Podcast Transcript

Episode 1: Acknowledging historical and ongoing harms, including those perpetrated by health care and public health institutions

Dr. Mcdonald-Mosley:

Hello and welcome to a new podcast series focused on advancing equity and family planning. This podcast is a partnership between Power to Decide and the Reproductive Health National Training Center. With funding from the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Throughout this series we will explore tactics, programs, frameworks, and ideals to increase reproductive and sexual health equity in health centers across the country. Through this podcast, we hope to give Title X clinics, providers and staffers practical, easy to access, action oriented training resources in order to advance health equity ain family planning services.

My name is Doctor Raegan McDonald-Mosley and I'm the CEO of Power to Decide. The campaign to prevent unplanned pregnancy. I have over twenty years of experience in this field including as a practicing OBGYN, with a dedication and commitment to reproductive health and justice.

Today, we have with us Dr. Jennifer Villavicencio. Dr.Villavicencio is a first generation Cuban American. She is an obstetrician gynecologist, with fellowship training in complex family planning. She has expertise in health, public policy, and communicating social complex subjects. Dr.Villavicencio currently serves as the lead for equity transformation at the American College of Obstetricians and Gynecologists.

In this episode we are going to discuss historical and ongoing harms in healthcare and public health institutions. So let's dive in. I want to start by rooting our discussion in the historical context of birth control trials that were conducted in Puerto Rico in the mid-1950s.

As you know, this was the first large scale human trial of the pill. It was launched in public housing projects in Puerto Rico by John Rock and Gregory Pincus. It was obviously a U.S. territory. Puerto Rico was one of the most densely populated areas in the world and officials supported birth control as a form of population control in hopes that it would stem poverty in Puerto Rico. As many as fifteen hundred women took the pill over the course of several years with these trials. But the pill formulation at that time had much higher levels of estrogen and progesterone than compared to the pills today and many Puerto Rican women

experienced blood clots and three women died over the course of the trials, and yet there was no autopsy done to investigate whether their deaths were linked to the drug use or not.
For these women the consequences of this study lasted decades. They were not fully aware of what was being given to them, that it was an experimental drug, and that it could have serious side effects and complications. After the FDA approved of the birth control pill in the 1960s and women in the U.S. complained of the side effects, women in Puerto Rico were still using and receiving the pill despite the noted dangerous side effects. Rocks and Pincus's teams eventually were accused of deceit, colonialism, and the exploitation of poor women of color in their efforts to bring a birth control to market.

Given that context, I want to start with sort of thinking about what are social determinants of health and what are structural determinants of health. How do these things interact with each other and also, how are they different and why is it important to understand the differences between the two. So let's start with that.

Dr.Villavicencio:

Thank you. I really appreciate you having me on and talking about this really important subject. In terms of social versus structural determinants of health. This is a really important place for any health care provider to start. We all have likely heard of social determinants of health which are the conditions in which each of us are born, grow, live, work, play and age. It includes things like: our neighborhoods; our playgrounds; our schools; conditions of the sidewalks; how many trees and how much shade we have in our neighborhood; the water and air quality. These conditions are significant drivers of health as you can imagine and so are really important from a public health standpoint when we're looking at Chronic disease or illness or even public health interventions.

Structural determinants of health however are one step behind that. They are the laws, policies, rules, systems, and structures that create those inequitable and harmful social determinants of health that we see creating health inequities in lots of communities, particularly in communities that differ by race, ethnicity, and class. One way I like to think about it is as I mentioned is thinking backwards from an illness or chronic condition. So what factors in that individual's life lead to their increased or decreased likelihood of poorer health? And then what has led to their increased or decreased severity of the condition you are looking at. As I mentioned, air quality, substandard housing, lack of adequate public transportation to access care are all answers to that question or those questions and their all social determinants of health. But then when you take another step backwards, what are the laws and policies that have made it so that person was born into, lives in, plays in, and ages in that area with bad air quality, substandard housing or lack of adequate public transportation. That's the structural determinants of health or the root causes of inequities.

I think it's critical to understand the difference between the two because they're all links in this progressive chain of health. And so we cannot improve health inequities, we cannot improve basic population health let alone health inequities the unjust differences in health outcomes between groups of people without understanding not only the social determinants of health, but also we can't fix

those in the social drivers of health inequities without understanding their origins and how they came to be in the systems that we all live in and that we all work in.

Dr. Mcdonald-Mosley:

Thank you for that very helpful and thorough definition and explanation between the structural and social determinants of health. So it sounds like we can think of the structural determinants of health as the root cause, underlying social determinants of health: norms, policies in institutions and practices for example.

What are some examples of the way that social and structural determinants of health contributed to this situation in Puerto Rico with the birth control trials we were just discussing.

Dr.Villavicencio:

I think the social determinants of health that contributed were the existence of a population of individuals who lived in an area or in what is essentially a U.S. colony. Their living there in lower income communities with less access to modern medicine at the time. They are seen as different because they are of different ethnicity and race in Puerto Rico.

I'm Latina from Cuba. So there is that Caribbean colony essentially really yielded almost like a petri dish for theses scientists who went there and said we have people who have, what they believed erroneously to be increased profundity because they were Latina and said this was a really good place to experiment and find how whether or not these medications work.

What's important to remember is that this was not necessarily some evil plot by some evil geniuses. This was determined by a lot of the biases and racism that existed at the time, and frankly still exists today. And so you have folks who are living, working, playing, and growing in a U.S. colony that is very very different socially from places in the United States where a lot of these scientists were coming from. From a structural perspective, you look at the laws and policies that created that system, that created those disparities and those inequities between Puerto Rico as an Island and the U.S. as the colonizer or the country and you can begin to see why those folks were continuing to be in that situation. It made it so that they were extraordinarily vulnerable. There's language barriers to start that's a social determinant. why is it that their the structural component to that piece is that you don't really teach or expect people to speak different languages in the United States. We haven't for a really long time despite the multicultural what I learned in school is the "melting pot" of the United States. We're not expected to know different languages and so we have language barriers, you have cultural differences. All of which were not expected or understood when these folks were coming over to experiment on Black and Brown bodies.

Dr. Mcdonald-Mosley:

That's really helpful. So in thinking about the current day. What are some structural determinants of health that exist even today and what are some tangible examples of the ways the healthcare or public health system

disproportionately aims to promote and protect health have actually played a role in causing harm to people's health.

Dr.Villavicencio:

When thinking about this question I immediately thought of three different scenarios that I'll briefly mention. The first is, I actually did my fellowship in Michigan and I worked at a clinic in Flint, Michigan. This was a couple of years after the height of the Flint water crisis where the water supply of this entire city that is predominately Black was poisoned by a miss handling of the water system, the infrastructure, by the government in Michigan. And while that sounds horrifying because it is, at a large level. When you get down to the actual social determinant, when I was sitting in front of a patient and had to hand her water. I couldn't just get water out of the sink to give her to swallow her pill. I had to get water bottles, in this particular clinic, in no where else where I worked to have people swallow their pills in the clinic with distilled water because we couldn't trust the water supply. You can imagine how that impacts the ability of people to live.

My co-fellow did a study on reproductive health outcomes on the Flint water crisis and she found a qualitative study that people were afraid and triggered and traumatized by getting water from the tap because of the simplest thing that we think about. When you get into the shower and open your mouth, you accidently swallow a little bit of water when you're in the shower. People in Flint were constantly worried about what that would do to them and their children. And so that is a very current example. It's really hard to just come up with one example, that's why I have a couple because laws and policies are not only entangled with each other, but also with time and physical space and that can feel really overwhelming.

So many programs and policies that we've just talked about with the birth control trials that reported to do good in public health space, have been incredibly damaging to specific communities like Black, Native, Latinx and Asian communities. Obviously a really important one to talk about on this particular podcast on family planning is the public health and medical push for individuals to use long acting reversible contraception that occurred in 2010s around care.

In LARC (Long Acting Reversible Contraceptive) is extremely effective. It helps reduce the unintended pregnancy rate that all of us in public health are always talking about, half of the pregnancies in the U.S. are unplanned. I know initially when I learned about this I thought "what could be wrong with this…this is great...these devices are amazing". Firstly those programs were developed in a historical background of cohesive and controlled reproduction. From the exploitation of Black reproductive bodies were economic capital gain in the antebellum era. To the ruthless sterilization campaigns of indigenous and Latinx people. When you think about that history and this bias with which these programs have on getting out these highly effective contraception to whom we focus on and whom we unconsciously think need birth control. You can see how this value judging and also overt racism intertwine disproportionately to impact young people of color.

The final example is happening right now. It is the a-historical way in which the COVID-19 vaccine was distributed. So public health authorities stated and distributed the vaccine to communities who were most impacted by COVID first, communities of color, lower-income communities, and neighborhoods of color because we saw that there was inequities in the way that people were getting COVID. Sounds really great on its face, but it's a-historical. That structure ignored and saw as working to eliminate disparities it backfired because it did not consider how individuals in these communities have deep generational memory of how Black and Brown bodies have been scientifically exploited in the past. Things like Tuskegee, Puerto Rico Birth Control Trials that we just talked about, Tuberculosis epidemics in incarcerated population on it goes throughout modern history.

While the public health officials were thinking this is great, were going to try to get vaccines to the people who need it the most. They were approaching it from a perspective that was completely a-historical and unfortunately targeting communities of color for a brand new vaccine landed very differently with those communities rightly so. Without an acknowledgement of that history, unfortunately likely led to a lot of hesitancy that we were seeing continuing on in certain communities of color.

Dr. Mcdonald-Mosley:

Wow, those are really poignant examples from the last few decades. Thank you for highlighting those for us. I'd like to think about what we can do about this.

How can we as healthcare providers, clinic staff, administrators, how can we hold our institution and systems accountable. What levers can we pull to un-do our staff the harm that healthcare institutions have caused?

Dr.Villavicencio:

I think that is a super important question and I appreciate you asking it because I think that when those of us who want to do good try to think about what we can do it can feel really overwhelming. I like to break it down from systems level to a community level and then an individual level.

Starting at the individual level we have to move beyond education. The vast majority of us walk around with the entirety of human knowledge in the palm of our hand everyday. In our phone we have literally the entirety of human knowledge, the most knowledge we've ever had. Google exists, use it. Get educated. It's no longer an excuse not to know what's going on.

Moving beyond "I'm gonna learn", or "my families gonna learn", or "my clinics gonna learn" we need to have done that already and if you haven't do your homework and get there.

The next individual place is acknowledging. We need to grapple, accept, and be accountable for not only the history but the current health inequities and the racism and structures that compound those and bound those inequities. We have to stop the conversation about whether it's fair to "pay for what our ancestors did". I hear that all the time. "Why should I feel guilty for that? " We're not asking anyone to feel guilty. We're asking people to acknowledge, to grapple with, and

to understand the harm that has and continues to happen from this. Think about how your work place, your health system, your clinic is harming people everyday. That's really really hard deep work.

For me I'm White passing and Latina. I have a lot of identity stuff going on and so it's taken some therapy for me to work on. It continues to take some therapy. I read books lots of books and then I take some breaks. I talk to people who are not exhausted all the time. I don't ask my friend of color to help me with these things. I have made it a personal goal of mine, part of my own growth to continue humbly to grapple, work, and acknowledge this history that I am both a part of and victim of based on my history.

It's everything from being the one to bring up race, ethnicity, class, and social and structural determinants at every single department meeting, M&M, every clinic session…right. I am that person. Have we talked about it today? I think that people actually end up appreciating it. First they may look at you with the side eye, what is this person doing. Breaking that ice, being brave enough tto bring it up up in a country which has socialized to be "color blind" can really be helpful.

It's making sure that there's ongoing education and workshops at your systems level so that folks can meaningfully engage in the work. Sometimes we want to do it, but we don't know how. Being that resource from the sort of community level. Being a resource because you have the ability and the emotional space to do that. Being that resource.

It's correcting students or colleagues when they say things that we've all said at one point like "man she needs a better birth control" or "she doesn't need to have another baby". Checking that in ourselves and checking that in other people in a kind calling in way.

It's asking a patient why taking their insulin is hard for them rather than just reiterating how bad diabetes is for you for the fourth visit in a row. Trying to figure out what the social determinants of that "noncompliance is".

I think there are a lot of different things that we can do. It's overwhelming because there are action items around every single corner and all you have to do is look for them.

Dr. Mcdonald-Mosley:

I love that call to really push ourselves and challenge ourselves in our institutions to do better, and center racism, classism, and inequity at all terms. I love that. I think having worked in Title X health centers for decades. I think it's really important for us to sort of do the work of acknowledging how our systems are designed to provide differential care.

You spoke about the push for LARC, so we're really happy to put LARC devices in but not so happy to take them out. And also, our systems and institutions aren't set up well for when people have complications with their LARC devices and embedded IUD and Implant that's too deep. If they have no health insurance and they came to you on a sliding fee schedule, how are you going to ensure that

they get high quality care to remove that device. Or if they have Medicaid, that their provider in their community that are going to do that. So really thinking about how your systems are set up and ensuring that people have access to quality care regardless of their race, regardless of insurance status, regardless of their country of origin. I feel like we all really need to do the work and think about that as well.

Dr.Villavicencio:

And speaking outside of medicine, I remember I had a patient who volunteered to me which i think is extremely rare, but volunteered to me that they had a significant amount of food insecurity. They didn't know where their next meal would come from. I remember feeling so helpless because I had no idea what to say to this person. As their physician, as their doctor I don't know where to refer you too. I don't know anything about food insecurity. So I took that frustration, frankly embarrassment that I had at that scenario and it's not something that I was taught, it's not necessarily my fault, but it will be my fault if I don't leave that clinic and learn. And so I went and read about food insecurity specific to my area and the community that I serve, and the nearest food pantries and shelters. I made sure that I got connected with organizations for when the next time someone says that to me I'll have some answers for them. Not the answers, but something.

Using every encounter you have to not only interrogate your own stuff, but to learn from it. It's not just based in medicine it's all these things together because that food insecurity impacts everything else about that person's health.

Dr. Mcdonald-Mosley:

I love that. Well it has been so great to talk with you today and work through these important questions. Do you have any suggested action steps or items for providers or staff that they can use to assess their clinic or institutions regarding reproductive and sexual health inequities or resources that they can find?

Dr.Villavicencio:

Yeah, so in addition to the stuff I just mentioned I try to think of one really concrete thing that folks can take away from this. One thing that I have found, I work in a lot of different clinics that I've traveled around and I always look at intake forms. I take an intake form. I make a copy of it and I bring it home. I fill it out myself and then I have other people in my community that I know, people in my circle who are not medical fill them out. I ask them about how these intake forms make them feel. Are their first impressions of it kind, welcoming, inclusive, individualized or is it making assumptions about things, is it exclusionary.

I think that sometimes ways we list race and ethnicity can be really hard. For me as a Latina I never know what box to check. So I would much rather have a line at the bottom that I can write my own in. Certainly gender and gender identity and preferred name. The way we ask about family history and biology.

All of those things if you take a look at your form you can find tons of ways to make that first impression that patients have of their healthcare experience more inclusive. I think ultimately lead to better conversations about what that individual patient needs and how we can help them.

Dr. Mcdonald-Mosley:

I love that. Those are actionable things that all of us can do in our health centers to look at our intake forms to ensure that they are reflecting our values. I will suggest if our listeners want to learn more about social and structural determinants of health and how they interact with one another that they look up an article published in February of 2021 in the journal of 'Women's Health called the Social and Structural Health Inequities in Maternal Health'. The first author is Dr. Crear-Perry who will be joining us on a future episode of this podcast. So check that out if you want to learn more about this issue and how it impacts Maternal Health specifically. Any parting words Dr. Jen?

Dr.Villavicencio:

Can I come to that podcast? That's going to be amazing. Thank you so much for having me on and I just want to let the listeners know that this is really really hard work. It's supposed to be hard work. It's supposed to be uncomfortable and growth. There is no growth without discomfort and especially in the medical field it is our job, it is our duty, our moral calling to make this place a little bit better than how we found it. Everyday kind of live those values.

Dr. Mcdonald-Mosley:

Thank you so much Dr.Villavicencio. I love hearing from you and talking with you whenever I can. Thank you for this informative discussion. We hope that our listeners will walk away with not only a better understanding of how to advance equity and family planning, but also actionable steps you can enact today.

To follow the work of Dr.Villavicencio follow @villaviMD at Twitter. You can follow me @doctorregan on Twitter and please stay connected with Power to Decide. Follow us at @powertodecide on all platforms.

This podcast was produced as a partnership between Power to Decide and the Reproductive Health National Training Center. Learn more at rhntc.org