a workforce that is trained in the social determinants of health and raise public awareness about the social determinants. And as was pointed out, again, that we do – we need a measurable definition of health equity and what it means to have health equity in absence of inequities. We have a definition that they're using in North Carolina, which is a workable one. But you'll see in reading the literature, there are so many definitions. So how do we uniformly measure our progress towards universal health equity? It was mentioned that Paula Braveman in California has done a wonderful job in moving the field of epidemiology forward in this respect because she again gives a definition of what we mean by health disparities and health inequality, and she uses the terms interchangeably.

And the key is focusing on the disadvantaged groups, as was mentioned, and then developing policies for these disadvantaged groups in leveling the playing field. So, she has a long definition, I won't go and read it here, but there is that definition. She offers a second one, but the point here is that we need consistent uniform definitions that can have an insignificant impact on policies, particularly when resources are scarce and the definitions are vague. It is also important for evidence-based policymaking and measuring progress towards universal health equity. We can also measure -- use other measures, as again was stated, both the quantitative and qualitative or mixed measures, whatever, as long as we use clear and uniform definitions. In order to promote political empowerment and awareness about these health inequities, as was mentioned by our panelist, social -- cultural sensitivity is imperative. And the way we can go about making sure that our interventions and our research are culturally sensitive, is to use such measures as community based participatory research and then also use venues that allow community members and stakeholders to have a voice in the whole decision-making process. And this type of research and political forms are really important to incorporate in our needs assessment processes.

So in summary, Dr. Hogan has challenged us to act now. And so, it’s time to take big bold steps to end these inequities. But again, and in the final analysis, we will need unprecedented support, meaning financial support and other support with resources to promote health equity, promote health across the life cycle. And we

need to start doing things -- we need to start doing things differently and stop thinking and acting in silos and work together with our mental health, women's health, clinical medicine, chronic disease and other partners to create an integrated health and social service system across the life course. Thank you for your time.

MILTON KOTELCHUCK: Given that we're running late, I'm going to keep my comments brief, and you've heard me talk before and so I won't repeat things that I've said. And I thank our panelist also for their really important comments. I just want to make two or three really quick points. One is the purpose of this session was to kind of kick off for the entire next several days and really this current year in which for the first time in a long time new concepts are sort of entering into the MCH field, life course, social determinants. We haven't been talking about these things for many, many years and I just want to acknowledge two facts. One is, many of our outcomes are not doing well. We are -- infant mortality is leveled, preterm births, low birth rate arising.

I'm not usually a pessimist, I usually give half up beat half, but things are not going well. Our old models aren't working and it's really good that we're in this period where we can start once again after our last round of great brainstorming in the '80s and early '90s to be thinking again about new approaches, not that we haven't been thinking this last few years, but just really to have some new intellectual ideas that is helping us to motivate our activities. And, you know, I do

want to acknowledge that we do have a change in [inaudible], allowed some new thinking to enter into our situation. But I want to say if the 20th century was the century in which we really did a tremendous job in reducing infant mortality and maternal mortality but did actually nothing really about disparities, maybe the 21st century will finally address disparities which is really an issue that should be just unacceptable to the MCH field. I'm preaching to the choir.

I do want to comment that Paul Wise, myself, and several others pointed out for a long time that just really the point that I thought Vijaya was making, Vijaya Hogan, was that just -- I don't have a graph but you know the gap between Blacks and Whites and infant mortality, things that make everything improve may be different than the issues that keep the gap from closing. And that we really need to think much more about what are the causes of that gap. Vijaya suggested several places where we’re misappropriating, where we’re directing our energy. But I just want to remind you that disparity is a dynamic event. Issues like new technologies that occur. They spread first in the middle class families before they get to poor families. So gaps increase and decrease. If you want to decrease the gap between Blacks and Whites, you could just have all the Whites come in -- these are good things. Everybody should stop smoking. But the White community smokes more, that’s closing the gap. ART, Assisted Reproductive Technologies, is increasing their numbers of multiple births among White women disproportional to Black women. That’s also closing the gap.

I don't think that’s what we’re thinking about here but just to say, you know, the point is, is that the cause of the gap and the cause of just doing improving outcomes may be very different. And we do have to spend more time and I thought Vijaya asked very appropriately, “What was happening in the ‘90s where the gap was going? When do the slopes change?” We need to be looking at that systematically and thinking about it. That’s really kind of the important intellectual thing that we are challenged to do. And we have this new era and this new opportunity. And the bureau, I want to just compliment the bureau for really starting to think really broadly and boldly about this. But I also want to say that we’re doing this together. None of us actually know. How you translate the life course and the social determinant models and the social inequity models. They do work well together. Okay, that is a nice part.

There are some subtle differences but they work well together. But we don't know how to challenge them, how to use them for action. Everybody gets the same point. We get great theory. We can produce all the numbers. We have fabulous models. There must be four or five models of how the world works. But it isn’t just how the world works. It’s what we can do about it. And we don't know. We’re all learning and we’re all sharing different kinds of activities that we’re doing. Now, that’s really important for us to say.

I also wanted to just note that I really like Vijaya Hogan’s four S’s, her slope, her intercept slope, substrata and stressors. And I actually think we should follow that

and think a little bit about that. I just want to say these things. As a critique of the life course that I pushed so much in various meetings and [inaudible], we are ahistoric. We just start in history and say there's a gap and we go on and we're going to do something about it. We don't set ourselves in any historical concept. I thought that was a really important critique for those of us who push one of these kinds of models.

Second things were stressors which I just want to remind everybody in that one slide that just said that 52 percent of all Black kids and 52 percent of all Hispanic kids live in poverty and only 14 or 18 percent of White families live in poverty. That tells it all. You don't need a lot more slides. And as people pointed out, kids who live in poverty tend to have parents who live in poverty. Those are poor families. They're not just poor kids. We measure poor kids but it's the poor families. That's why we're talking about women and families here and that's a really important kind of thing.

Many of us work really hard -- we worked hard to get SCHIP which was Title 21, I hope many of us are working really hard to get what should be Title 22, the Social Security Act, some kind of universal healthcare for everybody in this country. But how many of us are working on Title 23? Ensuring children and family security? I was really glad to hear Myrtis say it at the end, "Why are we not considering some of the activities, some of the European and East Asian

countries are doing in terms of family support? Where is paid family leave? Where is childhood allowances?”

UNKNOWN SPEAKER: We got it in New Jersey.

MILTON KOTELCHUCK: And they have it in four states including New Jersey, absolutely.

UNKNOWN SPEAKER: And parents did it.

MILTON KOTELCHUCK: Yes, they did. So, I just want to say that we want to -- if we’re going to start addressing broader issues that these life course models and social determinant models, we do have to move beyond our sector. And I think just as a historical note, it’s interesting that two of the cities that are the most or two of the most areas that are most doing work in trying to think how could life course really improve things have both come to economic issues, which was exactly what the United States did in the early part of the 20th century before we gave up on that route, and that went to the Europeans and we moved into an only clinical focus for addressing infant mortality, that were coming back to economic issues. I mean, we have to think about how could the MCH field play a role on this? We aren’t going to solve it alone but how can we play a role on this? So, I hope many of you are going to work on Title 23 when this becomes a more public area.

I did think that the issue of substrates or actually slope was really a tremendously important topic that Vijaya raised and she challenged us. I actually disagreed with something she said but she said, you know, we have to look at interventions that work differentially in different committees. I don't think that's the case. I think we have to ask, "Why does the same intervention not work equally well in every community?" That's what should be our challenge.

If they don't work equally well in each community, we should be looking for why they don't. And I thought Vijaya's subsequent work done substrata about why, you know, we think we're offering wonderful things and they don't work equally well in two groups. I thought that was really incredibly helpful in our thinking. It's not that we should just offer good services, but we should understand how they actually play out for people and address them. I can't believe I'm about to advocate that we work with the quality improvement movement in this country but that's what we ought to be doing. They're actually talking about it. They say, "Things aren't working. Why aren't they working? Let's look at it. They go into a kind of a detail. It's a weird way of thinking about it. It's not a typical MCH way. But we should be aligning with them because those good forces out there that say, why do our interventions not work equally well for all communities. I don't really think Black and White women are that different in terms of how prenatal care should affect them. But they aren't.

And it’s not a question of the efficacy but the effectance. How well this does work in practice? And we can actually address that. And I really like that Vijaya was beginning to explore what it meant to individual women when they were offered these services and why they couldn’t do it. And I was really sorry. I have to just say that she took out the two slides. I love this concept of psycho energetic resources. It counters Michael Lou’s allostatic load. It goes with that. Allostatic load is the stress on people, and psycho energetic resource is the individual’s response to where they’re going to expend their energy. I thought these are great life course concepts. We have no idea how to measure them. But that’s our chance, that’s what it means in this era is that we need to be thinking about how do we transform many of the different activities. Our research activities, our intervention activities to address social determinants, life course, easier than new concepts that we’re starting to think about and explore that may actually help us understand where some of the disparities is really coming from.

And last but not least, I just want to say that from the life course model, I just want to say that, again, the issue is what can we do? I just like to just put this out for people to think about that Debbie Allen’s boss, Barbara Ferrer, once was asked, “What is the life course meant?” And she [inaudible] says she wasn’t an expert. But she actually was and she said it meant three things to her. It meant there was more time for interventions. That things that we are concerned about take time, and that there are more time points to really be addressing things and not just a one-term intervention.

And secondly, that there was more -- that was sort of thinking about is temporal change. But there was more horizontal, that there were more people, more groups, more communities to involve in the way we are actually trying to improve things. And a lot of the discussion today was about what I would call horizontal integration, our linkage with different groups move ourselves and the MCH world part of our own silos. We cause some of our own problems a little bit, and link up with some of these other communities who are working with the same families, the same issues and we're not working well effectively and thinking enough about how our current programs and activities could link better and more effectively with other groups so that we're addressing some of these broader issues.

So, I think about vertical, how to have better pair within what we offer. Horizontal, our link to others, and longitudinal, our ability to think about issues over time. Life course adds us to that model so as the social determinants. They don't have such a temporal tone to them but they help us think about these kinds of issues. This is the kind of new thinking that I'm sure everybody is hoping that this conference starts and that is sort of a challenge for all of us to share and work together to learn new ideas. I love Debbie Allen's new concept of a problem -- what do you call it, problem?

DEBORAH ALLEN: Forum.

MILTON KOTELCHUCK: Problem forum. So, this is a good, problem forum, it’s a kind of new measure. It’s measuring what’s going on and it takes away the onus that we haven’t done things. It suggests where the things are. It allows us to create political will.

Anyway, without going on I would just say, you know, I really thank -- I want to really particularly for all of us to thank Vijaya Hogan for a very stimulating presentation. I want to thank our panels. I know we we’re -- I want to thank all of our panels for their very insightful thoughts.

And I know that we were hoping to have this more of as a dialogue because I think that was what Vijaya got us started. It was a challenge. She was challenging us to think about things and for all of us to think about how to do things in a new manner in this era. The bureau is open to it. We have a present and I'm allowed to say that because I'm not, I'm not a fed. You know, we have new opportunities here that we haven’t had for the last many years. We know we have tremendous needs and if we think infant mortality and low birth rate have been poor the last couple of years, that was all before the economic crisis hit. I can only worry that we’re all going to be explaining what’s been going on now when the figures come out in a couple of years. But we have a challenge and we have an opportunity and I think we’re all here to try to create something so that we’re not sitting at this table as Vijaya said 10 years from now saying, “Oh, what

did we do?” So, thank you all and we’re not going to now turn it over to Peter who’s going to, Peter van Dyck who’s going to have us move into the next section which is the awards.