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

Dr. Raegan McDonald-Mosley (00:09):

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 of family planning services. My name is Dr. Raegan McDonald-Mosley, and I'm the CEO of Power to Decide, the campaign to prevent unplanned pregnancy. I have over 20 years experience in this field, including as a practicing OB-GYN with a dedication and commitment to reproductive health injustice.

Dr. Raegan McDonald-Mosley (01:09):

Today we have with us, Dr. Jen Villavicencio. Dr. Villavicencio is a first-generation Cuban American. She's an obstetrician-gynecologist with fellowship training in complex family planning. She has expertise in health, public policy, and communicating socially complex subjects. Dr. Villavicencio currently serves as the lead for equity transformation at the American College of Obstetricians and Gynecologists. In this episode, we're going to discuss historical and ongoing harms in healthcare and public health institutions. So let's dive in.

Dr. Raegan McDonald-Mosley (01:44):

So I want to start by rooting our discussion in the historical context of the 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 US 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 and hopes that it would stem poverty in Puerto Rico.

Dr. Raegan McDonald-Mosley (02:17):

As many as 1500 women took the pill over the course of several years with these trials, the pill formulation at that time had much higher levels of estrogen and progestin compared to the pills that are available today. And many Puerto Rican women experienced blood clots, and three women died over the course of the trials, but 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 the study lasted decades as 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 US complained of the side effects. Women in Puerto Rico were still using and receiving the pill, despite the noted dangerous side effects. Rock 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.

Dr. Raegan McDonald-Mosley (03:14):

So 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. Jen Villavicencio (03:32):

Thank you. I really appreciate you having me on and talking about this really important subject. So in terms of social versus structural determinants of health, I think this is in a really important place for any healthcare provider to start. We all likely have heard about social determinants of health, which are the conditions in which each of us are born, grow, live, work, play, and age. That 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 different communities, particularly in communities that differ by race, ethnicity, and class.

Dr. Jen Villavicencio (04:46):

And one way that I like to think about it is I mentioned this thinking backwards from an illness or a chronic condition. So what factors in that individual's life led to their increased or decreased likelihood of poorer health. And then what has led to their increase or decreased severity of the particular condition that you're 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 they're all social determinants of health.

Dr. Jen Villavicencio (05:19):

But then when you take another step backwards, what are the laws and the policies that have made it, so that person was born into, lives in, plays in, and ages in, in an area with bad air quality, substandard housing, or lack of adequate public transportation. That's the structural determinant of health or the root cause of inequities. And 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 work in.

Dr. Raegan McDonald-Mosley (06:18):

Thank you for that very helpful and thorough definition and explanation between the social and structural determinants of health. So it sounds like we could sort of think of the structural determinants of health as sort of the root cause underlying social determinants of health norms, policies, institutions, and practices, for example. So what are some examples of the ways that social and structural determinants of health contributed to this situation in Puerto Rico with the birth control trials that we were just discussing?

Dr. Jen Villavicencio (06:46):

So 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 US colony. They're living there in lower-income communities with less access to modern medicine at the time, they are seen as different because there are different ethnicity and race in Puerto Rico. I'm Latina and I'm from Cuba. There's that Caribbean colony essentially really yielded almost like a Petri dish for these scientists who went there and said, we have people who have what they believed erroneously to be increased fecundity because they were Latina and said, this is a really great place to experiment and find whether or not these medications work. The thing is what's important to remember is that this was not necessarily some evil plot by evil geniuses.

Dr. Jen Villavicencio (07:47):

It was determined by a lot of the bias and racism that existed at the time, and frankly still exists today. And so you have folks that are living and working and playing and growing in a US colony that is very, very different socially from places in the United States where a lot of these scientists were coming from. And from a structural perspective, you look at the laws and policies that created that system, that created those disparities and those enact equities between Puerto Rico as an island and the US as the colonizer or the country.

Dr. Jen Villavicencio (08:29):

And you can begin to see why those folks were continuing to be in that situation and it made it so that they were extraordinarily vulnerable and were unable to... I mean, there's language barriers to start, that's a social determinant. The structural component of that piece is that we 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 when I was in school melting pot of the United States. We're not expected to know different languages. And so you had language barriers, you had cultural differences, all of which were not respected and understood when these folks were coming over to experiments on black and brown bodies.

Dr. Raegan McDonald-Mosley (09:13):

That's really helpful. So and thinking about the current day, right? What are some structural determinants of health that exist even today and what are some tangible examples of the ways that the healthcare or public health system, which purportedly aims to promote and protect health have actually played a role in causing harm to people's health?

Dr. Jen Villavicencio (09:34):

So 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. And this was a couple of years after the height of the Flint water crisis, where the water supply in this entire city that is predominantly black, was poisoned by a mishandling 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... I couldn't just get water out of the sink to give her to swallow her pill. We had to have water bottles in this particular clinic and nowhere else where I worked to have people swallow their pills in the clinic with distilled water because we couldn't trust the water supply.

Dr. Jen Villavicencio (10:39):

You can imagine how that impacts the ability of people to live. My co-fellow who did a study on reproductive health outcomes in 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 all think about when you get into the shower and you open your mouth, you accidentally 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 to their children. And so that's a very current example. It's really hard to just come up with one example. And that's why I have a couple because laws and policies are entangled not only with each other but also with time and physical space. And that can feel really overwhelming.

Dr. Jen Villavicencio (11:29):

So many programs and policies that we just kind of talked about with the birth control trials purported to do good in public health space have been incredibly damaging to specific communities like black, native, Latinx, and Asian communities. And obviously, I think a really important one to talk about on this particular podcast around family planning is the public health and medical push for individuals to use long-acting reversible contraception that occurred in the 2010s, around there. LARC long-acting reversible contraception is extremely effective and helps reduce the unintended pregnancy rate that all of us in public health are always talking about. Half of pregnancies in the US are unplanned. And so I know that initially when I learned about it, I was like, what could be wrong with this? This is great. These devices are amazing. And firstly, those programs were developed in the historical background of coercive and controlled reproduction from the exploitation of black reproductive bodies for economic capital gain in the antebellum era and then to the ruthless sterilization campaigns of indigenous and Latinx people.

Dr. Jen Villavicencio (12:43):

And so you think about that history and then you consider the bias with which these programs have getting out these highly effective contraceptions to whom we focus on and whom we unconsciously think need birth control. You can see how this value judging and also overt racism intertwines disproportionately to impact young people of color. And the final example is happening right now, is 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.

Dr. Jen Villavicencio (13:53):

Things like Tuskegee, the Puerto Rico birth control trials that we just talked about, tuberculosis epidemics in incarcerated population, on it goes throughout modern history. So while the public health officials were thinking, this is great, we're going to try to get this vaccine to people who

need it the most. They were approaching it from a perspective that was completely a historical and unfortunately, a targeting of communities of color for a brand new vaccine landed very, very differently with those communities. Rightly so, and without an acknowledgment of that history, unfortunately likely led to a lot of hesitancy that we're seeing continuing on in certain communities of color.

Dr. Raegan McDonald-Mosley (14:32):

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, right? How can we as healthcare providers, clinic staff, administrators, how can we hold our institutions and systems accountable? What levers can we pull to undo or stop the harm that healthcare institutions have caused?

Dr. Jen Villavicencio (15:00):

I think that's 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, really overwhelming. And so I like to break it down in from like a systems level to a sort of community level and then an individual level. And so 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 every day. 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 excuse not to know what's going on. And so moving beyond I'm going to learn, or my family is going to learn, or my clinic is going to learn. We need to have done that already. And if you haven't, do your homework and get there.

Dr. Jen Villavicencio (15:53):

The next individual places 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 found those inequities. We have to stop the conversations about whether it's fair to, quote, unquote, "pay for what our ancestors did." I hear that all the time, why should I have to feel guilty for that? We're not asking anyone to feel guilty. We're asking people to acknowledge, to grapple with, to understand the harm that has and continues to happen from this, and think about how your workplace, your health system, your clinic is harming people every day. And that's really, really hard deep work. For me, I'm white-passing and I'm Latina. And so I have a lot of identity stuff going on.

Dr. Jen Villavicencio (16:44):

And so it's taken some therapy for me to work on, continues to take some therapy. I read 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 friends of color to help me with these things. I have made it a personal goal of mine, part of my own growth to continue to humbly 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, social, and structural determinants at every single department meeting every M&M, every clinic session, right? I am that person. Have we talked about it today? And I think that people actually end up appreciating it. At first, they might look at you with the side-eye and like, what is this person doing, but breaking that ice, being brave enough to bring it up in a country which has socialized to be, quote, unquote, "color-blind", can really, really be helpful.

Dr. Jen Villavicencio (17:44):

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 really needs a better birth controller. 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, quote, unquote, "non-compliance" is. I think that 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. Raegan McDonald-Mosley (18:47):

I love that call to really push ourselves and challenge ourselves and our institutions to do better and center racism, classism, and inequity at all turns. I love that. I think, having worked in Title X health centers for decades, I think it's also 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 a LARC, right? And so we're like, really happy to put LARC devices in, but not so happy to take them out. And also our systems and institutions aren't frankly 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 and you were able to put it in on a sliding fee schedule, how are you going to be able to ensure that they get high-quality care to remove that device, or if they have Medicaid that there are providers in your community that are going to do that?

Dr. Raegan McDonald-Mosley (19:41):

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 their insurance status, regardless of their country of origin. I feel like we all need to really do the work and think about that as well.

Dr. Jen Villavicencio (19:55):

And thinking outside of medicine, I remember I had a patient who volunteered to me, which I think is fairly rare, but volunteered to me a significant amount of food insecurity. They didn't know where their next meal was going to come from. And I remember feeling so helpless because I had no idea what to say to this person as their physician, as their doctor, I was like, I don't know where to refer you to. I don't know anything about food insecurity. And so I took that frustration, frankly, embarrassment that I had at that scenario. I mean, 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.

Dr. Jen Villavicencio (20:38):

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, and made sure that I got connected with some organizations to help those who the next time someone says that to me, I'll have some answers for them, not the answers, but something. And using every encounter that you have to not only interrogate your own stuff but also to learn from it. It's not just based in medicine, right? It's all of

these things together because that food insecurity impacts everything else about that person's health.

Dr. Raegan McDonald-Mosley (21:12):

I love that. Well, it's 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. Jen Villavicencio (21:31):

Yeah. So in addition to the stuff that I just mentioned, I try to think of one really, really concrete thing that folks could take away from this. And one thing that I have found is I work in a lot of different clinics that kind of travel 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 circles who are not medical, fill them out.

Dr. Jen Villavicencio (21:57):

And I ask them about how this intake form makes them feel. Are their first impressions of it kind, welcoming, inclusive, individualized, or is it making assumptions about things and is exclusionary. I think that sometimes the way we list race and ethnicity can be really hard. For me as a Latina, I never know what box to check, right? And so I would much rather have a line at the bottom, I can write my own in, certainly gender and gender identity and preferred names the way we ask about family history and biology. All of those things, if you just 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. And I think ultimately lead to better conversations about what that individual patient needs and how we can help them.

Dr. Raegan McDonald-Mosley (22:50):

I love that. And those are actionable things that all of us can do in our health centers to look at our intake forms and ensure that they're 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 that was published in February of 2021 in the Journal of Women's Health called the Social and Structural Determinants of Health Inequities in Maternal Health. The first author is Dr. Joia 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. Jen Villavicencio (23:32):

Can I come to that podcast [inaudible 00:23:34] Perry? That's going to be amazing. No, 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, there is no growth without discomfort. And especially if we're in the medical field, it is our job, it is our duty, our moral calling to make this place a little bit better than when we found it. And so every day, try to live those values.

Dr. Raegan McDonald-Mosley (24:02):

Thank you so much, Dr. Villavicencio. I love hearing from you and talking with you whenever I can. Thank you for this informative discussion. And 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 that they can enact today. To follow the work of Dr. Villavicencio, follow @VillaviMD on Twitter. You can follow me at @DrRaegan on Twitter, and please stay connected with Power to Decide. Follow us @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.