SOCIAL DETERMINANTS OF MIGRANT HEALTH

CONFERENCE REPORT
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on behalf of the

Conference on Social Determinants of Migrant Health

Bellagio Conference Center
Rockefeller Foundation

Bellagio, Italy

October 7-10, 2014
After a day of travel, welcomes and introductions, the Conference on Social Determinants of Migrant Health formally convened at 9:00 am Wednesday, October 8, 2014. There were 23 of us, including three organizers and 20 presenters. Among our group were physicians, sociologists, anthropologists, epidemiologists, research funding executives, policy analysts, a specialist in social communications and an architect. We represented four countries and had worked in many more places throughout the world.

We defined the term migrant broadly. Presentations featured populations with varying degrees of precariousness, including families with more than one generation in the host country, migrant laborers, asylum seekers, recognized refugees, and trafficked persons.

It was an auspicious time, we thought. Two years ago, our topic was just coming together as an academic field. Many of us had worked on a special issue of a major journal, *Social Science and Medicine* (SSM), devoted to the social determinants of migrant health. Another outcome of working together was a proposal to the Rockefeller Foundation for a conference that would further strengthen the field, provide an ongoing means of communication and develop evidence-driven policy recommendations.

Now, as the conference had become a reality, migration was heating up as an issue around the world, bringing politics and policy to the fore. In the US, a president nearing the end of his tenure sought to make immigration reform a major legacy. In the UK and throughout Europe, nations struggled with labor and other migration issues. For some, these included histories of colonial dominance over the homelands of recent entrants. And in hot spots like the Middle East and the Mediterranean, migration policy continued to present itself as a test of humanity.
The issue had power to evoke the best and the worst of responses. Best because of traditions like the US and Canada as nations of immigrants, able to absorb wave after wave of new residents that once contributed to a population density greater than that of Calcutta on New York’s Lower East Side. And best because organizations like the United Nations (UN), World Health Organization (WHO) and Pan American Health Organization (PAHO) try their best, with little leverage, to advance policies for decent treatment of migrants and refugees.

Worst because the issue of race and fear of the “other” is never far from the minds of some in confronting neighbors, old or new. And the links between migration and health can call forth even greater fears. One hundred years ago tests for tuberculosis and eye infections were major barriers Ellis Island immigrants faced as the price of entry to the US. And even as we convened, the spread of Ebola through international travel was on everyone’s mind. It was no accident that as some of us debarked from our transatlantic flight home, high on conference possibilities, we were met at JFK airport in New York by the first US effort at compulsory screening.

For now, however, we were content to pursue our knowledge-building agenda. We were in a beautiful and peaceful place, and our issue, fraught with problems as it was, fit well with Rockefeller’s goals of transforming cities and advancing health equity and opportunity.
Barbara Krimgold of the Institute for Alternative Futures opened the conference with remarks on the history of our gathering, including the formation of a Place, Migration and Health Network and website by academic leaders supported by the Robert Wood Johnson and W.K. Kellogg Foundations, and the work on the special issue of SSM. She thanked Lucia Ruggiero, formerly of PAHO/WHO and known for maintaining the worldwide website on Equity, Health and Human Development (Equidad), for her involvement in designing and submitting the conference proposal to the Rockefeller Foundation.

Emma Sanchez-Vaznaugh of San Francisco State University proceeded to set the stage, first explaining the new approaches to immigrant health research taken by the organizers of the SSM issue. These included:

- A cross-national framework recognizing influences in both sending and receiving countries (the “push-pull” effect) and variation in immigration processes;
- Understanding the health patterns of migrants in relation to conditions in their sending and receiving countries rather than as a “specialty topic” with little context;
- An emphasis on social and structural explanations rather than simply acculturation or the lack of it; and
- The need for a life-course focus, longitudinal studies and better data, including samples of non-immigrant populations for comparison.

James Nazroo of the University of Manchester talked about the rarity of meetings like this with a community of like-minded people. We need to support each other, he said, because the work can be politically unpopular and not everyone is comfortable with it.
One concept Nazroo works with is the treatment of minorities masquerading as treatment of migrants. Poor migrants and their descendants take on racialized identities, and formal structures such as prisons and mental health systems tend to regulate and oppress racial minorities. The way some governments categorize people by country of their forebears’ origin is not helpful, and comparative research across groups, generations, genders, even nations is important.

Edna Viruell-Fuentes of the University of Illinois and Joanna Almeida of Simmons College then moderated a session where attendees introduced themselves and talked about their goals for the conference. In addition to the work they are doing, some talked about their background or that of their families as migrants or refugees; some about the need to break out of the confines of their specific fields; some about their personal involvement with oppressed migrants and refugees throughout the world; some about the need for combining quantitative studies with mixed methods and qualitative research; some about mid-career changes from health professions to academics, or from activism to government service; and some from personal knowledge of how older or sick people can be marginalized.
Laia Becares of the University of Manchester examined the effects of ethnic density, comparing Black Caribbean people in the US and the UK. In the US, ethnic density is thought to be protective for Black Caribbeans, and indeed they do better than other Black populations on health and socioeconomic (SES) measures. It has been hypothesized that their time of migration allowed them to take advantage of the US civil rights movement. Conversely, ethnic density among Black Caribbeans in the UK was not associated with improved measures. Becares also looked at the effects of ethnic density generally, and cast some doubt on the idea that first generation immigrants tend to be healthier than subsequent generations. Circumstances and attitudes at the time of migration may be more important.

Darrell Hudson of Washington University in St. Louis examined the relationship between racial discrimination and SES and depression among US Blacks. “The American dream of upward mobility is not always true,” he explained. In Hudson’s sample population, more education and higher income was associated with a greater likelihood of depression. He also found that Caribbean Blacks born in the US faced more depression than those born in the Caribbean, possibly due to greater discrimination in the US.
Edna Viruell-Fuentes picked up on the critique begun in the opening session of existing immigrant research and its over-reliance on cultural traits. “We romanticize culture and assume that it protects first generation immigrants, but that may not be the case,” she said. For example, she found US-born people of Mexican descent actually had stronger heterogeneous social networks than those born in Mexico. Resources such as health care and life opportunities are more important than culture in determining outcomes. “Let’s look at immigration policies that limit access to these resources and also cast Latinos as perpetual foreigners despite their historical presence in the US,” she urged.

Continuing his critique of categories, James Nazroo recalled a quotation from historian Henry Louis Gates: “The personal statement for my application began: My grandfather was colored, my father was Negro, and I am black…” The important thing is not the category itself but what else is going on, he said. It’s not about ethnicity or race, it’s about ethnic and racial inequalities in health, and those reflect the intersection of class, gender, disability, age, sexual orientation, religion and other variables. He also noted that ethnic and racial inequalities seemed to have gone off the UK “health in all policies” agenda. In looking for policy solutions, he suggested that in the UK local jurisdictions had become major employers as well as providers of services and if they expanded opportunities for immigrants that might help deal with inequalities.

Emma Sanchez-Vaznaugh continued the critique of trends in existing migrant research. She noted that superior birth outcomes among first generation Latina immigrants had often been cited as evidence of protection for this group – a phenomenon known as the “Hispanic paradox.” Observing mixed results in past research, she and her co-authors mounted a new study reflecting the experience of 10,841 women who gave birth in California from 1999 to the present. They found no evidence of the so-called paradox. In their study, Latinas generally had higher rates of preterm birth and low birth weight than white women. Socioeconomic differences appeared to explain the differences in birth outcomes, although the researchers could not establish a causal role.
Lisa Goldman Rosas of Stanford University reported on her efforts to promote community level potential for change, called “Nuestra Vos,” or “Our Voice.” Citizen-scientists collected data via photographs and electronic tablets in two California neighborhoods and in Cuernavaca, Mexico, focusing on changes in the built environment. They then met with policy makers to improve environmental health and safety. Changes are being documented and the process expanded to other areas and improvements.

Joanna Almeida presented a study in progress on the effects of anti-immigrant sentiment on perceived discrimination against US Latinos – an area that has not been well documented. Using a telephone survey in Spanish and English, she is mounting a nationally representative sample to test the theory that national policy debates and state legislative changes affect the way Latinos view discrimination.
As the presentations continued on October 9, Faith Mitchell of Grantmakers in Health served as moderator and introduced three panelists whose work goes beyond the usual immigrant health topics. They included an architect, an emergency physician and specialist in ehealth, and a Middle East expert.

Fred Krimgold of Virginia Tech University discussed the relationship between migration to cities and slum formation. Of particular concern, he said, is forced migration due to natural disasters and/or conflict. People with limited resources are forced to settle in areas that may be physically or socially hazardous. In developed countries more severe problems are mitigated by a tradition of land use management. Providing examples from Haiti, India and Bangladesh, he reported that enormous urban growth is taking place without regulation. UN agencies and the Rockefeller Foundation are examining barriers to regulation, including poverty, ignorance and corruption. However, simply transferring practices of the developed world has been unsuccessful. New approaches may build on resilience and involvement of new leaders.

Kendall Ho of the University of British Columbia presented two related issues. As an emergency physician, he noted the enormous increase in cell phone use – up to 80 percent in Canada – and the desire of nearly half of all ER patients for e-contact. How can people interested in health, especially for hard-to-reach populations, take advantage of this trend? Ho sees a time when mobile phones can help diagnose heart attacks, perform pregnancy ultrasounds, diagnose skin
cancers, conduct brain scans and track sleep patterns—to say nothing of tracking treatments and scheduling appointments. Multicultural populations may need more live events and assistance with technology but the younger generation is leading the way. At the next level of aggregation, “smart cities” are formulating policies around ehealth, as shown by examples from Guangzhou, China and Vancouver, Canada.

Sawsan Abdulrahim of the American University in Beirut spoke on migration issues in the Middle East, where there are unclear lines between forced migration, migration for labor purposes and trafficking. Equally problematic are national borders originally drawn by the British and French yet not accepted by nationalists and religious activists. Gaining status to settle in one place can be nearly impossible as categories are disrupted and policies shift. For example, Lebanon formerly accepted refugees but no longer does so. One woman Abdulrahim followed, originally from Sudan, went first to Iraq and then to Syria. Originally classified as a refugee, she hired a smuggler and has been in Lebanon for several years as an undocumented worker. Complicated stories and statelessness abound; there are Syrian refugees throughout Lebanon but Lebanon doesn’t want to acknowledge them.
Lucia Ruggiero of Global Health International Advisors moderated the next session and introduced four panelists whose work in their home countries and abroad crosses over into clinical and policy areas.

Sarah Willen of the University of Connecticut reported on her work as a medical anthropologist with children of irregular migrants in a “Pirate Day Care” center in South Tel Aviv, Israel. Fifteen years ago, these unmonitored, often risky day care arrangements served children born in Israel to unauthorized migrant workers, but more recently it is primarily children of asylum seekers who are kept in cribs all day, with up to 20 children per untrained caregiver. According to municipal welfare offices and local schools, the majority of these children suffer severe and longstanding physiological, social, linguistic, and emotional developmental delays. She noted that Israeli policies toward irregular migrants, many of them from African countries, are not widely publicized, and that Israel does not accept the “birthright” concept of citizenship for children born in-country urged by the UN.

Kevin Pottie of the University of Ottawa spoke of his efforts to develop evidence-based guidelines for improving access and health care to vulnerable migrant populations as part of the Campbell-Cochrane Health Equity Methods group. A practicing physician himself, Pottie is a member of various advocacy organizations and understands the urgent need for migrant and refugee services.
However, he also urged the importance of systematic reviews and the use of health equity tools in setting goals and obtaining care for needy populations. The “right” kind of providers may be missing (female doctors for gynecologic services; dentists; optometrists).

Patricia Miranda of Pennsylvania State University discussed disparities in health services along the pathway to citizenship, presenting data from the US National Health Interview Survey and the Medical Expenditure Panel Survey. Like some of the researchers who presented earlier, she found no “healthy immigrant” effect. In fact, duration of residence in the US and citizenship were key determinants in use of preventive health services including endoscopy, cervical cancer screening and mammograms. Insurance coverage matters; the fact that even legal immigrants are not eligible for coverage under the Affordable Care Act until they have been in the US for five years is a drawback to receipt of care.

Lisa Cacari-Stone of the University of New Mexico spoke on the importance of policy as a determinant of health. “How do you balance the need to be unbiased with the impact of politics and policy?” she asked. Evidence-based research is key. For migrants, she said, policies regarding health, immigration and welfare have the greatest impact. But it is also important to include other areas that affect health directly or indirectly. She referred the group to the WHO 2013 Helsinki Statement on Health in All Policies, as follow-on to the Alma Ata Declaration on Primary Care of 1978. Moreover, particularly in the US, the level of government is important to migrant health as devolution from federal to state and even local decision making has caused major variation in coverage and services. In fact, some US counties have devolved responsibility even further as institutions are given the final say on who is served.
Priorities for Future Policy Relevant Research

On October 10, the final day of formal conference activities, Irene Dankwa-Mullan of the National Institutes of Minority Health and Health Disparities moderated the penultimate session and introduced three panelists whose work will help shape a policy-relevant agenda.

Cathy Zimmerman of the London School of Hygiene and Tropical Medicine discussed her work on human trafficking — a not always acknowledged subset of migrant health. Definitions are difficult because there is disagreement even among activists over personal rights and moral judgments. However, exploitation is at the core of trafficking, along a continuum that may include extreme/criminal abuse. Based on migration models, Zimmerman has explored health risks for trafficked persons, including extended hours without rest, physical or sexual violence and severe injury, and mental health issues including depression, anxiety and PTSD. Some victims go back to their country of origin and are re-trafficked because of their extreme economic need. In terms of policy, immigration rules often play a larger role compared with health and welfare.

Oscar Mujica of PAHO spoke about health equity monitoring in the Americas. There is a growing concern, he reported, on social inequality as a threat to sustainability; putting equity at the center of the post-2015 sustainable development agenda is thus emerging as a regional need. Migrant health should be assessed through an equity lens and migrant status can also serve as an equity stratifier when monitoring health inequalities. Harmonization of conceptual,
methodological, and instrumental approaches to monitoring migrant health equity is required to better inform policies and action.

Claire Brindis of the University of California San Francisco reported on her work with a sample of “Dreamers” in Los Angeles and the Bay Area. Nationwide, nearly two million young people under 31, illegally brought to the US as children, have had deportation postponed for two years under the federal administrative action known as Deferred Action for Childhood Arrivals (DACA). Focus groups revealed generally good health and functional status, offset by a substantial level of depression, stress and uncertainty about the future. With formal legal status afforded through DACA, they felt improved confidence and self-esteem as the immediate threat of deportation was removed. Many had difficulty with the DACA application, limited access to health and mental health care, and ongoing concern for undocumented relatives. This very early study points to the need for more research.
To close the formal presentations, Bonnie Lefkowitz, a former federal official with the US Department of Health and Human Services, moderated a panel on funding possibilities, introducing three presenters who administer or advise on health research.

Faith Mitchell described her role as director of a nonprofit group advising foundations and corporate giving programs. Many of her clients are interested in health services, but there is also interest in research, including the social determinants of health – an area Mitchell previously directed at the US Institute of Medicine. A good proportion of her work is state or locally based, and may be a good match with migrant health issues. Mitchell urged prospective applicants for funding to consult foundation directories for interests of organizations in their areas.

Dionne Godette also urged applicants who seek funding to do their research. “Start with the strategic plan of the funding organization,” she advised. “There are reasons why they use or don’t use particular terms. Then go and talk to a program officer or institute director. They may be interested in your proposal, but need to package it to reflect their planning priorities. Some cross-national studies are funded, but the work needs to be relevant to US populations.” Policy, Godette noted, can be a red flag if it sounds anything like lobbying. Better to define it as designing solutions to meet needs that have surfaced through research. Participating on review committees will help potential applicants see what’s being sought and approved.
Irene Dankwa-Mullan reported that roughly 80 percent of NIH funding supports extramural researchers. There is interest in projects that consolidate “big data” from existing studies, enhance social as well as physical well being (population and behavioral health; transdisciplinary approaches), training the next generation of researchers and enhancing diversity. She presented data on funding studies of behavior, epidemiology and health care delivery for each NIH institute, including community-based participatory research. For the future, she saw a need for better ways to study immigrant health and the impact of immigration, greater disaggregation of immigrant groups, accounting for nonlinear patterns, more attention to the context of receiving countries, more longitudinal studies, and moving beyond health care access to social and economic determinants.
Recommendations

Recommendations for the future were discussed among participants, including ways we can continue to share information – a repository, a toolkit, network development and information plans. To facilitate followup, a Call to Action was then prepared, outlining a research agenda and providing further detail on information sharing. In addition, the political implications of our work drew comments during and after the presentations and participants were eager to find ways of translating research into policy. Recommendations in each of these three areas are summarized below.

The group defined principles for future research: Recognition of the many factors affecting migration, a trans-disciplinary approach (for example, mixed research methods and a strong commitment to consumers of knowledge) and incorporation of ethics and equity. It was noted that the way research is done should reflect better use of existing data and systematic reviews of what works as well as incorporation/use of new information such as qualitative data, information on social capital and resilience, segregation, neighborhood characteristics and biologic measures.

RESEARCH

Three topics were singled out for special attention:

- A lifecourse perspective before, during and after migration, and accumulation of risks for an individual. This might include longitudinal cross-border studies, the use of stress markers and retrospective measures of experience in order to measure the cumulative impacts of migration, living as an undocumented migrant and/or other precarious legal status.
- Policies and politics as determinants of health. Studies need to consider immigration policies in diverse areas such as economics, education, government, housing, welfare, justice and the environment. These may have positive as well as negative effects. Historical context and cross-national comparisons are important.
- Migration processes, contexts and resilience. All phases of the migration experience need to be examined, including economic opportunities in the receiving community, consequences of deportation or the threat thereof, and who thrives and why.

The group also noted the importance of studies specific to health access and delivery, a reciprocal relationship between research and program/policy planning and effectiveness, and training opportunities for new and established investigators.
Participants supported continuation and expansion of our existing research, program and policy network of diverse stakeholders. A means of ongoing communication among the group that met at Bellagio was strongly recommended. This can be achieved through continued use of the www.placemigrationandhealth.org website and use of the new www.cultureofhealthequity.org website, particularly its page on the Social Determinants of Migrant Health.

Contingent on identifying a funding source, the group also recommended the creation of a digital repository of literature, data bases, tools, methodologies and best practices to further communication and education. Other uses of the repository discussed by attendees could include:

- Links to social media, including Twitter, Facebook, LinkedIn, Google, YouTube and blogs.
- Links to selected bibliographies for sharing information and solutions.
- Mapping of funding resources.
- An inventory and evaluation of programs seeking to improve the status of migrants through action on the social determinants of health.
- Case reviews of the impact of the social determinants of health.
- Opportunities to use search and manager references such as Google Scholar, Medline, Cochrane and others and a set of inclusionary criteria.
- Online tools such as virtual meetings and webinars.
- Facilitation of thematic working groups and engagement of opinion leaders.
- A policy section where ideas can be exchanged, proposed legislation and regulatory changes featured, and information provided about how to support promising proposals.

Participants noted that a focus on social determinants should not be seen as a substitute for political action but rather an all-important link between the health of migrants and a broad range of policies affecting them. As researchers, we felt we could and should engage in policy-related studies and highlight results through policy briefs and dissemination of results.

Policy-relevant topics might include dispelling erroneous myths about migrants and promoting humane approaches to immigrant integration, determining the benefits of immigrant integration and the breakdown of stratification for the larger society, identifying the top policies in terms of impact on the health and well-being of immigrant children and families, and promoting promising
social interventions as opposed to just behavioral change. This might include evaluation and reporting on new solutions such as the Healthy Cities/ehealth effort proposed by conference participant Kendall Ho.

In addition, as appropriate to our individual situations, many of us wanted to take positions and advocate directly for effective policies. Following are some targets for action mentioned by participants:

- **International**: One possibility for cross-national action would be to review actions/statements by international organizations, including but not limited to the UN and its component organizations WHO and PAHO as well as international relief organizations. Individual countries could be urged to sign on to or comply with existing statements, being specific about areas of particular interest. One sample yardstick: the Common Basic Principles for Immigrant Integration Policy adopted by the Justice and Home Affairs Council of the European Union. These principles include fairness and lack of coercion in employment; education, including the host country’s language and history; equal access to goods and services and attention to migrants by all levels and departments of government. A more general point of reference mentioned by participants was the WHO 2013 Helsinki Statement on Health In All Policies. WHO and PAHO are known for their work on the social determinants of health and are often acknowledged by advocates of such approaches.

Conference participants also cited the UN concept of “birthright” that recognizes citizenship for children born in a particular country whatever the status of his/her parents. Most nations in the Western Hemisphere, including the US and Canada, recognize this concept. European and Asian nations usually do not, or do so on a limited basis. They often require that one parent be a legal resident, as does the UK.

- **Individual Countries**: Policies regarding entry, enforcement and deportation vary widely. The often-changing patchwork of entry barriers in some Middle East and Mediterranean countries was cited by several presenters as especially inhumane, leading to repeated deportations of individuals and confinement in refugee camps under extreme conditions.

Much interest was expressed by participants in conditions in major “receiving” countries like the US, Canada and the UK, all of which were represented at the conference. These three countries vary in the proportion of the population affected and the disposition of those seeking to immigrate. The US is relatively restrictive regarding entry policies, with 13 percent of its population, or roughly 41 million people, classified as migrants. Of these, 19 million are naturalized, another 8.9 million are eligible for citizenship and an estimated 12 million are
classified as illegal and subject to deportation. In the past, the growing numbers of people in this precarious state were reduced by actions taken under the Reagan and George H.W. Bush administrations. Current proposals for a new round of US reforms, providing pathways not only to legalization but also to full citizenship, were deemed worthy of support.

In the UK, like the US, 13 percent of the population, or close to 9 million, are immigrants. Canada, on the other hand, has one of the world’s most liberal immigration policies, with 6.8 million people foreign born – an estimated 20.6 percent of the overall population.

Entry requirements and enforcement/deportation are far from the only problems. For receiving countries generally, a major issue is how well or poorly they integrate significant immigrant populations into their overall societies. Several presenters noted the relationship between immigrant status and race. De facto housing segregation of multi-generation migrant communities is widespread. For immigrants, policies regarding employment, and eligibility for and access to health, welfare, education and other benefits may vary from those for the general population.

For example, access to educational and life opportunities, paid family and sick leave, and the two years of free community college recently proposed in the US are important to the overall population and particularly important for migrants. In addition, even legal immigrants face major barriers to health care – in many US states they cannot receive Medicaid unless they have been in the US for five years. Moreover the Affordable Care Act limits certain benefits for legal immigrants, and DACA designees are included with others who lack status and thus are not eligible at all. More generally, the enormous variation in state and local policy powerfully affects who gets what other benefits. Thus in the US and perhaps other countries political action must be aimed at all levels of government.

- **Other:** Also affecting the status and welfare of migrants are the ways various professional groups, including health and social service providers and businesses, influence their members and deal with discrimination. Finally, for our own professional purposes, preserving academic freedom and the ability/responsibility to deal with the real-world implications of our work are essential.
Conclusion

Participants are reflecting on how well the Bellagio Conference on Social Determinants of Migrant Health succeeded. We came away with a roadmap for future research. In addition to individual studies, we have begun to discuss a second meeting and the possibility of another special issue of a major academic journal. We’ve designated ways of continuing to share information and started to think about action to advance more equitable policies.

“It was a great opportunity to share ideas,” one of our number said. “People from different disciplines managed somehow to speak the same language. But most important is the prospect of continued activity on behalf of people we care deeply about.”
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