International Network for Research on Inequalities in Child Health (INRICH) || Agenda for INRICH WiZiQ Conference – 15.02.2010

Note: timings for each item assume 90 minutes for the meeting]

Joint Meeting Chairs: Nick Spencer & Louise Seguin

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1. Welcome [1 minute] – Nick

2. Introductions [4 minutes] – participants

3. Scientific debate following on from controversies initially discussed in 2nd INRICH workshop (November '09) (I suggest discussion of the role of stress in relation to child health inequalities - however, may be other suggestions) [40 minutes] - Nick to lead if stress* is focus

4. INRICH business: [40 minutes]
   - Summary of 2nd Workshop [5 minutes] – Louise
   - Collaborative projects - update [5 minutes] – Nick/Russell
   - Integration of new Students in the network [5 minutes] **
   - 3rd Workshop - venue/dates/theme/travel/funding etc. [15 minutes] – Jailson/Louise/Nick
   - Current INRICH finances & future funding [10 minutes]- Isabelle/Louise

5. AOB & date of next virtual conference [5 minutes]

*** Please see Annex below for e-mails from exchanges after the first virtual meeting**

**** On Integration of new Students in the network : please read Kate Pickett's request in Annex below**

Annex – Documents for WiZiQ Conference

1. For discussion on Stress : e-mail exchanges after the first virtual meeting held last June 18, 2009

Thanks to Barbara for starting this important discussion.

Barbara Starfield wrote 20.06.09:

It seems to me that a focus on psychosocial factors runs the risk of minimizing important societal factors that predispose to behaviors. For example, high rates of obesity and diabetes among native Americans are attributed to behaviors resulting from psychosocial stress, but the fact is that native Americans were not obese before the government began to drop surplus foodstuffs (such as white flour and corn meal) on them. All of a sudden a societal factor became a behavioral factor.

In the paper on misperception of weight status, obesity is postulated to be a social phenomenon with parents and peers setting the 'standard', but what about the omitted variable of common environment e.g. exposure to the same foodstuffs?

We probably all can agree on the 'common final pathway' (biological 'stress' mechanisms), but what about the antecedent pathways?

Both the Commission on Social Determinants of Health and the RWJ Commission focus heavily on the 'social' influences on health, but 'social' means interactions among people. Neither Commission gave much play to external influences on interactions among people i.e. societal influences (policies) on social influences.

Louise Seguin wrote 20.06.09:

I agree with you. For us also, stress is not seen as a cause of disparities. We look at this as one of the pathway between environmental adverse conditions such as poverty and the child's health. It gives us some understanding of how does the social environment "get under the skin".

Clearly, as you say societal influences are definitely important as an "antecedent pathway" in the chain of events yet it is not always easy to measure them and their impact. One of our hopes is that collaboration between researchers from different countries with differing social policies might help us bring to light these influences. In fact this is one of the network's objectives.

I hope we will be able to go on with that discussion.

Luis Rajmil wrote 21.06.09:

Just in order to reinforce Barbara's idea, it seems to me that a statement from David Gordon years ago is working today (please, correct me if I'm wrong): "do not be poor, but if you are poor stops being it as soon as possible; do not live in a poor and contaminated neighbourhood; do not carry out a badly full and precarious work".

Dave Gordon wrote 21.06.09:

For those of you who may not be sure what Luis is referring to – please find attached two slides which show the 'Top Ten Tips For Health' according to the English Chief Medical Officer (Liam Donaldson), which he included in the introduction to the UK Government's response to the Acheson report (Independent Inquiry into Inequalities in Health). The second slide shows the alternative top ten tips for health produced by myself and my colleagues at Bristol.

As Michael Marmot often says he has colleagues who believe that a major cause of CHD is the insufficient prescription of Statins, my belief is that major causes of CHD are deprivation and poverty. Both views are arguably correct at the individual level but probably not at the population level!?

There is quite good epidemiological evidence that childhood (and adult) poverty can result in premature death (in adulthood) from CHD, Stomach Cancer and Haemorrhagic Stroke. I

have always been very uncertain as to why differential levels of stress resulting from inequality/social hierarchy should kill differentially from these particular diseases?

Ten Tips For Better Health – Liam Donaldson, 1999

1. Don't smoke. If you can, stop. If you can't, cut down.
2. Follow a balanced diet with plenty of fruit and vegetables.
3. Keep physically active.
4. Manage stress by, for example, talking things through and making time to relax.
5. If you drink alcohol, do so in moderation.
6. Cover up in the sun, and protect children from sunburn.
7. Practice safer sex.
8. Take up cancer screening opportunities.
9. Be safe on the roads: follow the Highway Code.
10. Learn the First Aid ABC: airways, breathing, circulation.

Alternative Ten Tips for Health

1. Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2. Don't live in a deprived area, if you do move.
3. Be able to afford to own a car
4. Don't work in a stressful, low paid manual job.
5. Don't live in damp, low quality housing or be homeless
6. Be able to afford to go on an annual holiday.
7. Don’t be a lone parent.
8. Claim all benefits to which you are entitled
9. Don't live next to a busy major road or near a polluting factory.
10. Use education to improve your socio-economic position

Nick Spencer wrote 22.06.09:

Dear all,

Some further points in support of Dave, Luis, Barbara and Louise:

1. There is still a lack of clarity about the exact nature of stress and we should be very cautious about using the term without being very clear exactly what kind of stress we are referring to. As I understand it, acute stress is effectively a normal physiological response that is essential to normal life. Chronic stress, on the other hand, has the potential to overload the normal stress mechanisms and blunt the normal responses.

2. As Gary Evans and colleague have documented (see attached), there are many life stressors directly associated with poverty and low SES - in my view, although it is important to document how these stressors act to produce chronic stress, we need to focus on the social circumstances that produce the stressors as these are at the root of the problem. There is a danger of focusing on relief of stress rather than improving living conditions and reducing the stressors that are responsible for the stress.

3. In support of the point Dave Gordon made about the differential impact of early poverty on adult outcomes, it is clear that poverty/low SES do not have exactly the same impact on all childhood adverse health outcomes. Some are very strongly socially patterned and others less so. There is also some evidence of changing socially patterning in relation to some outcomes. If stress were the main pathway through which social circumstances 'get under the skin' in childhood then we would expect all adverse outcomes to be similarly socially patterned. A much better hypothesis, in my view, is that poverty/low SES exerts its influence through cumulative socially-related exposures over time (with intergenerational factors playing an important role in childhood). In addition, poverty/low SES is frequently associated with multiple co-existing adverse exposures (see Evans and Kim again). Different exposures and combinations of exposures are likely to result in different pathological manifestations. Chronic stress may well be one of these exposures; however, many of them are direct physical exposures such as poor housing conditions, poor diet etc. It is very difficult to argue that the effects of multiple deprivations that children suffer in many developing countries work mainly through stress mechanisms - children in richer countries tend to have fewer major deprivations but their living conditions are often associated with direct adverse physical exposures.

2. Kate Pickett's request**

Date: Sat, 30 Jan 2010 18:55:27 +0000
From: kp6@york.ac.uk
To: inrich@centrelearoback.ca
Dear Lucie,

I plan to try and recruit a PhD student to work with me on a project comparing social gradients in child indicators which are good predictors of adult health, across more and less equal societies. I would love to have collaborators from within INRICH for this project, which would be funded by the UK ESRC. In particular, it would be great to collaborate with people who have access to nationally representative datasets with individual indicators of child wellbeing (I am particularly interested in height, IQ and mental health/behaviour) and parent's socioeconomic status.

Is there a way to seek interest from INRICH members for this? Perhaps just by forwarding this email? Or are there more formal ways to develop collaborative projects?

I would hope to recruit a student to start in October 2010.

Best wishes, Kate
Kate E Pickett, PhD FRSA, Professor of Epidemiology, Department of Health Sciences
University of York