Title

Bringing Health to Life: An Institutional Ethnography of the Social Determinants of Health Framework in a Maternal and Child Health Setting

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By

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Abstract

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Health inequities, or avoidable and unjust differences in health status across groups, are widely considered public health and social problems. Maternal and child health (MCH) inequities, such as those in maternal and infant mortality, low birthweight, or preterm birth, are some of the most enduring and marked inequities in the US. Given the way that MCH outcomes are used as a metric to understand the functionality of a health and social service system overall, these inequities point to deep-seated structural issues in US healthcare. Additionally, a growing body of literature demonstrates that more than genetics, individual behavior, or even quality of medical care, it is the social determinants—the conditions in which we live, learn, work, play, and age—that determine MCH and other health inequities. Despite this growing acknowledgment, little is known about the role and experiences of frontline health and social service workers who are charged with applying this knowledge in day-to-day practice. Moreover, little is known about how such frontline workers are shaping this knowledge when it "hits the streets."

This dissertation analyzes the enactment of the social determinants of health (SDOH) framework, or the public health framework that outlines the role of upstream factors in determining health outcomes. To do so, I conducted an institutional ethnography of frontline health and social service workers charged with addressing racial, ethnic, and economic MCH inequities. My field site is a mid-size (approximately 90 employees) non-profit providing a range of MCH services in a large, West Coast City where health inequities reflect the broader MCH inequities in the US. I sought to uncover what the everyday routines, experiences, and practice dilemmas of this workforce could reveal about tackling MCH inequities and implementing the SDOH framework., This work employed discourse analysis of agency documents, participant observation, and semi-structured, in-depth interviews throughout a nine-month period of fieldwork. Data were analyzed using a grounded theory as well as directed and conventional content analysis approach to coding and theme development. Analysis was informed by street-level bureaucracy theory and a materialist and structuralist approach to the production and amelioration of MCH inequities.

Several primary findings emerged from this study. First, I explore interprofessional collaboration as it relates to enacting and animating the SDOH framework. I find that the frontline workforce relies on three key types of collaboration to bring the SDOH to life: within agency collaboration and role-blurring, collaboration with a safety-net hospital, and common cause, or the engagement in a shared analysis and framework for political action. Next, I explore the impact of prevailing social norms on implementation of the SDOH framework. Specifically, I consider how definitions of the private, heteronormative, nuclear family emerge in a health and social service setting. I find that frontline workers negotiate the legacy of problematic and often contradictory health and social service policies regarding who constitutes a family and when during pregnancy a family is understood to exist. Finally, I explore a continuum of frontline provider perspectives regarding the SDOH framework and health inequities. I consider provider engagement with the SDOH framework through the lens of sociologist C. Wright Mills' "sociological imagination," or the ability to understand one's actions and circumstances as part of broad, historically-contingent social forces. I understand engagement with the SDOH framework to exist on a continuum from apathy and burnout to possessing a sociological imagination, and, finally, to structural competency, or the trained ability to analyze and intervene upon the upstream factors that produce health inequities.

Enacting the SDOH framework in MCH and other settings is an important part of addressing health inequities and ultimately, ameliorating social disadvantage. The SDOH framework informs the development of an emerging SDOH workforce, or a network of health and social service professionals who are integrating practice systems and institutional resources to adequately meet social as well as physical health needs and ultimately, address health inequities and social disadvantage. Studying frontline SDOH-related work from the vantage point of those with the most intimate experiences of service delivery, I investigate up close the role of health and social services in integrating social and clinical care. Additionally, this workforce is shaping SDOH knowledge and practice with their daily decisions and strategies to meet client need. I conclude that strategies to combat health inequities must be understood in terms of frontline workers' lived experiences and perspectives for meaningful and impactful practice change to occur.

Dedication

For my parents, Traci and Dennis Downey

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It has become a sweet, common practice for writers of many disciplines to thank the "midwives" of their work and I gratefully follow suit. This project would not have come into the world without the support and labors of many. My advisor, Anu Manchikanti Gómez, has been a tireless mentor, guide, editor, and collaborator. She oriented me to the world of reproductive justice scholarship and has been a steady hand helping to steer this ship into the harbor. Additionally, her writing group in the Sexual Health and Reproductive Equity Program provided an incubator for all the ideas brought forth here. I hereby promise to her: I have finally learned the difference between which and that.

Working with Seth Holmes helped me to articulate the conceptual and ethical stakes of this project. He models the provider-scholar praxis to which I aspire. Susan Stone has one of the strongest, largest minds I have ever seen. Her generous mentorship, listening ear, and solid advice made sure that my doctoral work was rooted in social welfare while stretching to other fields and disciplines. Greg Merrill has fostered the development of generations of health practice students and I count myself very lucky to have been under his wing for a few years. Erin Kerrison and Tina K. Sacks model how to study health inequities with the necessary critical and compassionate lens.

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Chapter 1

Introduction

Health policy-makers, providers, and scholars, particularly those concerned with vulnerable and marginalized populations, struggle to reconcile the immediate demands of healthcare provision, the policy goals of promoting health equity, and implementation barriers (Braveman et al., 2011a; Braveman & Gottlieb, 2014; Krieger et al., 2008; Marmot et al., 2008). The adverse impact of social injustices, ranging from racism, xenophobia, and poverty to social isolation, gender discrimination, and mass incarceration, on health and well-being is well-documented (Bonnefy et al., 2007; Braveman et al., 2011a; Wilkinson & Marmot, 2003; World Health Organization, WHO, 2010). These social injustices produce health inequities, or preventable differences in health outcomes (both morbidity and mortality) across disadvantaged groups (Centers for Disease Control and Prevention; CDC, 2013).

The social determinants of health (SDOH) framework outlines the ways in which health inequities are largely determined by factors outside of and preceding health or social service encounters, such as physical environment, education, job status, socioeconomic status, and immigration status (Dahlgren & Whitehead, 1991; Marmot et al., 2008; Braveman & Gottlieb, 2014). Yet, health and social service settings are often charged with ameliorating health inequities, highlighting the disconnect between what is expected of health providers and the resources they have to follow through on the mandates of their profession (Ashcroft, 2010; Craig et al., 2013; Robert Wood Johnson Foundation, 2011). Community-based health providers such as physicians, nurses, health social workers, or community health workers are often only able to serve one patient or client at a time, but risk individualizing social problems when they cannot connect patient and client care to broad reform of the structures that produced differential impacts of disease and illness in the first place.

Community-based health and social service providers are given the impossible goal of eliminating longstanding, structural health inequities through systems that are largely designed to address individual-level pathologies (Ashcroft, 2010; CDC, 2013; Craig & Muskat, 2013; Robert Wood Johnson Foundation, 2011; WHO, 2010). This contradiction poses urgent problems across health and related social service professions, including ethical dilemmas (Apker et al., 2005; Kass, 2001; Miller & Apker, 2002); sickness and absenteeism (Harris & White, 2009; Kadushin & Harkness, 2014); stress, compassion fatigue, and burnout (Dyrbye & Shanafelt, 2011; Nolte et al., 2017; Shanafelt, 2009); and departure from the profession entirely (Collins, 2007). These challenges to providers begin in the educational stage and continue through professionalization (Seppala et al., 2014; Ying, 2009). When we recognize this contradiction between provider goals and health and social service system design as a problem, additional, contingent questions become increasingly relevant. For example, how do health and social service providers navigate these contradictions? Acknowledging the role of structural forces, what might be the role of such providers in eliminating health inequities in vulnerable populations? What theories must to be mobilized to begin to answer these questions?

Bringing Health to Life: The Current Study

The following study is an ethnographic examination of what is required to enact and animate the SDOH framework, from the perspective of health and social service workers themselves. These workers can be understood as street-level bureaucrats, or the subset of civil society and sociopolitical institutions that interface directly with the general public (Lipsky, 1980). My field site is a non-profit providing a range of maternal and child health and wellness services in a large, West Coast City where I sought to uncover what the everyday routines, experiences, and practice dilemmas of this workforce could reveal about tackling maternal and child health (MCH) inequities.

I focus on MCH outcomes because of the ways in which they reflect the overall functionality of health and social service system and because eliminating maternal and infant health inequities specifically is widely understood as important public health and social welfare goal, both globally and nationally. Given the impact of these inequities on social and economic success for individuals and communities later in life (Fine et al., 2009; Lu & Halfon, 2003; Schulz et al., 2001), ameliorating these inequities may result in a healthier and more equitable society overall (Institute of Medicine, 2007). In this introduction, I first describe inequities in MCH outcomes in-depth. Second, I describe the theoretical construct of street-level bureaucracy and how it applies to the SDOH workforce like that of my field site.

Next, in Chapter 1, I explore interprofessional collaboration as it relates to enacting and animating the SDOH framework at the field site, referred to as Family Center throughout. Most research on interprofessional collaboration in health-related settings focuses on physician, nurse, social worker dynamics. I expand on this literature by centering the collaboration of social workers, health educators, case managers, mental health clinicians, and community health workers at my field site.

In Chapter 2, I explore the impact of prevailing social norms on implementation of the SDOH framework. Specifically, I consider how definitions of the private, heteronormative, nuclear family emerge in a health and social service setting. These definitions create complex and often contradictory eligibility requirements and service provision that frontline workers must adjudicate. These definitions surface two problems: first, who is understood to comprise a legitimate family, and second, when during pregnancy a family is understood to be constituted. I link frontline workers' current dilemmas with a larger discussion of how the welfare state has enforced definitions of family over time.

In Chapter 3, I explore a continuum of frontline provider perspectives regarding the SDOH framework and health inequities. Using C. Wright Mills' (1959) concept of the "sociological imagination," I understand a frontline worker's engagement with the SDOH framework as existing within a range of possible perspectives, from apathy and burnout to sociological imagination, and, finally, to structural competency, or the trained ability to analyze and intervene upon the upstream factors that produce health inequities (Metzl & Hansen, 2014). Structural competency, in turn, is understood as a development of the sociological imagination to the specific problem of health inequity.

Finally, I conclude with recommendations for practice and future directions for research. Implementing a SDOH framework offers great potential to improve health and social services and ameliorate health inequities. Each of these pieces considers an under-theorized aspect of what it means to bring the SDOH framework to life, focusing on an MCH setting. The results suggest the potential for the frontline workers of the SDOH in shaping this framework as they strive to eliminate health inequities as part of their daily labor. These results address gaps in current SDOH literature and theory by examining this framework in terms of its implications for frontline workers in an MCH setting. Ideally, the energy and resources deployed to measure and document specific MCH inequities can be shifted, at least partially, to investing in practice models that incorporate the needs and perspectives of those with the most intimate experiences of service delivery, thereby improving health and well-being for all.

Maternal and Child Health Inequities

Inequities in MCH map onto persistent social, economic, and political divisions in the US, with low-income, Black and Native/Indigenous women facing the worst health outcomes (Ananth et al., 2001; Goldfarb et al., 2018a; Institute of Medicine, 2007; Lu & Halfon, 2003). Some of the most glaring MCH inequities are in pregnancy-related and infant mortality, with preterm birth and low birthweight being of key concern as well (CDC, 2017a; Zaharatos et al., 2018). Here I briefly review the most prominent and problematic contemporary MCH inequities.

Maternal Mortality

According to the CDC (2017a; Petersen et al., 2019), pregnancy-related deaths are those deaths of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. About half of pregnancy-related deaths in the US are considered to be preventable (Main & Menard, 2013). Since the CDC implemented its *Pregnancy Mortality Surveillance System* in 1986, the overall pregnancy-related mortality ratio in the US had increased, from 7.2 deaths per 100,000 live births in 1987 to a high of 18 deaths per 100,000 live births in 2014, declining to 16.9 in 2016 (CDC, 2017a; Petersen et al., 2019). Black and Indigenous/Native American women die far more often than White women (with a pregnancy-related mortality ratio of 40.8 and 29.7 per 100,000 live births, respectively; (Petersen et al., 2019). These inequities do not change over time (Petersen et al., 2019). Importantly, D'Alton and colleagues (2019) understand maternal health–and inequities therein–as an underappreciated and under-researched aspect of the broader maternal and infant health paradigm; they note the emphasis on technological advancements in fetal and neonatal medicine have failed to address the stagnant maternal mortality ratio, maternal mortality inequities, and rise in incidence of maternal morbidity. For example, they note that an overall decline in the maternal mortality ratio should not decrease the urgency of attending to inequities or to severe maternal morbidity conditions, such as postpartum hemorrhage, peripartum transfusion, hysterectomy, or eclampsia (where health inequities between Black and Indigenous/Native American women also persist; Petersen et al., 2019).

Infant Mortality

Infant mortality, or the death of an infant in their first year, is a related but distinct outcome to maternal mortality (CDC, 2019). Over 22,000 infants died in the US in 2017, with a rate of 5.8 deaths per 1,000 live births (CDC, 2019). Infant mortality rates were highest among states in the South. The five leading causes of death were birth defects, preterm birth and low birth weight, sudden infant death syndrome (SIDS), maternal pregnancy complications (e.g., hemorrhaging, maternal death), and injury (e.g., suffocation; CDC, 2019). According to the most recent available data, preterm birth and low birthweight were among the leading causes of infant mortality, accounting for 17% of all infant deaths (Martin et al., 2017). Again, racial and ethnic differences underlay this health outcome. The 2016 overall infant mortality rates by race and ethnicity are presented in Figure 1, showing that non-Hispanic Black infants die at a higher rate than any other race/ethnicity (11.4 deaths per 1,000 live births). As the figure demonstrates, American Indian/Alaska Native infants die at a rate of 9.4 infants per 1,000 live births. Native Hawaiian and Pacific Islander infants die at a rate of 7.4 infants per 1,000 live births, with Hispanic and non-Hispanic White infants die at a similar rate, 5.0 and 4.9 deaths per 1,000, respectively. Finally, Asian infants die at a rate of 3.6 deaths per 1,000 live births (CDC, 2019).

For Black women, preterm birth and low birthweight were the leading cause of infant mortality (Health Resources and Services Administration, n.d.).

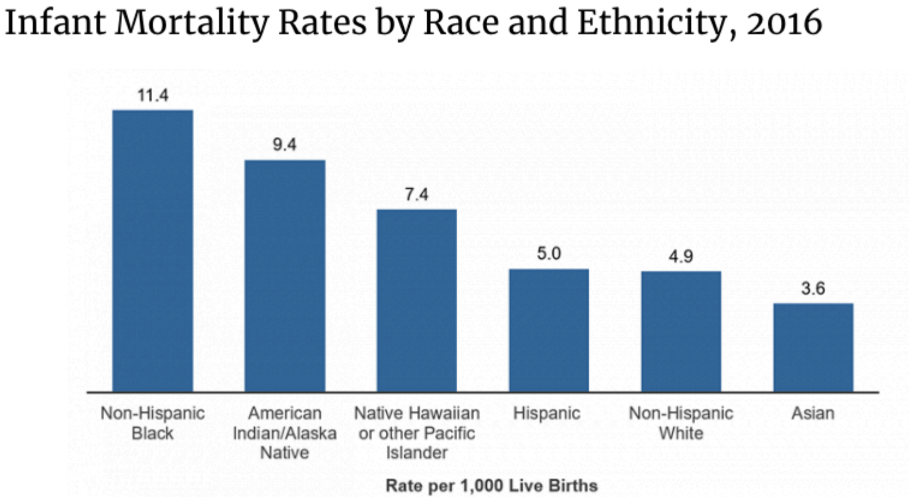


Figure 1. Infant Mortality Rates by Race and Ethnicity, 2016. Source: CDC, 2019.

Preterm Birth and Low Birthweight

Related to infant mortality, inequities in births classified as premature (gestational age less than 37 weeks) and low birthweight (less than 2,500 grams at birth) persist as well (Institute of Medicine, 2007). Despite the resources devoted to reducing preterm birth and low birthweight (Alexander et al., 2002), both these rates have significantly risen in recent years. One in ten births in the US is now preterm, with 8% of all infants born at low birthweight (CDC, 2017b; Martin et al., 2017). Moreover, racial and ethnic inequities in rates of preterm birth and low birthweight continue. For example, the preterm birth rate among Black women in 2016 was 13.8 per 100 live births, compared to 9.0 per 100 live births among White women (CDC, 2017a). Occurrences of low birthweight follow a similar pattern. Per 100 infants born to Black women in 2015, 13.8 were under a healthy weight, compared to 6.9 per 100 infants born to White women (Goldfarb et al., 2018b). Both preterm birth and low birthweight are linked to long-term health effects and "hidden" disabilities that manifest later in life in educational settings and the workplace, including increased risk of behavioral (e.g., attention deficit hyperactivity disorder) and neurological (e.g., autism spectrum disorder) issues; lung and breathing issues (e.g., asthma and pneumonia); severe gastrointestinal and nutritional issues; and hearing loss and delayed hearing development (Saigal & Doyle, 2008; Kafetzis et al., 2003). There are a host of limitations in the literature around hidden disabilities and preterm birth or low birthweight: most studies do not assess the known overlap between perinatal factors, only assess one or two disorders, and assess potential effects of co-occurring disorders). Population-level analyses on the impact of preterm and low birthweight in the US are lacking (Schieve et al., 2016). Nonetheless, at least one population-level analysis demonstrates there are overall strong associations between preterm birth, low birthweight, and physical and developmental disorders later in life (Schieve et al., 2016).

Understanding Maternal and Infant Health Inequities

Significantly, these health maternal and infant health inequities cannot be explained by biological or genetic factors alone. For example, David and Collins' (1997) landmark study of infant birthweight demonstrated that when comparing birthweight across African-born Black, US-born Black, and US-born White women, US-born Black women faced the poorest outcomes. The African-born women in the study were new immigrants from the same region from which the ancestors of most US Black women came. If genetics were to play a prominent role in determining racial health inequities in birthweight, the infants of the African-born black women should have had lower birth weights than those of the US-born Black women. These researchers found the opposite: regardless of socioeconomic status, the infants of Black women born in Africa weighed more than the infants of Black women born in the US (David & Collins, 1997). As demonstrated by Lu (2017) and other scholars (Collins & David, 1990; Collins & David, 2009; Halfon et al., 2014; Lu & Halfon, 2003; Orchard & Price, 2017), these differences also cannot be explained by traditionally invoked risk factors such as health behavioral factors (e.g., smoking), educational status, or socioeconomic status alone. For example, the contemporary pregnancy-related mortality ratio for a Black woman with college degree (or more education) is 5.2 times that of a White woman with similar education ((Petersen et al., 2019). It is important to note the relationship between race, educational status and socioeconomic status in the US and that some studies demonstrate that infants born into low socioeconomic status of any race or ethnic group are more likely to be preterm, of low birthweight, and to die before one month of age than infants born into middle or high socioeconomic status (Lu, 2017).

The Street-Level Bureaucrats of MCH

It is thus well-accepted that MCH inequities are socially determined. What many scholars continue to document and debate are the specific pathways by which social determinants cause health inequity (Braveman & Gottlieb, 2014; Gehlert et al., 2008; Krieger et al., 2008). For example, the CDC issues the *Morbidity and Mortality Weekly Report* (MMWR) series, which regularly features updates on the impact of a range of factors such as race, ethnicity, socio-economic status, or gender on various health outcomes. This line of inquiry is primarily concerned with articulating which factors, among many, can be isolated and described as significantly associated with particular conditions (e.g., Black women and infant mortality). Other scholars critique a focus on specific pathways, advocating for an analysis of *fundamental causes* (Krieger, 2008; Link & Phelan, 1995; Phelan et al., 2010), such as poverty, that impact health and produce "risk of risks" (Link & Phelan, 1995); causes that are consistently associated with overall health status even when "the profile of risks, protective factors, and disease expression changes completely" (Flaskerud et al., 2012, p. 494). Still others eschew a debate or critique of pathways and advocate a broad, holistic understanding of social determinants (borrowing from a blend of social sciences theories), including the overlapping relationships causal pathways, fundamental causes, institutional practices, and individual behaviors (Krieger, 2001; Krieger et al., 2008; Spiegel et al., 2015; Townsend et al., 2020). Across these frameworks of health inequity, scholars call for collective action on the part of providers, patients, and broader communities to intervene in the forces that produce health inequity. Bonnefy and colleagues (2007) organize these frameworks for understanding health inequity into four categories: materialist/structuralist, psychosocial, social production, and ecological. This study posits a materialist/structuralist approach, which sees lack of resources and income as drivers of ill health combined with a social production approach, which assumes "capitalist priorities for accumulating wealth, power, prestige and material assets are achieved at the cost of the disadvantaged" (Kelly et al., 2007, p.11) to inform analysis of a social problem associated with health inequities: the health and social service provider double-bind.

From a materialist and social production approach, one key construct both impacting and impacted by social determinants is healthcare's *street-level bureaucracy*. Street-level bureaucracy theory is instructive for understanding the "established and respected forces in society" above individual pathways (Carmichael, 2003, p. 151, in Metzl & Hansen, 2014) implicated in maintaining a status quo of health inequity. Street-level bureaucrats share the following characteristics: 1) they are constantly called upon to interact with citizens in the regular course of their jobs, wherein they represent social and political authority and policy goals; 2) they have significant independence and autonomy in occupational decision-making (otherwise known as discretion); and 3) they potentially have extensive impact on the lives of their clients, disproportionate to the material support they themselves receive to do their jobs (Lipsky, 1980). Their work is inherently political; the street-level bureaucrat was first conceptualized by Michael Lipsky (1969) in the late 1960s as both byproduct and enforcer of the Great Society's reforms, which were intended to eliminate racial and economic injustice. Notes historian Richard Flacks (1988), these reforms and the "war on poverty" (p. 63) were never adequately financed due to in part to the Johnson administration's ongoing commitment to escalating the Vietnam War, a connection Lipsky fails to address.

In his initial concept paper and subsequent scholarship through the 1980s, positions his analysis as in part a response to "recent American urban conflict (that) has focused attention on bureaucratic structures providing services to the poor" (Lipsky, 1969; p.1) What's more, he saw street-level bureaucrats as both a result of and cause of an "urban crisis" of simmering racial and class tensions due to the ways that client/patient perception of street-level bureaucrats influenced client perception of the state as a whole (Lipsky, 1980). For the socially disadvantaged or marginalized, street-level bureaucrats (e.g., police officers, lower-court judges, physicians, nurses, and social workers) are often the gatekeepers to necessary resources, such as food, shelter, and medicine. Injustice and inadequacy at this level of civil society signifies injustice and inadequacy within the state. Street-level bureaucrats' significance to healthcare provision is fundamental: "the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainty and work pressures, effectively become the public policies they carry out" (Lipsky, 1980, p. xiii).

Although Lipsky's original research did not focus on health providers, there have been calls for its wider application to this field (Bergen & While, 2005a; Finlay & Sandall, 2009; Piore, 2011). A significant body of literature describes health providers as a particular type of street-level bureaucrat (Bergen & While, 2005b; Evans, 2004; Lipsky, 1980; Piore, 2011; Walker & Gilson, 2004), though it must be noted that not all healthcare providers fit the description of street-level bureaucrat and not all street-level bureaucrats are healthcare providers. Here, health provider refers to those working in healthcare settings (e.g., primary care clinics and hospitals) to provide services that help individuals prevent and treat illness and maximize physical well-being. Healthcare provider also refers to those providing necessary services such as case management or health education where the primary goals are changing health outcomes and the support or maximizing of the services offered in healthcare settings and therefore is not limited to licensed medical professionals (National Academies of Sciences, Engineering, and Medicine, 2019).

Health and social welfare scholarship also identify a decades'-old policy to practice gap, citing a lack of connection to rank-and-file community health providers (i.e., street-level bureaucrats) as a root cause (Chinitz & Rodwin, 2014). My work is chiefly concerned with frontline health providers who fit Lipsky's original description of a street-level bureaucrat (having autonomy and discretion as a core experience of their job, being tasked with implementing larger social projects and goals such as eliminating health inequities, and possessing inadequate and unpredictable resources to achieve these goals) and thus considers all providers who work in community settings, who accept public assistance as part of payment for their services, or who rely on federal or state funding or contracts to support their work. Part of health providers' unique experience of street-level bureaucracy is the vivid, urgent nature of their services: quite literally, healthcare's street-level bureaucrats deal with intimate access to people's bodily needs, with high need and high suffering. Their work has immediate implications on real people's lives or deaths, pain and suffering.

The role of discretion in professional decisions that can extremely impact patient or client physical needs makes street-level bureaucracy (with its robust theorization of discretion) of particular relevance to healthcare. Some scholars note that changes in healthcare policy or provision are best understood from the position of the street-level bureaucrat (Bergen & While, 2005b). Most research on health services' street-level bureaucrats (particularly in social work) has focused on their discretionary power (Ellis, 2014; Evans, 2004). Discretion, in this framing, is part of successfully utilizing professional knowledge and having been granted (by a manager, a state agency, or even a client or patient) the freedom exercise right judgement (Ellis, 2014; Evans, 2004). Additionally, street-level bureaucracy also provides a framework for understanding low-resource health settings, which is arguably more relevant to a structural analysis of health providers, health inequity, and class.

Working environments have been demonstrated to play a direct role in healthcare providers' experience of their profession and the care they provide (Harris & White, 2009; Nolte et al., 2017; Walker & Gilson, 2004). Through street-level bureaucracy, we can understand the day-to-day lives of healthcare provider in terms of their inability to follow through on goals society demands of them. For example, in a cross-sectional survey with physicians (n=1,939), more than a quarter (27%) anticipated a moderate-to-definite likelihood of leaving their practices within two years. Relative dissatisfaction with pay and with relationships with the community were associated with plans for leaving in nearly all physician groups (generalists or specialists, across ages; Pathman et al., 2002). Few studies have directly examined the influence of physician workplace conditions on healthcare inequities using street-level bureaucracy theory, but Varkey and colleagues compared 96 primary care clinics in New York City and in the Midwest serving various proportions of minority patients and found that physicians working in clinics serving at least 30% minority patients reported decreased access to necessities like medical supplies, examination rooms, referral specialists, and pharmacy services despite their patients being more frequently medically and psychosocially complex. Clinics with at least 30% minority patients are more likely to have chaotic work environments and fewer physicians reporting high work control or high job satisfaction (Varkey, 2009). In another example, nurses in low-resource community settings report prescribing medicines without adequate training, often in the absence of supervision, legislation and regulation because the resources for physician consultation for example were consistently lacking. This caused ethical conflict and stress among nursing staff as well as presented a risk for patients (Miles et al., 2006). Finally, despite relatively little research regarding social workers' perceptions of their own roles within health care settings, several studies do indicate the health social workers experience similar challenges with role ambiguity leading to professional burnout and excessive role demands leading to emotional exhaustion among health workers (Collins, 2007; Craig & Muskat, 2013). Frontline health and social service workers in community health centers cite the difficulties of serving as "bouncer, broker, and glue" (Craig & Muskat, 2013, p.10), as well as caretaker, underscoring the role ambiguity aspect of poorly resourced street-level bureaucrats.

In summary, the relationship between MCH inequities and the experiences of health providers who are tasked with addressing them is fertile ground to understand the persistent nature of such inequities, as well as overall social disadvantages in the US. Those impacted by health inequities, including MCH inequities, deserve comprehensive, quality services that can attend to their social as well as physical needs. When those on the frontlines of service provision to marginalized and vulnerable populations receive the resources, education, support, and influence over their working conditions commensurate with their vital role in society, we are closer to eliminating all health inequities and building a society where all people have the opportunity to parent with safety and dignity (Ross & Solinger, 2017).

Chapter 2

Interprofessional Collaboration and the Social Determinants of Health Framework in a Maternal and Child Health Setting

Introduction:

Amidst ongoing concern about health inequities, interprofessional collaboration in health services has emerged as a potential solution to address these unjust and avoidable differences in mortality and morbidity and to address the "social determinants of health" (SDOH; Bibbins-Domingo, 2019; Hager et al., 2019; Institute of Medicine, 2003; McPherson et al., 2001; Messac et al., 2013; National Academies of Sciences, Engineering, and Medicine, 2019). Practice models that link clinical and social care may improve prevention and detection of illness and disease (Vest et al., 2019), patient safety (Wakefield et al., 2008; Gröne et al., 2001), and job satisfaction among nurses, social workers, physicians, and community health workers (Chang et al., 2009; Körner et al., 2015; Marmo & Berkman, 2018). They may also improve access to services that address some of the most prominent factors impact health status such as food, housing, education, employment, income, or environmental conditions (Barker & Oandasan, 2005; Paul et al., 2017; Social Work Policy Institute, 2011; Vest et al., 2019).

However, the literature base for interprofessional collaboration with regards to addressing SDOH is still developing (Reeves et al., 2017). Much of the established scholarship on how allied health providers could or should work together to advance the SDOH framework comes from expert stakeholder overviews rather than empirical literature (Lane et al., 2018; Noriea et al., 2018). Now that the SDOH framework has "come of age" (Braveman et al., 2011b; p. 381), leading experts call for the ongoing study of how precisely health services might bring the SDOH framework to life in their various settings (Braveman et al., 2011; WHO, 2010). Additionally, there is little in-depth, qualitative work on interprofessional collaboration and the SDOH framework (Bandyopadhyay, 2011). In order to examine an interprofessional collaboration model that incorporates the SDOH framework and to provide a rich description of an interprofessional model to address health inequities, this paper describes an ethnographic study in a maternal and child health (MCH) setting as its frontline workers attempt to intervene upon longstanding health inequities and their social determinants. I focus on this setting both because of the persistent nature of MCH inequities in the US (Hoyert & Miniño, 2020) and the role of MCH as a "litmus test" (Matthews et al., 2019, p.1) for the overall functioning of health and social welfare systems (Matthews et al., 2019; Van Lerberghe et al., 2014). Furthermore, the WHO SDOH Unit's research on National Health Workforce Accounts, a project to track myriad trends in health care workforce development to address the SDOH, makes no mention of social service workers, considering only "health" workers employed in biomedical professions. Social services workers, even those employed in health settings, are excluded from the calculation of various metrics, including worker education, training, retention, and remuneration (WHO, 2017).

In this paper, I argue that any effective implementation of the SDOH framework will require the collaboration of a diverse range of health and social service workers. I explore the collaborative approaches and strategies employed by frontline health and social services workers at a unique MCH setting from the perspectives of frontline workers themselves. I situate these workers are part of the emerging SDOH workforce (National Academies of Sciences, Engineering, and Medicine, 2019), examining their collaboration strategies to build on and inform recommendations and best practices for health and social care that can eliminate health inequities in MCH and beyond.

Maternal and Child Health in Context

In order to understand the need for effective SDOH-informed health and social services for pregnant women, infants, and children, we must first understand the context of MCH inequities in the US. Despite the resources dedicated to improving MCH at national, state, and local levels (Institute of Medicine, 2007), racial, ethnic, and socioeconomic-based differences in health status remain (Bartick et al., 2017; Halfon et al., 2014; Lu & Halfon, 2003; Main & Menard, 2013). This stratification both reflects and exacerbates longstanding forms of violence and discrimination, such as the privileging of some groups' fertility over others (Colen, 1995). Low-income women and women of color, particularly Black and Brown women, fare far worse than their higher-income and white counterparts in nearly every measure of MCH, including maternal and infant mortality (CDC, 2017a, 2019), preterm birth (CDC, 2017a; Institute of Medicine, 2007), low birthweight (Womack et al., 2018), and breastfeeding initiation and duration (Bartick et al., 2017). Previous research demonstrates that inequities may remain despite increased access to prenatal care, suggesting that medical care alone cannot close these health gaps (Collins & David, 1990; David & Collins, 1997).

In order to understand the persistent nature of these inequities, researchers, practitioners, and leading health agencies have adopted the SDOH framework (Adler et al., 2016; Bambra et al., 2010; WHO, 2010). The SDOH framework highlights the fact that life chances are structured by the unequal conditions in which people are "born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life," (WHO, 2010, p. 76), which in turn perpetuate avoidable differences in health. Thus, housing, education, labor markets, food security, and public health policy are all understood to influence health at individual, group, and population levels (Bonnefy et al., 2007; Braveman & Gottlieb, 2014; WHO, 2011).

As the SDOH framework has come of age, it is increasingly deployed in health research, policy, and education (Braveman et al., 2011a). Despite its mainstream presence, the role of frontline health and social services workers in enacting the SDOH is poorly understood (Farmer et al., 2006; Pies et al., 2012). Additionally, Wise (2003) states that the role of health-related services is "often ignored" and "devalue(d)" (p.154) in public health's analytic frameworks. Therefore, implications for the emerging SDOH workforce are unclear. On the one hand, the SDOH framework emphasizes the importance of considering conditions outside the clinical environment in order to provide quality care. On the other hand, leading healthcare research organizations, such as the US Department of Health and Human Services (2011) and the Institute of Medicine (2003), emphasize the central role of an adequately trained, equipped, diverse workforce in eliminating health inequities (Institute of Medicine, 2003; US Department of Health and Human Services, 2011). Ambiguities regarding role scope, definition, and authority when it comes to how collaboration and implementation of the SDOH framework could lead to or exacerbate existing barriers to effective collaboration that already burden the health and social service workforce (Goldman et al., 2016; Mizrahi & Abramson, 2000; Reeves et al., 2017). Decades of social research demonstrates that frontline health and social service workers are key to understanding the realization of public health and social welfare goals such as addressing the SDOH, given the role they have in gatekeeping access to services as well as determining the nature and reach of services (Lipsky, 1980). When workers are charged with broad goals and limited resources to meet those goals, they may develop strategies, informed by their discretion, to fulfill their occupational duties and meet client needs.

This study utilizes ethnographic methods to investigate the role of frontline workers in enacting and animating the SDOH framework in an urban maternal and child wellness center (i.e., "Family Center") in a large, West Coast city. By *enact*, I refer to the routines, practices, behaviors, and interactions that make the SDOH framework real, observable constructs in the world. By *animate*, I refer to the meaning, values, and narratives that workers ascribe to the SDOH framework. Specifically, I seek to understand the ways in which frontline workers understand role collaboration in order to meet the demands of the SDOH framework. Through examining agency documents and reports, interviews, and nine months of participant observation, this study reveals several key strategies that workers and the organization as a whole employ to successfully meet the broad demands of the SDOH framework and bring it to life. Borrowing from Seim (2017), I take an abstract concept from public health practice (i.e., the SDOH framework) and understand it as a complex labor process requiring the collaboration of variously situated workers.

Theoretical Background

Street-level bureaucracy

One way of understanding the network of social workers, nurses, physicians, and community health and other frontline workers in MCH settings is as health's *street-level bureaucracy*. Street-level bureaucracy theory helps to describe the associations through which those impacted by health's social determinants come to be assessed, processed, managed, and treated. The SDOH frameworks are brought to life by street-level bureaucrats who are structurally positioned between a patient/client base and a management tier, and social welfare and public health scholars who develop models, frameworks, and practice recommendations. The street-level bureaucrat was first conceptualized by Michael Lipsky (1980, 1969) in the late 1960s as both byproduct and enforcer of the Great Society's reforms, which were intended to eliminate the racial and economic injustices causing intense social unrest in the US. As historian Richard Flacks (1988) notes, these reforms and the "war on poverty" were never adequately financed due, in part, to the Johnson administration's ongoing commitment to escalating the Vietnam War, a connection Lipsky fails to address.

While Lipsky neglected some of the power relations between government agendas and social services, he does describe the power relations within public services in detail. There are horizontal relationships among fellow street-level bureaucrats (professionals who are in charge of carrying out public policy), as well as vertical, hierarchical relationships between these workers and the actors who coordinate their labor (e.g., managers, administrators, funders, academics, policy-makers) at the "top" and clients at the "bottom." His research on public policy demonstrates that the working conditions of street-level bureaucrats determine the quality of care that clients can expect; working conditions also determine the specific manifestation of public health policy, given the amount of discretion and autonomy street-level bureaucrats have in implementing the rules and routines of their jobs (Evans, 2004). Here, I extend this argument around policy to a public health framework—the SDOH. I argue that the amount of discretion and autonomy the street-level bureaucrats in my study have in carrying out their jobs grants them considerable influence on what the SDOH framework becomes when it "hits the streets."

Street-level bureaucrats share the following characteristics: 1) they are constantly called upon to interact with the public in the regular course of their jobs, wherein they represent social and political authority and policy goals; 2) they have significant independence and autonomy in occupational decision-making (otherwise known as discretion); and 3) they potentially have extensive impact on the lives of their clients, disproportionate to the material support they receive to do their jobs. The labor force in this study are exemplary street-level bureaucrats, tasked with goals such as “breaking cycles of poverty” and “reducing,” “eliminating,” “addressing” or “eradicating” MCH inequities for poor families of color while lacking the capacity to provide every client with the necessary resources to actually achieve such outcomes.

Where Lipsky’s original research focused on police officers, teachers, lower-court judges, and child welfare workers, other social scientists and policy-makers eventually applied his theory to healthcare providers (Bergen & While, 2005b; Hupe & Hill, 2007; Piore, 2011; Walker & Gilson, 2004). Here, healthcare provider refers to those working in healthcare settings (e.g., primary care clinics and hospitals) to provide services that help individuals prevent and treat illness and maximize physical well-being and is not limited to licensed medical professionals. Healthcare providers also provide necessary services, such as case management or health education, where the primary goals are changing health outcomes and the support or maximizing of the services offered in healthcare settings (National Academies of Sciences, Engineering, and Medicine, 2019). Thus, social workers, community health workers, doulas, social service navigators, or mental and behavioral health workers who may not be employed in a medical setting but nonetheless locate their labor in organizations addressing MCH inequities are considered street-level bureaucrats of health provision for the purposes of this analysis.

A significant body of literature describes health providers as a particular type of street-level bureaucrat that has immediate implications on vulnerable peoples’ lives or deaths, pain or distress, surviving or thriving (Finlay & Sandall, 2009; Gale et al., 2017; Hughes & Condon, 2016; Joffe, 1988; Walker & Gilson, 2004). Meanwhile, healthcare scholarship has identified a decades old policy-practice gap, citing barriers to interprofessional collaboration and lack of connection between policy-makers and rank-and-file health providers (i.e., street-level bureaucrats) as root causes (Chinitz & Rodwin, 2014). Part of healthcare providers’ unique experience of street-level bureaucracy is the vivid, urgent nature of their services: quite literally, healthcare’s street-level bureaucrats deal with intimate access to people’s bodies, high need, and high suffering. Additionally, street-level bureaucracy also provides a framework for understanding low-resource health settings, where already vulnerable clients are most heavily impacted by the SDOH and poor health outcomes across the life course.

The power of discretion in decisions that can so impact an individual’s physical well-being makes street-level bureaucracy, with its robust theorization of discretion, of particular relevance to healthcare; indeed, some scholars note that changes in healthcare provision are best understood from the position of the street-level bureaucrat (Bergen & While, 2005b). Most research on healthcare’s street-level bureaucrats (particularly in social work) has focused on their discretionary power (Ellis, 2014; Evans, 2004). Discretion, in this framing, is part of successfully utilizing professional knowledge and having been granted (by a manager, a state agency, or eve. n a client or patient) the freedom to exercise judgment (Ellis, 2014; Evans, 2004). Therefore, I attend to the ways in which workers utilize discretion when enacting the SDOH.

With this research, I seek to build upon Carol Joffe’s (1988) landmark ethnography of family planning providers’ work experiences, as well as Khiara Bridges’ (2011) ethnography on prenatal care in a large, urban, public hospital. Both scholars used ethnographic methods to provide richly detailed examples of the lives of clients and frontline health and social services workers in order to reveal broader social tensions around race, reproduction, and care work. This study complements these ethnographies by shifting the lens from more conventional healthcare settings to a comprehensive social service setting that provides clinical care and also receives referrals from and refers clients to clinical settings. I also build on street-level bureaucracy theory by demonstrating that frontline workers not only shape public policy but public health and social welfare knowledge as well.

Methods

This study employs ethnographic methods to investigate how frontline workers shape and build the SDOH framework in an MCH setting. Specifically, I utilize institutional ethnography, which is designed to analyze the worksite as a place where social, political, and economic forces unfold on a daily basis. Institutional ethnography is part of a long tradition of social research that a) has researchers embed with workers and clients in the work environment; and b) attempts to study contested issues in the sociopolitical world through the experiences of frontline workers (Smith, 2005). The approach was developed by sociologist Dorothy Smith (2005) to enhance social research's capacity to deal with "everyday" problems, knowledge, and relationships that are mediated through work and workplaces and are politically charged. Distinct from traditional ethnographies, institutional ethnography takes a worksite as the primary unit of analysis, rather than the social and domestic sphere of a culture or subcultures, and is thus part of a turn in ethnographic methodology away from the study of an exoticized "Other" and towards Western institutions, including health and social service agencies (van der Geest & Finkler, 2004). The study protocol was approved by the Committee for the Protection of Human Subjects at the University of California, Berkeley.

Setting

Family Center is a nationally recognized maternal and child wellness agency in a large, West Coast city, providing comprehensive social services to the city and region. Located in a predominantly working-class and rapidly gentrifying Latinx neighborhood, the agency is at the epicenter of a nationally recognized, even infamous, housing crisis. Family Center workers consistently noted that while there had never been enough resources to house all the families they supported, recent years had been an extreme version of this challenge, with unprecedented numbers of families being homeless for the first time. In order to engage clients, Family Center focuses on the potential motivations of prenatal health, pregnancy, and parenting to empower marginalized people to disrupt intergenerational family poverty. It serves a population of low-income women, primarily women of color, their partners, and their children. According to the most recently available data, Family Center serves nearly 4,000 families, two-thirds of whom were families with children ages zero to five, every year. Family Center clients are part of a population marked for increased risk of maternal and infant health inequities. Over 40% were homeless or unstably housed, 75% had an income of $20,000 per year or less, and 85% identified as people of color.

The majority of clients seek services due to self-identified pregnancy and parenting-related needs. With regards to services provided, approximately 10% of clients received substance use counseling, approximately 9% of clients received intimate partner-related counseling, and approximately 7% of clients received specialized services for medically high-risk pregnancies. All clients who received these specialized services were clients of the Health Center, the team within Family Center that most directly addresses healthcare and health outcomes. Appendix 1 provides a comprehensive list of Family Center's services.

Family Center was founded over 30 years ago by a nurse practitioner specializing in prenatal health who envisioned a program that could connect homeless pregnant women to necessary medical services, at a time when few in the public health and medical agencies were addressing this issue at a local level. From an early focus on access to prenatal care, Family Center has expanded to provide a range of services that address many aspects of the SDOH. It is applauded on the city's Department of Public Health website as one of only a few agencies addressing the social determinants of maternal and child health inequities. The agency has grown from its initial 3 person (a nurse practitioner, social worker, and community health worker) to a staff of approximately 80, half of whom are former clients. Social workers form the core frontline workforce, alongside community health workers, staff doulas, program directors, interns, and a range of volunteers, such as massage therapists, yoga instructors, and volunteer doulas. On-site partners, including nurses, psychologists, and lawyers, work closely with staff to provide continuity of MCH care.

Participants and Data Collection Methods

This study is chiefly concerned with health and social service providers who fit Lipsky's original description of a street-level bureaucrat (having autonomy and discretion as a core experience of their job, being tasked with implementing larger social projects and goals such as eliminating health inequities, and possessing inadequate and unpredictable resources to achieve these goals). In order to investigate the perspectives of these participants, I compiled information in five key ways. First, I participated in two key aspects of life at the Family Center: staff meetings and prenatal education classes. I attended weekly all-staff and Health Team meetings, in which workers discussed themes relevant to my study (including issues related to staffing, collaboration, emerging casework challenges, and updated evidence related to MCH practice). I also attended a cycle of 10 prenatal education classes and 2 breastfeeding support courses. I obtained written consent from prenatal education and breastfeeding clients in order to observe these sessions and record themes that emerged around relevant themes, such as access to prenatal health services, client care preferences, and client need. I took detailed written field notes of all meetings and groups sessions. Second, I recorded audio field notes at the beginning and end of each field day to summarize events and initial impressions. Third, I conducted informal interviews with frontline workers. As relevant events unfolded, I invited workers to talk to me about their immediate actions, addressing the successes, failures, and dilemmas they encountered in doing their jobs. Fourth, I conducted 21 semi-structured interviews with frontline workers and an executive team member. Interviews provided an important counterweight to ethnographic observation, allowing me to develop a rich understanding of how agency workers shaped and built upon the SDOH framework. Interviews explored workers' daily routines and responsibilities, perspectives on the organization's overall mission, perspectives on client health status, and finally, perspectives on the most relevant social determinants of health (Appendix 2). Finally, I had extensive access to documents, such as agency reports, flyers, and instruction manuals. These records were selected for review on the basis of their relevance to emerging research themes. For example, annual reports provided helpful insight into how the agency understood its mission and values and therefore the mission and values to which workers were expected to adhere.

Analysis

Data analyzed for this study include field notes, semi-structured interviews, and agency documents (e.g., annual reports). All interviews were transcribed verbatim. I used Microsoft Word to code field notes, transcriptions, and agency documents and to write memos (La Pelle, 2004). All text was organized into one table; coding occurred in this table, and codes were sorted to consolidate text segments with the same code. I entered emerging themes into a matrix to develop and preserve thematic connections between related episodes over time. Multiple data sources allowed me to triangulate data points and to analyze resonance and differences among them. In this sense, neither agency documents, worker self-report, or researcher observation alone could account for how and why workers behaved the way they did. Through sustained and ongoing engagement with the field, I could balance my observations against official organizational knowledge (e.g., agency memos) and worker self-reports. As durable patterns of practice emerged over time, I developed conclusions and iteratively built evidence for how the conditions of work shaped workers' everyday routines and logics.

In addition to studying day-to-day practice at Family Center, I developed connections with three key informants from social work practice, birth work, and academic anthropology, with whom I consulted on my evolving analysis. In the year I conducted my fieldwork, I also attended three national webinars on the implementation of the SDOH framework convened by public health scholars and four colloquia sponsored by the local teaching and research hospital on topics relevant to the SDOH framework and MCH inequities. I conducted unstructured, background interviews with three social service workers at other local health-related social service settings to understand more fully the role of the agency as it related to others in the area. These data sources allowed me to develop a rich understanding of how Family Center fits into a wider context of local actors and organizations that attempt to put the SDOH in practice. Accordingly, I followed the ethnographic principle of "generalizing within" a case rather than "generalizing from," meaning I used data to understand more fully the observed and unobserved aspects of Family Center itself rather than presume generalizability to all health and social services agencies. Family Center can be understood as a unique site, albeit one that shares many similarities to other agencies and contexts.

Findings

My time at Family Center demonstrates specific ways in which collaboration within and beyond the agency is used as a strategy to enact the SDOH, as well as how collaboration is organized and experienced by workers, yielding important insights for the collaboration and workforce development necessary to enact the SDOH. Given the emphasis on collaboration in recent SDOH scholarship, these findings add to the growing discussion of facilitators, barriers, and best practices for collaboration in the SDOH workforce (Benfer, 2015; Downey et al., 2019; NASEM, 2019; Reeves et al., 2017; Whiteside, 2004). As this literature suggests, workers are collaborating in contexts of shrinking revenue for health and related social services and growing inequality. Workers at Family Center frequently discussed their city's growing social inequality when they discussed their organizational mission to combat health inequities. At staff trainings, team meetings, and in informal discussions, each worker with whom I discussed health inequities understood these health differences to be unjust, avoidable, and their occupational duty to address. Many of the workers are former clients; they often spoke in terms of "our families," "our moms," and "our communities," with both passion and dismay at the level of need and suffering they encountered in the course of their work. Linking social services with health services for vulnerable groups provided workers with some sense of agency and meaning in the face of visible inequalities, but also overwhelm. As my findings illustrate, absent a clear protocol for animating and enacting the SDOH framework but with broad mandates to intervene in health's social determinants, these workers developed specific strategies, as one worker mentioned to me, "on the fly." At Family Center, a key strategy to address the SDOH is interprofessional collaboration. Below, I investigate three different types of collaboration as strategies to bring the SDOH framework to life.

The SDOH framework grants considerable flexibility in its recommendations around structuring work and workforce development. On one hand this is a benefit; these frameworks are open-ended concerning the specific role of health and social service providers, making them highly portable between healthcare systems and settings. For example, in the widely-cited Dahlgren and Whitehead's (1991) "rainbow" model of SDOH, "health care services" are grouped as one tier of the "living and working conditions" tier without differentiation between types and role of providers, settings, or systems.

This open-endedness also leaves room for considerable discretion on the part of health and social service workers tasked with implementing SDOH-informed care. For example, at Family Center, workers are expected to hold both social and clinical need and must decide which social factors among many (e.g., access to housing, public transit, safe working conditions, or education) to prioritize, hold the most likelihood of appeal to the client, and have the most impact on MCH outcomes. Thus, lines between the "clinical" and the "social" are actively blurred in an SDOH-informed setting, and workers are the agents of this process. For example, workers can utilize both a clinical definition of high-risk pregnancy and their own assessment to flag a pregnancy as high-risk in the agency's electronic health record system. Workers could utilize client self-report and their own observation to determine if a client's level of social need required determination of a pregnancy as "high-risk," which would make them eligible for intensive case management.

Within agency collaboration

Health Center staff frequently shadowed and trained in facilitation of one another's groups in order to meet the demands of agency life. Should Katie, a staff doula who also facilitated some health education groups, need to attend a birth, there were three Health Team members who could take over her group. Likewise, should Ayanna, whose primary role consisted of checking in with pregnant women in their third trimester and engaging them in services, need to attend a meeting at the nearby hospital, there were six Health Team members who could lead her orientation session (the first point of contact for many clients with the Health Center). As noted by Katie, the staff doula: "Sometimes I introduce myself as a doula, sometimes as a health educator. For any staff person that is available, they need to be able to answer (to the client). Collaboration is needed because it's really important how we work in teams. We need to be able to cover for one another and collaborate to meet our team goals."

Over tea and cookies, Health Team members met once a week to check-in about who might need coverage and when. Per worker report, other teams (e.g., housing, mental health) replicated a similar cross-training structure. One strength of consistent collaboration in the form of cross-training, "checking in," and work overlap is that the discretion of a single worker does not determine a client's experience, a common critique of the street-level bureaucrat (Lipksy, 1980). Additionally, workers frequently sought out professional development to expand their practice knowledge, a necessary tactic given the coverage overlap needed in their ever-evolving SDOH landscape. It was up to their own discretion which professional development opportunities they attended, when they attended, and how many they attended. Health Team workers recognized the gaps in their knowledge regarding MCH, and used their own discretion as to which specialty knowledge they would seek out.

Four times during my fieldwork, I attended (along with Health Team workers) workshops convened by the local teaching hospital on timely maternal and infant SDOH topics, such as inequities in maternal and infant mortality and breastfeeding rates, and the role of doulas in addressing racism in maternal and infant healthcare. This was an example of specialist knowledge provided to generalist practitioners who had to utilize discretion as to how to incorporate it into their own practice, in addition to using discretion whether they chose to attend such events. Workers were not mandated to attend any particular event and selected events, if any, to attend. Such professional development enhanced collaboration because a worker without knowledge of an MCH topic, such as doula care or lactation consultation, could gain sufficient background and best practices to bring back to their team.

On one hand, this expanded the ability of workers to understand and deliver services in a SDOH framework. Workers could collaborate with one another when called upon to balance their own interpretation of what constituted a priority, client-identified priority, and most impact on MCH outcomes. Because the agency tracked outcomes such as maternal mortality and infant mortality, birth weight, toxicology, and prematurity, frontline workers without clinical training were nonetheless expected to have some fluency in these topics. Collaboration assisted workers in filling in the gaps of their education or training.

On the other hand, modes of collaboration led to stretching to thin and uneven service—clients might not be sure they would get the facilitator they trusted, with whom they had the most rapport or experience. They may have to repeat their story or their request for a birth doula, which I observed several times during prenatal education classes. Health Team workers expressed anxiety at the amount of time they needed to spend arranging coverage, catching one another up on health education group progress or individual client outcomes, or debriefing about particular clients created more meetings for them. One worker expressed concern that this work was not acknowledged by alleviating other duties such as agency committee work or time off. Absent any clear protocol, it was also left to workers to determine what and what not to share in these follow-up meetings. In an interview, an executive team member summed up one of the difficulties in balancing the collaborative approaches required to deliver SDOH-informed services. She shared that "(f)rom a strategic standpoint, leadership losing focus can make you less effective in the things that you are able to do really well." In the course of my fieldwork, I saw this concern reflected in frontline workers as well. There was strong commitment in the frontline workforce to collaborate with one another while being strategic about time, resources, and shifting client need but this task sharing always occurred with a fear that something would, as one worker stated, "fall through the cracks."

Collaboration with a major healthcare system

Family Center started in a hospital system. The agency was created by a healthcare worker who, dismayed by the number of homeless, pregnant women in her city without basic prenatal care, gained a small grant and started what would become Family Center out of a small, abandoned office in a public hospital. Organizational- and individual-level collaboration continue today—Family Center hosts a midwife from the hospital for group prenatal care each week. Two Health Center workers are based in the hospital two days a week to assess patients for clinical and social need in the prenatal period. Additionally, the hospital system also relies on pregnancy and parenting groups, including prenatal education that I shadowed, to recruit participants into research studies. At least three of the 10 prenatal education classes I attended, Family Center facilitators made announcements and provided materials for participation in clinical research projects at the local teaching hospital. Most recently, Family Center collaborated with the hospital system to house a specialty health clinic after this clinic was threatened with closure due to a combination of loss of grant and donor support and steep capital expenses needed to bring the clinic up to code under the Affordable Care Act. This clinic is now co-located with Family Center. Its arrival coincided with the development of a case manager in the Health Team, whose main task is to counsel individuals and families on the specialty practice areas focused on by this clinic. More than once, Emmie, the case manager, reflected to me how much she appreciated being able to complete a "warm handoff" and walk her clients over to the co-located clinic to initiate healthcare. Emmie would assess readiness for initiating specialty care, a form of discretion in her work that reflected her gatekeeping role to health services. For example, if clients brought up career or educational goals, Emmie would use this as an avenue to discuss the clinic's services as well as Family Center's job training and educational programs, mentioning her case manager colleagues in those teams. In turn, the clinical workers relied on Emmie's description and referral to their services as a key part of patients' initiating care.

While collaboration between the agency and the hospital is a well-established feature of organizational life at Family Center, interprofessional tensions still sometimes arose between these settings. These tensions echo documented tensions between clinical and non-clinical professionals including lack of understanding or appreciation of other professionals' roles (Barker & Oandasan, 2005). In an interview, Anne, a former nurse and current health educator and lactation consultant at Family Center, noted the differences between a clinical environment and the family resource center environment, both vis-à-vis quantity and quality of care. Notably, she viewed the clinical environment through the lens of a being former hospital worker herself.

> Yeah, well you have more time than a doctor's visit, and our focus is different here, really, than it is in a clinical environment, I think. There tends to be (the doctor's) agenda on how to make the client and family healthier, whereas when families come here, they come with their agenda, and we meet them there. So, if they say, 'No, I'm not breastfeeding,' I can ask the question, 'So how did you come to that decision? Have you heard positive things about breastfeeding? What negative things have you heard? What made you come to the decision that you came to?'…
>
> Then there's the hospital, the, 'We do it a certain way because we've always done it [that way]. We can get most work done if we do it this way without taking into consideration what the principles are.' The principles are your client or your patient and what that person is going through right now, so that they can integrate what you're trying to help them with. And if they can't integrate it, then you're just throwing, I don't know, nothing. You're throwing money into the toilet, or something. You're not making an effective change.

Anne went on to describe the ways that social factors can be disregarded in a clinical environment.

> There are core elements that sometimes get placed on a level of unimportance (in a clinical environment), when in fact they should be the primary. So, this person comes in, and they could be disregarded because, oh, they're drunk. Or they're

> really poor. Let's see this person here because they look like they're dressed better, or something like that.

Addressing gaps in clinical practice around the SDOH became part of the collaborative process between frontline service workers at Family Center and the hospital system. This observation was shared by Katie, a health educator and staff doula at Family Center. When describing her own unsatisfactory birth experience at a local hospital, she noted that she was so passionate about providing quality doula care to her community because she wanted women to have an experience different from hers. When I asked what kind of different experience, she shared:

> …a different experience because I think women, they don't know the information about all the kind of thing we can do before and during the pregnancy, like nutrition, exercise, prepare emotionally, prepare woman…(because) like different hospitals have different systems. It depends how the nurse, doctor, and midwife, (how) they connected with you when you talk with them. You can feel, 'Oh, I'm going to be in good hands. Oh, I no like because I receive a bad face,' something like that.

For Katie, doulas like herself addressed the inconsistencies in clinical care around the prenatal period, as well as during labor itself. She also spoke to the ways in which doulas addressed racism and discrimination within the clinical encounter. Here, Katie spoke to well-documented social determinants—racism and ethnocentrism—that emerge at a key moment where a personal, social, and clinical moment (pregnancy and birth) intersect.

> And I feel like when they see Latino people, like who don't speak English, I feel it's less like how can say? They can support more. It's more like neutral. But when I work with English speakers, it's more attention, more this, more that. I say, 'Wow, wow, what a difference,' the woman is suffering a lot or they no want to send to hospital in the beginning when they feel really strong contraction, I notice some client have a favored probably ethnicity. And then I feel like some people feel a discrimination when they're talking. When I in there, they know I'm taking notes. They (medical providers) feel a little pressure because clients just say, 'Thank you for coming. Because I was advocating for myself, I really feel really bad. And the midwife doesn't listen to me. And the nurse, too, because nurse is following direction from midwife. And you are here, please help me to advocate. I really want this kind of medicine because they no accepting my decision.' I say, 'Okay, we going to call right now the midwife, and you going to talk from me, okay? We going to notice if they going to let you know or give you the medicine.' And that happens. When (the) doula is really good, they (medical providers) feel a little pressure from us, like they need to treat with respect our client, any client that's a different ethnicity.

While not all Health Center workers spoke directly of racism and ethnocentrism on the part of medical providers, each noted both common cause (or a shared political framework and goal) with medicine as well as differentiation between their roles and medical providers' roles as aspects of their collaboration work. One way this dynamic emerged was around time with clients. Ashley, the Health Center director, noted to me: “I mean, I don't want to frame this as doctors failing to address the situation. I think they really share that frustration that there is a limited scope to the medical model. And, there is a lot that affects health that medicine and medical interventions don't really address, in a traditional sense.” She went on to describe why she felt her role was in a setting like Family Center over a medical setting because of the ways it allowed her to adapt interventions and allocate resources such as time more flexibly. Acknowledging her limited view on working in a medical model, she stated in an interview:

> Ashley: I mean, my visibility is limited because I don't work in that sphere but what I've understood from the medical providers that I work with, funding is a big piece of it. That, so even some of the midwives that we work with here who do Centering Pregnancy, they bill for sessions one through ten. And they get paid for those sessions but if they want to have a postpartum reunion, they do that on their own time. Right so there is those limitations around what the billing allows that doesn't create a lot of flexibility for a holistic or even for a responding to individual needs in the moment. And then just the time structures that are driven by insurance and funding. That's it. Just the ability to spend time is very limited.
>
> Interviewer: And would you say that pregnancy and early parenting is type of, sort of, healthcare moment that requires more a holistic sense of time?
>
> Ashley: I would say that, yeah. Yeah, I think that pregnancy is not a, doesn't fit into a medical model very well. There is clearly a very real need for medical support around pregnancy but it is also very different from a lot of the things that the medical model was designed to, to support. As a deeply personal and intimate family event, as a huge transition, the life of a birthing person, those are things that traditional medical interventions don't really have the space for or the flexibility to support, in my experience.

In this way, workers used internal and external collaboration to strike a balance between specialist and generalist practice in order to enact the SDOH framework in their MCH setting. Workers experienced common cause with clinical providers such as physicians (the specialists) yet felt that their role as workers was distinct because of the limitations of the medical model, especially around empathy with patients, time with patients, and the personal and social transitions that occur during pregnancy and parenting.

Common Cause: Political engagement as SDOH collaboration

Leading SDOH scholar Paula Braveman and colleagues (2011) argues that rather than lack of evidence or understanding, it is political will that presents the chief obstacle to intervening on the SDOH (Braveman, Egerter, & Williams, 2011). Additionally, many scholars argue that the work of street-level bureaucrats, like those at Family Center, is inherently political.

In his initial concept paper (1969) and scholarship through the 1980s, Lipsky positions his analysis in part as a response to "recent American urban conflict (that) has focused attention on bureaucratic structures providing services to the poor" (Lipsky, 1969, p. 1). What's more, he saw street-level bureaucrats as both a result and cause of an "urban crisis" of simmering racial and class tensions due to the ways that client/patient perception of street-level bureaucrats influenced client perception of the state as a whole. For socially disadvantaged or marginalized individuals, street-level bureaucrats (e.g., police officers, lower-court judges, physicians, nurses, and social workers) are often the gatekeepers to necessary resources for health such as food, shelter, and medicine. Justice and fairness at this level of civil society signifies justice and fairness within the state. Street-level bureaucrats' significance to healthcare provision is fundamental: "the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainty and work pressures, effectively become the public policies they carry out" (Lipsky, 1980).

I first noticed that Family Center responded to the contemporary versions of urban crises mentioned by Lipksy (1969) in the posters and artwork hung up throughout the building. By engaging in timely political initiatives that were broader than the mission of the agency, Family Center deepened collaboration within and outside of its walls. Two initiatives exemplify the ways in which political engagement enhances SDOH collaboration. First, the agency engaged in political action around local housing policy. In the first months of my fieldwork, on any given day, at least half of the frontline workers were wearing t-shirts supporting a housing measure up for popular vote that Spring. It increased taxes on profits of large companies by 0.5 percent, raising up to hundreds of millions of dollars per year for homelessness services, primarily in the form of expanding shelter beds and increased mental health services. Given the level of wealth present in the city, there was a significant pool of profit to draw from. When I asked Rita, a social worker on the Health Team about what she thought about the agency engaging in overtly political initiatives, she said she treated this type of work as a natural extension of direct service work: "Yeah, I feel like Family Center has an obligation to be political in some ways to advocate for families, but also anti-racist and anti-patriarchal." She went on to describe the equity committee, which brought workers from disparate teams together to strategize about ways address the impact of racism both within the agency (e.g., recruiting and retaining workers of color in leadership positions, planning cultural heritage celebrations) and outside it (e.g., supporting this housing legislation).

Another way political engagement emerged in the agency is through its safety committee. Like the equity committee, it brought workers from disparate teams together to plan presentations and trainings for the entire agency. The role of the safety committee was to design and lead programming that prepared the agency for natural and human-caused emergencies that could endanger the physical well-being of workers and clients alike. Membership was voluntary and lasted for a year. The safety committee took their role seriously and expansively. In addition to fire and earthquake drills, the safety committee planned a training on emergency response in the event of a raid by Immigration and Customs Enforcement (ICE). This training was developed in direct response to timely, pressing concerns and gnawing fear that gripped the region and indeed the country that summer. Coordinated federal raids targeting undocumented migrant parents and their children took place throughout the nation in the months leading up to this training. These raids were part the Trump administration's ongoing plan to enforce deportation orders on those deemed ineligible to remain in the country. While relatively few detentions ultimately resulted in that season's raids (in a twist on street-level bureaucracy, individual ICE field offices “were reportedly given the discretion to decide when to begin” (Dickerson et al., 2019), and the administration did succeed in producing a culture of threat, stress, and fear in immigrant communities, including the community served by Family Center.

Family Center workers seemed acutely aware of the threats to maternal and infant health that result from immigration enforcement policy. In addition to the all-staff training, the posters and artwork around the agency, immigration was discussed as a form of maternal stress. As Katie, the Health Center staff doula, shared with me:

> (P)eople are just quiet because they are afraid or they are scared they are going to call immigration. This is a big stress for me because we have a lot of the Spanish community in (City). Every day is really stressful…Moms, sometimes they cannot participate in outside because they are scared to. So, it's a lot of stress, I feel. That's why we have a lot of C-sections, a lot of induced labor, because of the stress. It's a lot of stress because I think some families, they now have really support from the system. I know immigrant people, they no qualify for services, like food stamps. They don't have what the other people have. And they need to work so hard. One woman needs to work so hard outside to provide food for her kids.

Katie’s words resonate with previous scholarship on maternal and infant health inequalities and immigration. A study following the, at the time, largest workplace raid in US history in Postville, Iowa, demonstrated higher risk of low birth weight for infants born to Latinx (including immigrant) women after the raid, compared to the previous year (Novak, Geronimus, & Martinez-Cardoso, 2017). There was no difference in birth weight among infants born to non-Latinx women. The findings highlight that racialized maternal health stressors related to immigration enforcement, stressors which extend beyond immigrants and extend the impact on US-born Latinx persons (Novak et al., 2017).

Family Center’s frontline workers did not shy away from acknowledging the politics behind the “social determinant” of immigration policy and practice on MCH. Both the introduction and debrief of the trainings emphasized the political context of these threats (e.g., described the threats in terms of racism, nativism, and xenophobia) and the role of all workers in assuring client safety. I found this framing of “safety” to be a fitting example of discretion on the part of the frontline workforce; safety can be interpreted in many ways, and frontline workers and the organization as a whole understood safety as political. Through an extended role play scene, each worker, from the maintenance person to the executive director, knew when and how they were to respond should one of these threats become real.

> Interviewer: For someone who's a little bit skeptical about why is it my role to intervene vis-a-vis ICE and clients, what would you say to that person who's a health worker or social service crew member?
>
> Eleanora: Because people are so affected by the outcomes of what they would do and intervene in your lives and cause havoc in their lives or separate their lives or isolate them or any number of things. Take them away, separate their families. The fear that's just instilled in people, and some of them very rightly instill, because they've experienced it or they've seen it. People who've worked hard in their lives and so to have that kind of interruption or

potential loss, the little bit you gain and then the potential great loss. I think all of it fits in health because it's about the environment, it's about the kind of culture you want to build and you want to make sure that people have a life of dignity and safety at the same time. I think all of it fits in health because it's about the environment, it's about the kind of culture you want to build and you want to make sure that people have a life of dignity and safety at the same time.

Interviewer: Can you talk about how it fits in specifically to the maternal child health realm?

Eleanora: Well, I think it probably is integral just because I mean we're talking about as we're seeing, even on the news, etc., the separation of families. I think that there was such a bond often between mother and child. I think that the fear of losing that and you've witnessed so many stories at this point around women in particular, but families being separated from their children. I mean it's just tragic. It's really tragic. I think it's really important for people to feel like they're safe in this environment.

Participating in the ICE preparedness all-staff training was one of the significant experiences in my fieldwork. I arrived that morning expecting a typical all-staff training, one that might end early so I could get coffee and catch up with workers about their weekends, their families, upcoming football games. However, I sensed something was different when I crossed the street approached the entrance. There seemed to be far more activity centralized around the doorway than usual. When I greeted Gabriela, the worker on reception duty, I noticed she was examining two new bolt locks in the doorframe. She was testing them to see if they worked. She explained to me that a contractor had just installed these locks in case of a raid by ICE. Because she was one of the primary workers with reception duty, she was one of the first prepared to intervene with ICE agents. Gabriela described to me the protocol she was prepared to follow should an ICE raid occur. While I will not describe all the protocol details in order to protect the agency, Gabriela described how she would recite over the announcement system a coded phrase the safety committee had developed to signal an ICE raid. This would alert the executive committee members present in the building to come down to the front waiting room to assist her. In the meantime, designated workers with experience and rapport with undocumented clients would support these clients in moving from the agency to safe locations. Other workers would keep calm those clients who did not need to evacuate or document footage of ICE agents and police. Gabriela seemed nervous yet resolved as she recited the specific phrases she was trained to offer, the phrases the American Civil Liberties Union (Dickerson et al., 2019) advises impacted people should say when ICE agents demand entry. *Do you have a judicial warrant? I do not consent to this search. I want to speak to lawyer.*

Gabriela was also on the safety committee and would be presenting at the beginning of the training. She shared the she was nervous because, in part, just going through the motions of an ICE raid was unsettling to contemplate. I was deeply impressed with the thoroughness of the training. Everyone played their role with commitment. Even though I knew it wasn't real, I felt fear and anxiety grip my stomach when, for example, the deputy director, playing an ICE agent, stormed through the lobby demanding to see clients' identification. Those workers modeling upset and disruptive clients played their part for laughs in some moments, cutting through the palpable tension felt by contemplating an ICE raid. In an interview, Anne shared with me her first impressions of this part of collaboration on political issues:

> I noticed that when I first got here. I said, 'Is that kosher? Can we promote something?' Many companies or corporations don't allow you to be political. You can't wear political clothing. But that's an internal decision. It's just what they decide. And so, if we decide yes, let's be political, our life, I mean the personal, is political really. I mean, if you really look at things that matter, then why then shouldn't we? I remember I was only here for maybe three weeks or so, maybe it was three months, I'm not sure, but our executive director was going to speak at a rally down at City Hall, and they wanted a lot of support, so they brought some of us down so that we could stand up there with her and say yeah, we believe in her, in what she's doing, in what we're doing. So, I think it's quite wonderful that we put ourselves on the line politically, and socially.

I asked if she thought the measure that the executive director was asked to promote would directly benefit Family Center clients. She went on to say: "(T)hey have all this huge bank of money and now there's several meetings that are happening around how that money is going to be used first. So, the more involvement they have from people who are aware of what the needs are, then you again make your personal beliefs political by going to these meetings and having a say." Here, Anne speaks to the ways in which political engagement brings the agency into common cause and community with stakeholder at rallies, City Hall meetings, and meetings with the housing department officials with discretion over how funds are allocated. Both appropriating the funds and their specific allocation require political engagement. Workers engage in political action to shape the broader SDOH in their city and setting, while defining this engagement as part of their occupational duties, in order to escape the street-level bureaucrat's double-bind. The double-bind refers to being tasked with broad social welfare goals, yet never receiving the funds and resources to achieve those goals. While workers might not be able to meet the social needs current caseload, they engaged in political action to address the root causes of this scarcity.

Discussion

The SDOH is a powerful explanatory framework for understanding the role of upstream, non-clinical factors on health outcomes, especially the proliferation of health inequities. However, the exact means of providing health and social services to address the SDOH adequately remain unknown. Though health and other complex systems are increasingly tasked with affecting the SDOH, key aspects of accomplishing this – such as what constitutes the SDOH workforce are ambiguous and prone to misunderstanding. Understanding the SDOH workforce as comprised of particular "street-level bureaucrats" clarifies their roles and the constraints on their success in addressing the SDOH of MCH. Through this institutional ethnography, I seek to offer an extended case study of how one health-related social service agency delivers care in the SDOH framework and addresses MCH inequities in an urban context beset by these inequities. I understand its workers as street-level bureaucrats because they have a great deal of discretion in deciding which social factor among many to address first and how to do so, limited resources to actually meet the mandates they are given (e.g., eliminate inequities in maternal mortality, breastfeeding, break cycles of family poverty) are inadequate, and they represent the face of public policy and government to their clients. These street-level bureaucrats employ several types of collaboration as a means of enacting the SDOH framework in their setting. First, workers were highly collaborative with one another. Second, workers and the organization as a whole were highly collaborative with a major healthcare organization in proximity to their setting, in this case the local public safety-net hospital. Finally, workers collaborated (with one another and outside partners) in an explicitly political sphere.

My research surfaces two central findings. First, these workers shape and create health frameworks and knowledge like the SDOH with the decisions they make every day. Consistent with Lipsky's (1980) street-level bureaucracy theory, these workers act as gatekeepers and determine the nature and quality of services provided to vulnerable populations. Their labor is characterized by the lack of resources they have to actually achieve the broad social welfare and public health goals with which they are tasked (e.g., birth equity), resulting in an occupational double-bind. Workers use interprofessional collaboration to meet the demands of the SDOH framework, bringing them into frequent deliberation with one another. I find the SDOH framework is a complex labor process that expands the role of social workers in healthcare settings while reinforcing existing professional or social stratifications. I examine a) services as pathways to embodiment of health inequities (Krieger, 2011); and b) the ways in which social power structures workplace interactions. These findings suggest that the perspectives of frontline workers on interprofessional collaboration should be taken into account in the ongoing conversations about educating, training and supporting the SDOH workforce (Bibbins-Domingo, 2019). Not doing so may inadvertently ignore practice-based evidence or disrespect, devalue, or undermine frontline health and social services workers (Wise, 2003, p. 155). Ignoring the perspectives of frontline workers may also miss opportunities to deepen their knowledge around the importance of the SDOH or collaboration; attending to these gaps may improve communication by providing shared vocabularies and frameworks (Neff et al., 2016, 2019).

Second, I argue that these workers understand their use of the SDOH framework as part of a political practice in which they interrogate their role as representatives of the state to their clients. Workers endorsed that incorporating aspects of the SDOH framework (e.g., access to prenatal care, housing security) into service delivery is necessary but unlikely to eliminate health inequities without a simultaneous commitment to addressing more fundamental causes, like wealth inequality and institutional racism. This makes structural competency— or the trained ability to analyze the upstream factors that influence health— highly relevant to the implementation of the SDOH framework. Structural competency, an emerging paradigm in health care practice and education, seeks to address medicine's overemphasis on the individual (e.g., biology, behaviors, characteristics) while at the same time addressing the hierarchies that produce unjust health conditions (Metzl & Hansen, 2014). A growing movement of clinician-scholars, educators, and practitioners see structural competency as a means to train health practitioners to analyze, comprehend, and intervene upon the structural factors (such as wealth inequality) that impact health inequities (Bourgois et al., 2017; Downey et al., 2019; Downey & Gómez, 2018; Duncan et al., 2016; Metzl & Hansen, 2014; Neff et al., 2019).

Structural competency rejects the separation of health-related issues into discrete symptoms, risk factors, or individual-level variables and embraces a holistic view of the social, political, and economic causes of health inequities. Both a determination and a structural competency approach work to expand the SDOH framework by expanding the possibility of what could be considered a social determinant, a health problem, or a health intervention, with significant implications for the role of frontline worker collaboration (Metzl & Hansen, 2014; Spiegel et al., 2015). For example, the process by which zoning laws are crafted may be considered social determination of health where health is stratified by zip code. Similarly, coalitional political advocacy amongst health providers might be considered a health intervention to address wealth inequality. Thus, the determination approach and structural competency point to the next phase of social determinants research and practice. No doubt, new and old forms of interprofessional collaboration will be necessary as health and social services in MCH settings evolve to incorporate a structurally competent, social determinants perspective. As suggested by my findings, doing so would mean revisiting training and curricula for frontline workers, developing standard competencies for workers gaining new skills in SDOH-informed practice, and revisiting policies that govern the role and scope of frontline workers. For example, Bibbins-Domingo and colleagues (2019) recommend restructuring reimbursement and licensure policies for "social care workers"; at Family Center this could mean doulas like Katie who provide valuable assessment, referral, and collaborative intervention into the social need of marginalized women having a higher reimbursement rate to acknowledge the value of such labor.

These findings demonstrate the relevance of an institutional ethnography that engages street-level bureaucracy theory to examine what happens when an organization attempts enact and animate the SDOH framework. Street-level bureaucracy has typically been applied to public policy; this study builds on the theory by applying it to a public health framework. Consistent with similar ethnographies (Goodson & Vassar, 2011; McGibbon et al., 2010), this study shows that logics developed outside the agency shaped workers' everyday routines and duties. Additionally, it also contributes to the refinement of the SDOH by theorizing how specific health and social services workers in a unique setting deal with the broad demands of this framework. The specific experiences of frontlines of health and social service delivery, and as well as shape possibilities for those vulnerable parents who rely on workers' strategies to access quality, relevant health and social services.

Study Strengths and Limitations

Deploying an ethnographic approach, the current study design allows for extended examination of patterns and themes related to collaboration as they emerge over time and in vivo. A great deal of public health and social service knowledge is produced outside of the institutional walls in which it is fashioned and re-fashioned into real, observable constructs in the world (Smith, 2005). This study grants a rich, dynamic, and up-close portrait of a difficult to observe phenomenon in that it focuses the everyday implementation of a complex and abstract knowledge framework. As an exploratory study, this work helps clarify the exact nature of the issues at play in the enactment of the SDOH framework and inform future research on the SDOH workforce and SDOH-informed care. This study also investigates the SDOH framework as it plays out in maternal and child health and social services, which are considered an indication of a nation's health and social service system's overall functionality and therefore vital for SDOH research and practice to understand (Matthews et al., 2019).

The current study has several limitations. First, this study focused primarily on frontline worker perspectives and experiences, with the inclusion of one manager and exclusion of clients. Including additional managers and clients could enrich the analysis of the enactment of the SDOH framework at Family Center. The study design also does not account for several of the health and social policy shifts at play in Family Center's city or region that may or may not be influencing SDOH of MCH for Family Center clients or SDOH-informed practice at this field site. Participant observation with frontline workers at the agency itself inevitably limited my access to those workers whose duties occurred primarily outside of the agency, which may have led to gaps in my analysis of collaborative strategies. As demonstrated by various ethnographers, the social positionality of the researcher influences their data collection and analysis, as well as how their research is viewed by others (Bourdieu et al., 2013; Bridges, 2011; Flores, 2016; Foley, 2002; Gobo, 2008; Holmes, 2006). In ethnographic work such as the present study, interactions between the researcher and the participants become data for analysis. For example, my position as a White, middle-class, professional student who moved to the region during a wave of gentrification perpetuated by similarly situated White, middle-class professionals may have influenced the way participants spoke to me about the economic and racial inequities they observe and experience. Additionally, my health and social service-related training (as a former doula and social worker) may have influenced participants' comfort and confidence in asking me to escort clients, run errands, or convey messages and information to clients and fellow workers.

Conclusion

I ground my inquiry in the fertile debates over a more nuanced framing of the SDOH framework and workforce development recommendations for frontline workers tasked with implementing the SDOH. Health and social services settings like Family Center are dynamic sites of collaboration and innovation, shaping what the SDOH framework becomes in context of real-world client need. Wary of the reductive nature of a determinants approach, which may inadvertently promote an over-emphasis on static, individual demographic characteristics such as race or ethnicity, some scholars argue for a *determination* approach (Spiegel et al., 2015). In the face of deepening health inequities, they argue that *determination* captures the dynamic social processes affecting health status and more directly points practitioners, researchers, and policy-makers towards the systemic factors that "drive, promote and reinforce inequities" (Spiegel et al., 2015). For example, the WHO's Rio Declaration on Social Determinants of Health (2011) notes:

> The social *determination* [emphasis added] of health is much more than a collection of fragmented and isolated "determinants" that, from a reductionist viewpoint, [is] associated with classic risk factors and individual lifestyles. We must not allow the concept of social determinants of health to become banal, co-opted or reduced merely to smoking, sedentary behavior and poor nutrition, when what we need is to recognize that behind those symptoms and effects lies a social construction based on the logic of a globalized hegemonic culture whose ultimate goal is the commercialization of life itself.

Determinants do not arrive *prima facie* as such in the world; factors become determinants by the social processes controlled and shaped by specific, powerful actors. Scholars advocating for the determination approach argue that this language points more directly to the social forces that can respond to and ameliorate these inequities. Understanding frontline workers and their strategies to bring the SDOH to life, such as various forms of collaboration, may motivate their full inclusion in the development of training, curricula, best practices, and policy reforms to address health inequities, including persistent, unjust, and avoidable inequities in MCH

Chapter 3

Who and When a Family: Social Norms and the Social Determinants of Health Framework in a Maternal and Child Health Setting

Introduction

I was surprised to see the man from outside in the busy agency lobby. He was alternately leaning against the desk and weaving again…He urgently asked for a social worker. Lonnie, the front desk manager, stood up and addressed him loudly and clearly, letting him know that, "This isn't a shelter. This is a place is for pregnant women. This is a place for families" … Eleanora, a member of the executive team, looked down at Lonnie and the lobby from a third-floor balcony and gave a thumbs up. Good job, Lonnie, she said. She then gave Lonnie the name of a shelter for single adults to write down if the man, or someone else like him, should come through again.*

This passage is from one of my early field notes, excerpted from over a hundred of pages of notes I collected between August 2018 and May 2019, when I began conducting participant observation in a maternal and child health and wellness center in a large, West Coast city. This field note illustrates a fundamental tension within my field site, Family Center*, as it strives to intervene upon the social determinants of reproductive, maternal, and child health while being constrained by normative social categories around "the family" that pervade health and social service provision in the US (Ajandi, 2011; O'Brien, 2019). As noted by Cheal (2008), the family is consistently the social form through which states design political agendas, policies, and platforms, particularly related to health and healthcare, often without interrogating long-held assumptions around who comprises a family and when a family is understood to exist.

In my time at Family Center, I observed the formal and informal work practices and systems through which the private, heteronormative, nuclear, biological family becomes the standard for any family and is subsequently positioned as deserving. I also observed practices that reinforced the biosocial transformation of a pregnant body from a gestating individual into a family. Furthermore, I observed how frontline health and social service work operates within a wider welfare state that sends contradictory messages about precisely when a pregnant person and a fetus become a family. Questions of "family" are thus both categorical and temporal, centering around *who* is immediately understood to be a legitimate member and creator of family and *when* a pregnant body becomes a family. The deployment of family also poses challenges to implementing a social determinants of health (SDOH) framework. Delivering health and social services through "families" (known as the "familial" welfare regime (Esping-Andersen, 1990); in order to ameliorate health inequities may ignore the problematic social determination and of the hegemonic definition of family.

Such contestation means that Family Center is living a paradox. On the one hand, its workers promote and even celebrate a vision of reproductive, maternal and child health inclusive of the family-making of those typically excluded from model parenting—women actively using drugs, incarcerated women, poor women, immigrant women, women with open Child Protective Services (CPS) cases. Its monthly baby showers, held in an ocean blue yoga room festooned with streamers and balloons, are full of people who do not meet the requirements of an "ideal" mother, who are nonetheless welcomed and celebrated into motherhood. Its family planning case manager discusses pleasure and desire as part of sexual health, often with women and partners whose sexual lives receive stigmatization from many sectors of health and social services. Family Center workers present a counterpoint to the persistent discourses of stratified reproduction (or the systematic privileging of the fertility and family life of White, middle-class, and/or heterosexual couples) that dominate contemporary US social and political life (Colen, 1995). On the other hand, its workers are operating according to principles that transfer, whenever possible, responsibility to the private, nuclear family; divide health and social service recipients according to a binary logic "single" or "family"; and require them to balance competing definitions of when a pregnancy makes a person eligible for clinical and social service programs, particularly "family-focused" programs. For example, most pregnant clients are eligible for services and programs, such as the state's Temporary Aid for Needy Families (TANF), in the second trimester of pregnancy. However, pregnant clients ages 18 or older with no other eligible children in the home and who have obtained a high school diploma or the equivalent are eligible for TANF anytime upon verification of pregnancy. As I will demonstrate, frontline workers are both invested in supporting families and uncomfortable with the myriad definitions of who belongs in a family and when a family exists.

Drawing on Family Center as an example, I conclude that the current organization of the maternal and child health and social service system means workers navigate multiple and inconsistent narratives around pregnancy and parenting, all while holding the definitions of and support for "the family," which becomes a guiding force in an otherwise fragmented system. In the course of their navigating the reinforcement of "the family," workers play a crucial role in determining the quality and nature of maternal and child health and social services to their clients. Next, I conclude that these standards around family create unequal, tiered system of cares where those who perform the conditions of normative family, including the intent to carry a pregnancy to term, are privileged over those who cannot or do not. Such standards also presuppose that those who fall outside of the traditional family do not have families or the potential to make networks of care that are meaningful and valuable. Finally, these standards reinforce a problematic understanding of women's value as rooted in their ability to engage in production of a normative family.

From family medicine to family planning to family shelters, the family as a social form in health and social services exists relatively unquestioned. In the spirit of one of ethnography's central tenets, to make familiar the strange and make strange the familiar, I seek to deliberately trouble the assumed normalcy of the term "family" in health and social services. My analysis offers a frame for understanding family-oriented services as a site of social contestation. Rather than existing *a priori*, "the family" is best understood to be produced and reproduced by people, especially through health and social services.

Background

The Origins of "The Family"

In this paper, I seek to understand, from the perspective of a frontline worker, how discourse around the family emerges in reproductive, maternal, and child health and wellness services and in turn shapes practice. My findings must be understood in terms of the historical roots of the contemporary welfare state, the political economy of health inequities, and social movements around reproductive justice and family abolition, which interrogate the definition of family that is enshrined in social service systems (Lewis, 2019; Ross & Solinger, 2017). Following Colen's (1995) work on stratified reproduction, I argue that historical patterns and sociopolitical processes are evident in the "local, intimate, daily events" (p. 79) in which maternal and child health and wellness are brought to life. The most evident of these patterns are the Poor Laws. Dating back to Elizabethan England, the Poor Laws were a set of legal codes which demanded that the indigent, the sick, and the disabled exhaust all support from their biological family unit before seeking (heavily conditional) state-sponsored relief. When relief came, it was typically in the form of forced labor in exchange for a modicum of food, shelter, and clothing. Many have analyzed the impact of importing these principles from the Poor Laws into the US welfare state (Cooper, 2017; Ehrenreich, 2002; Eubanks, 2018; Piven & Cloward, 1972). For my purposes, the most relevant feature of the Poor Laws is their emphasis on state-managed definitions surrounding the family (i.e., married, biological, patriarchal), which formed the foundation of US social policy (Quigley, 1997). Its installation has long been gendered and racialized; the Poor Laws were re-invented during Reconstruction (Farmer-Kaiser, 2004) and the Great Depression (Piven & Cloward, 1972) in ways to provide uplift but also to reinforce racial and gender categories by delivering aid through the male head of a patriarchal, biological family unit.

When the Social Security Act created Aid for Dependent Children (ADC), it was intended to support widowed mothers and their children and was expanded to include poor women with children who may or not have been married. As the name implies, aid was designed to support a vulnerable subject–children–and, by proxy, those who were directly responsible for their existence and well-being (mothers). With ADC's inclusion of more and more indigent women and women of color following World War II came greater surveillance and punitive measures, such as "midnight raids" to discern if an able-bodied man was cohabiting with the welfare recipient (Gustafson, 2009). The assumption was that if an able-bodied man were in any capacity cohabitating with a welfare recipient, that man should a) sell his labor for wages and b) support the women and children with whom he was living. Social service workers were the frontline implementers? of this surveillance, supported by funders and legislators who envisioned ADC as part of a welfare system that could curb immoral or lazy behavior endemic to the poor and working-class (Gordon, 1999). As Gustafson (2009) states: "The unstated but underlying goals of the rules were to police and punish the sexuality of single mothers, to close off the indirect access to government support of able-bodied men, to winnow the welfare rolls, and to reinforce the idea that families receiving aid were entitled to no more than near desperate living standards" (p. 649). As fellow welfare scholars demonstrate (Abramovitz, 2018; Gordon, 1999), these underlying goals were part of a larger political project to enforce participation in the waged economy.

The relationship between the normative family, welfare deservingness, and the state becomes most explicit during the 1990s debates around welfare reform (Hancock, 2004). For example, the text of 1996's Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) begins: "The Congress makes the following findings: (1) Marriage is the foundation of a successful society. (2) Marriage is an essential institution of a successful society which promotes the interests of children. (3) Promotion of responsible fatherhood and motherhood is integral to successful child rearing and the well-being of children." Given the ways in which welfare reform promoted strict work requirements over universal uplift, critics have argued that "responsible" and "successful" refer to a nuclear family unit that can successfully compete in a market economy and, as quickly as possible, end its dependency on the state for financial and other resources (Hancock, 2004; Masters et al., 2014; Piven & Cloward, 1972; Roberts, 2017). Furthermore, critics have also argued that by promoting marriage and enforcing paternal contributions to childrearing (whether or not a mother wished to maintain a relationship with a father) welfare reform served to re-inscribe the state's role as both a judge and jury of legitimate need and of "normal" family life, just as the Elizabethan Poor Laws did (Cooper, 2017). Finally, critics have demonstrated the racist and sexist origins of welfare reform, which claimed to address broad stereotypes of "lazy" and "overly-fertile" women and families of color who relied on state support for a modicum of fulfillment of basic needs (Hancock, 2004; Roberts, 2017; Thomas, 2000).

Understanding the legacy of welfare reform is relevant to my findings regarding Family Center in three ways. First, this understanding situates the discourses and practices around "the family" in a historical and political context. Next, it demonstrates the durability and portability of downloading to families (via social service systems) debt, mutual aid, care work, and financial responsibility across multiple settings. Finally, it demonstrates the racialized and gendered expectations embedded in the normative definition of family where women's implied deservingness is in their reproduction of the private, nuclear family. In turn, welfare reform positioned the ideal private, nuclear family as middle-class and White by associating welfare with laziness and irresponsible sexual and reproductive choices, both inaccurate, violent stereotypes levied against women of color. I locate these particular ways of positioning the family as deserving as part of a long-term mission to shift the responsibility of social reproduction to the family and justify the state's abdication of its role in supporting universal well-being, particularly the well-being of poor, immigrant, and non-White women.

Social Norms and Social Determinants of Health

Elsewhere, scholars have raised concerns about the ways in which gender and family norms emerge in health practice. For example, "Where's the 'M' in Maternal-Fetal Medicine?" (D'Alton, 2010) and "Putting the 'M' Back in Maternal-Fetal Medicine" (D'Alton et al., 2013, 2019) question the subversion of the needs, outcomes, and identity of women to the fetus. This work argue that healthcare providers uphold the norm of subordinating women's needs to their children's is upheld by healthcare providers and researchers to the detriment of women's health, well-being, and autonomy. I extend D'Alton and colleagues' (2013, 2019) arguments regarding gender, social welfare, and public health to analyze the executants of these discourses—the frontline workers like those of Family Center. D'Alton's critical analysis of maternal-fetal medicine is necessary for SDOH scholarship and practice because hegemonic social norms structure the SDOH framework just as they do maternal-fetal medicine. Frontline health and social service workers tasked with implementing a SDOH framework may operate in systems that rely on prevailing social norms around gender and family (e.g., women as unpaid caretakers).

The SDOH framework, as outlined by Dahlgren and Whitehead (1991) and in the WHO (2010) the CDC (2017b), or the *Healthy People* (2020) initiatives, does not explicitly name "family" as a SDOH. However, many scholars locate the family—its conditions, relations, practices, and formation—as a SDOH (Deatrick, 2017; Inserro, 2019; McNeill, 2010; O'Campo et al., 1994; Ramos-Morcillo et al., 2019; Russell et al., 2018). For example, assertions in SDOH literature such as "(t)he well-being of families is the cornerstone on which society rests" (McNeill, 2010, p. 61) may erase the uneven, gendered labor of childbearing and childrearing that persist contemporary society born by mothers (Miller Torr & Short, 2004) and exploited workers, often women of color (Colen, 1995). Claims in the SDOH literature that the biological family exists to "socialize and protect its members" (Deatrick, 2017, p. 426) may assume that biological families are categorically safe, supportive, and health-promoting while the violence, rejection, and attendant poor health outcomes that some individuals experience in the family system are ignored (Needham & Austin, 2010; Ryan et al., 2010). When health and social welfare scholars invoke "family" as a social form while failing to consider questions around the type of family they envision (or exclude) or elide discussion of the lives of the people who work to make these families well, they reinforce a health and social welfare system that relies on some members of society to be stressed, burdened, and subjugated in order to function.

Emphasis on "the family" in the SDOH literature may also contribute to discourse which blames families (and often by proxy, mothers) for health outcomes later in life by conflating the fact that early life experiences *influence* health and life chances with the inaccuracy that early life experiences *determine* health and life chances (Wise, 2003). As noted by Jonathan Metzl (2014), some health literature proports to interrogate social determinants, but mislabels structural disadvantages (what Metzl calls "social and economic pathologies", p. 1) as "family" and then "maternal" factors. For example, one study on childhood social disadvantage, cardiometabolic risk, and chronic disease in adulthood (Non et al., 2014) measures "family instability" as being raised by a single mother. Additionally, the widely-cited Adverse Childhood Events (ACEs) Study includes as "household dysfunction" being raised by a single parent and links this experience with poor health outcomes later in life (Felitti et al., 1998). The majority of single parents are women (Pew Research Center, 2018). The assumption of such work is that simply being raised by a single mother (rather than the structural vulnerability produced by losing childcare, income, or the emotional loss of one parent in a society that privileges legally married, two-parent households) is inherently a deficit. Moreover, this discourse of blame is seen in the transformation of the relative risk relationship between maternal stress and infant low birthweight into an irreversible, causal pathway towards a generational, shared, and doomed fate of ill health and poor quality of life (Wise, 2003). While prenatal care can and should consider the ways in which health and social services can address long-term well-being, treating the in-utero period as time of definitive encoding rather than meaningful intervention may locate health inequities in mothers rather than structures, systems, and institutional forces. The SDOH framework has the potential to correct this deterministic framing and influence research, policy, and practice that considers the role of the state and other socioeconomic institutions in managing the resources, constraints, and formations of the family. However, current SDOH literature fails to adequately analyze the social norms that produce certain versions of the family as more legitimate social, political, and economic forms and the subsequent impact of this process on health inequities. In this paper, I bring together the history of the welfare state, the family, and their current influence on SDOH-informed practice to address this gap.

Data and Methods

This study employs institutional ethnography (IE), a method of social research in which researchers often embed with workers and clients in the work environment, studying contested issues in the sociopolitical world through the experiences of frontline workers (Smith, 2005). sociologist Dorothy Smith developed IE to enhance social research's capacity to deal with "every day" problems, knowledge, and relationships that are mediated through institutions like work and workplaces and are politically charged. Smith and other institutional ethnographers emphasize that micro forces (e.g., worker expectations of pregnant clients) are both result of and also impact wider political-economic structures. Distinct from many traditional ethnographies, IE eschews a focus on behaviors and norms of cultures or subcultures, and is thus part of a turn in ethnographic methodology away from study of an exoticized "Other" and towards analyzing Western institutions, including health and social service agencies (van der Geest & Finkler, 2004).

Institutional ethnography is conducted with the situational knowledge provided by long-term participation, observation, and relationships, moving beyond *description* to ask questions about *how and why* knowledge is organized, enacted, and valued in a given setting. It has been used extensively in healthcare settings, investigating how professionalized groups, such as nurses and social workers, experience their everyday decisions and conversation from the standpoint of the group itself (McGibbon et al., 2010; Mykhalovskiy, 2008; Mykhalovskiy & McCoy, 2002; Rankin, 2003; Sinding, 2010). In comparison to other ethnographic methods, IE pays particular attention to the role of text (e.g., policy memos, flyers), making it an ideal methodology for studying health and social service settings that heavily rely on written, as well as verbal and gestural communication, to create and share knowledge.

In IE, texts serve to reinforce what is considered authoritative or "ruling" knowledge in a particular field site (Smith, 2005). At Family Center, this means texts that emerge both within the center (e.g., assessment protocols, annual reports), as well as outside of the Center (e.g., Department of Housing policies and memos). IE is highly attentive to knowledge and logics "produced elsewhere" that shape participant life, and is thus ideal for a study of family norms in and through SDOH practice. Family norms shape worker and client experiences but did not necessarily generate from these workers and clients themselves (Smith, 2005). In other words, the family norms in the SDOH framework are implicit and explicit part of Family Center (and other similarly situated agencies) because these logics has been "produced elsewhere" but are nonetheless defining features of agency life. Following Holmes (2006), I utilize ethnography to "identify significant practices, political economic forces, and cultural concepts" that might be subtle or latent (i.e., definitions of family and the core elements of the SDOH; (Holmes, 2006). As I will demonstrate, many of the assumptions around health and family enforcement in fact originate outside of Family Center itself. IE is helpful in uncovering how institutional forces task frontline workers like those at Family Center with adjudicating family norms, as opposed this task arising organically from the frontline workers themselves.

The Field Site

Family Center positions itself as a family resource center (FRC), with a particular emphasis on the social determinants of reproductive, maternal, and child health inequities in the city and region. As an FRC, Family Center is part of a web of social service organizations which focus on the family as unit of intervention through a variety of integrated services. FRCs are an attempt to bring traditional case management, education, and other (e.g., medical, mental health) services under one roof in order to minimize the barriers to accessing care for stressed and vulnerable families (Cleek et al., 2012). Some FRCs are based within institutions like schools or housing projects where others, like Family Center, are free-standing (Sherman, 2015). Like the early Settlement Houses, they may also focus on reducing social isolation for ethnically, linguistically, and culturally marginalized groups (Sherman, 2015). In FRC practice, there is a sometimes implicit, sometimes explicit, assumption that the family is the primary founding unit of society, that strengthening the family will result in social cohesion. As implementation of the SDOH framework requires clinical settings to engage with social service workers, the interaction of healthcare systems and FRCs may steadily increase.

Compared to other social service agencies in its region, Family Center is mid-sized, with approximately 100 full-time employees. More than half of its employees come from its unique community health worker program, which recruits staff from former clients and the wider client community (primarily poor and working class Latinx African-American/Black women). I focus on one team within Family Center, the Health Team, which most frequently interacts with traditional clinical institutions and services (e.g., hospitals). In the client community, in philanthropic networks, and among fellow non-profits, Family Center has a reputation for connecting with women and families during health challenges to create lasting client relationships. It is located in a rapidly gentrifying neighborhood comprised primarily of first and second generation Latinx immigrants and adjacent to a growing number of tech industry employees from elsewhere in the US and around the globe. Gentrification and a housing crisis large enough to draw global attention means that many African-American/Black and Latinx residents have been displaced to working-class suburbs, but often still travel to the organizations to receive services.

I accessed Family Center through the frontline workforce. Having completed Masters of Social Work internships as a medical social worker at a hospital and next as a case manager at a similar agency, I interacted with Family Center workers as a fellow social service provider. I am also a former birth and abortion doula, which enabled me to build rapport and trust with frontline workers as we shared a similar vocabulary in social services, maternal and child health, and client well-being. The Committee for the Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

Fieldwork

My fieldwork at Family Center lasted for nine months. For six months, I visited three days per week followed by three months of two days per week. I was primarily located in the Health Team. As a participant observer, my initial activities included clerical work, making copies and internal deliveries, as well as preparing tea, coffee and snacks for weekly prenatal education (n=10) and breastfeeding classes (n=3). I attended all-staff meetings and trainings as well as Health Team meetings, all held every Thursday. I also attended activities outside of the agency. These included colloquia at the local teaching and research hospital, where community stakeholders such as Family Center staff were invited to brainstorm strategies to address some of the starkest health inequities in the city and region.

As I built trust and rapport with both staff and clients and gained more familiarity in agency practices, I began to take a more active role in agency life, particularly prenatal and breastfeeding groups. For example, in one prenatal session, after being asked by health educators who knew my experience as a doula, I led a question and answer session on the role of birth doulas in hospital settings and demonstrated the use of a scarf (*rebozo*) in labor. The agency's architecture influenced my participation. While—as demonstrated by my field note excerpt at the opening of this paper—the front door was heavily monitored by staff, once clients were in the building they had relative freedom to move between spaces, excluding the executive teams' floor. Otherwise, open doors and free access to rooms and hallways were the norm. Clients often walked into the area where I was stationed and approached me for resources (e.g., diapers, clothing), to inquire about getting a referral for certain services (e.g., doula care, prenatal massage), or to find their provider. I became acutely aware of my role as a frontline actor myself, a sort of gatekeeper to gatekeepers as I fielded questions. This provided me with a level of understanding of the frequent requests made by clients at Family Center.

In the current study, I analyzed field notes, interview transcripts, and relevant agency texts to investigate workers' perspectives on the SDOH. Participants were primarily recruited in person via an all-staff meeting as well as a Health Team meeting. Following a description of the study, consent forms were distributed and collected. This process was repeated for the Health

Team in the event that any Health Team workers were absent from the all-staff meeting. To be eligible for the study, participants needed to be 18 years of age or older, employed full or part-time or volunteering at the agency, and English-speaking (a requirement for working or volunteering at the agency). A purposive sampling approach was utilized, seeking breadth and depth of worker type.

Interviews ($n = 21$) were conducted in-person and averaged 67 minutes in length. Upon completing the interview, each participant received an incentive of a $25 gift card. The semi-structured interview guide probed for workers daily routines and practices with respect to client care, collaboration practices, and workers reflections and explanations for client health inequities (e.g., “What is a healthy pregnancy?”).

I qualitatively analyzed participants' descriptions of their daily work routines and reflections on family. All data (interview transcripts, agency texts, field notes) were read repeatedly to achieve immersion and a sense of the whole. Next, two types of content analysis were employed—directed and conventional (Hsieh and Shannon, 2005). For directed content analysis, terms from Dahlgren and Whitehead rainbow model (e.g., “living and working conditions: housing”) served as *a priori* directed codes and were applied to interview transcripts, agency texts, and field notes. Next, conventional content analysis was applied to the same data to achieve inductive category development, where data were read line by to line to capture emergent codes and sub-codes (e.g., “family responsibility”). Here, who constitutes a family and when a family is accepted as such emerged as broad themes which informed the development of codes. Throughout analysis, I employed a “*sort and sift, think and shift*” method, in which I created analytic memo profiles of each interview transcript and of groups of similar field notes to capture important emergent themes (Maietta, 2006). These memos informed the iterative development of codes, which were completed after all analytic memos were finalized. Interview transcripts, agency documents, and field notes were organized into tables and coded in Microsoft Word and subsequently arranged in a matrix that allowed for sorting (La Pelle, 2004). For analysis in this article, I focused on codes regarding family responsibility, pregnancy, and program eligibility.

In the following results, I describe workers’ general perspectives on the systems that define who makes a family and when a family is understood to occur. I also outline how workers make decisions based on family status when allocating resources.

Findings: Who and When a Family

My fieldwork with Family Center reveals that for its workers, the installation of a normative definition of family forces challenging questions around who is considered to be a member of a family, when a pregnancy constitutes a family, and what are the most critical periods in the life course for social services to intervene or invest in family life. It also reveals that frontline health and social service workers bear a burden of navigating these questions as part of their daily work routines. Here, I describe the ways family is rendered and re-rendered at Family Center. I also describe the institutions with which Family Center workers interact as a necessary part of service delivery.

Who

Who counts as family and how does this impact health and social service provision, specifically related to reproductive, maternal and child health? This became one of my most frequently revisited lines of inquiry during my nine months at Family Center. While some of my conversations at Family Center workers centered traditional gender roles (that is, female-identified mother as caretaker or nurturer), this was not universally the case. Frontline workers consistently referred to “moms and babies” and “our moms,” and in the same conversation would discuss the importance of grandparents, fathers, community members, educators, and their own relationship with clients as part of the network of care required to bear and raise children. One Health Team member was active in several state and national advisory boards and initiatives focused on supporting fathers in engaging in prenatal and early childhood care. Additionally, the standard agency t-shirts were supplemented with a pink, LGBTQ-affirming t-shirt which read, “Family Center: All Families Welcome Here” above an illustration of men, women, and children holding hands above an LGBTQ symbol. Both the plain standard t-shirt and the “All Families Welcome” were accepted as “official” uniform attire.

What united the workforce was an emphasis on family life as the site of intervention because of the absence of other forms of support. During formal or informal interviews, when I would ask workers about their role and purpose within Family Center, nearly all would respond with some version of the agency’s mission and goal to break cycles of family poverty. Workers described family in terms of its role as the default site responsibility and care because social forces such as unemployment, migration, or displacement disrupt access to care. As Katie, a health educator reflected with me while discussing an interaction she had with a homeless family on the street, “…a lot of families are totally alone in this country. This is the other thing, probably (this) mom has different illnesses because they have no family. They feel totally alone. They think nobody love them. Nobody takes care of them.” Here, Katie describes the nuclear family in terms of its key supportive role in providing for the physical, emotional, and material needs of pregnant people. Frontline workers often described their role as restoring the capacity for families to take care of themselves; annual reports, web content, and flyers also quoted frontline workers in this line of thinking. However, contradictions of this perspective do not fully reflect the complexity of frontline workers’ thoughts on the issue. Consider the following interview with a case manager from the Housing Team. Here, she discusses a new public fund for homelessness services recently approved by ballot measure. She refers to a city worker who is in charge of distributing this new fund to agencies like Family Center within the city.

> But for [Name of the Fund], he's stressed because he's literally one person handling this pot of money and it's just growing, which means more applications. And he was talking about how a lot of the other, the money for other people in that department is used, well he specifically talked about how much discussion there is around busing homeless people out of the city as a solution. And I've always heard that. I'm from [City] and I've always heard people, just side conversations, "Oh, we should just bus them out of the city as a solution for homelessness." And I wanted to ask him, what does that look like? Because I just picture us just pushing people on a bus off to another city.
>
> But he said—and this is actually, I believe sometimes it does happen and I think they may want to do it more because of this funding—and what happens is, if someone is homeless, their team at Housing and Urban Development will then ask them, "Do you have family in other parts of the US? Would they let you stay? Would they help you? Would they let you stay at their house if you went there?" And they have them call and then figure that out and have an actual plan to be

> able to live somewhere, maybe across the country. And then they pay for the bus or ticket, which is interesting to me, I guess.

Here, the assumption that family responsibility is a viable solution to a public, social crisis is apparent, echoing the responsibility of the family seen in the Poor Laws. Just like in the Poor Laws, family resources and relationships must be exhausted before the state's assistance is available. Moreover, it is the state's role to impose the participation of family members in absorbing the needs of one another. State agencies deploy resources, like bus tickets or airfare, through frontline workers to facilitate family responsibility. In other words, private, nuclear kinship—no matter where these kinship networks are located, the quality of the relationships therein, or the importance of social networks outside of kinship—becomes the site of debt, mutual aid, and care. Far from being absent, the state is present but only insofar as it will support private, nuclear family's dependence on one another.

Another instance of emergence of social norms around the family that arose in my fieldwork was the Point in Time count. As part of my participant observation fieldwork at Family Center, I volunteered, alongside about a dozen other frontline workers and two executive team leaders, in the city's annual "Point in Time" or PIT count. Each year, on a single night in January, the Department of Housing and Urban Development (HUD) conducts an annual survey of the homeless population in the nation. This report is used to measure progress on addressing rates of homelessness, to assess the efficacy of different policies, or to allocate federal funds (HUD, 2019). In Family Center's city, the task of counting the homeless population fell to a broad network of volunteers from the city's social service agencies led by a team of three research consultants.

Our PIT training occurred in the high school's basement cafeteria and consisted of an hour-long PowerPoint presentation that essentially walked us through the tally sheets we would be filling out in teams of four as well a basic safety protocol, led by a bored police officer who seemed to me like he drew the proverbial short straw that night. We were to mark off a general age category (18-35, 35-50, etc.), gender (to our discretion), location type (park, parking lot, etc.), and vehicle type, if vehicle present (car, RV, van, etc.). We were also meant to note whether our observations were of an individual, a group of individuals, or a family.

Here, "the family" as a unique and uniquely deserving site of relief and uplift emerged in that we were given specific protocols for what to do if we saw an unsheltered family. Unsheltered families were defined as at least one adult and one child staying outside, in a tent, or in a vehicle. In other words, the deployment of family resources required a child. If we observed such a configuration, we were to immediately call or text two Family Shelter Outreach team leaders (members of a municipal department created to combat homelessness), who would offer the family shelter and other "supportive services" for that evening. We were directed to be prepared to offer the team leads the street address and intersection, location type (e.g., vehicle, park), identifying information (e.g., number of people in the family). No other type of observation was identified as needing specific instructions or outreach.

Our trainers, hired from a data consulting company, explained that for the purposes of the PIT count, the HUD definition of homelessness would be used. This definition includes individuals and families who are a) living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangement; or b) with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground. Our job was to count those in the second category. The first category would be counted by more specialized volunteers on subsequent nights. The narrow definition of homelessness is in contrast to the considerably broader definition adopted by the city and my field site, which expands those considered "homeless" to include those who are "doubled-up" in the homes of family or friends, staying in jails, hospitals, and rehabilitation facilities, and living in Single Room Occupancy (SRO) units.

The local housing authority specifically recruited Family Center volunteers to bolster the counts' ability assess family homelessness, but my team of four quickly felt the difficulty in meeting this task. Several times during our shift, driving around dark streets in the city's Western edge, we were confronted with the subjective nature of deciding whether or not a group with a minor were a family. Ultimately, we did not note any families on our tally sheets. As one worker asked me rhetorically after the count, what are we supposed to do, look for a kid's bicycle outside a trailer? Given the importance of the PIT count for determining federal resources, this felt like a significant gap in the system's measurement and conceptualization of homelessness. Family Center (and their clients) fell somewhere in the middle of this gap.

My experiences at the PIT count recalled a significant moment from participant observation at all-staff training several months prior. A member of the executive team was discussing the passage of legislation that would divert millions of dollars in profits from local corporations into homelessness services. The executive team member stated to the staff "if we can get money for those tent people, we can get funding for our families, for our moms and babies!". The staff received the statement positively. I was left with questions about who "tent people" were and how are they different than the agency's "moms and babies." After informal interviews with several Health Team staff, I understand that the executive team member referred to the fact that most of the funds were earmarked for services which target the homeless individuals staying in tents and encampments (but not necessarily "families"), as well as substance use and severe mental illness in the city's homeless population. Those staying in tents and encampments would typically not have custody over a child nor be in a stable, monogamous relationship and therefore would not meet the definition of "family" for the purposes of some services at Family Center and other organizations.

In some moments, workers seemed to affirm the differential deservingness of families in comparison to single-individual, but this was not always the case. At times, frontline workers question the norms around the family versus single client dichotomy, indicating that workers are potential sites of intervention in the reproduction of complex health and social inequalities. My interview with Rosa, a mental health clinician, is an example of this questioning in process. In the course of our interview, she described a particularly memorable former client to me, a single woman, an artist and writer who lived in an SRO hotel. Rosa then looked forlorn when discussing such clients' prospects for safer, better quality housing. I asked her about her expression and she replied:

> Rosa:
> The other part about this is the housing situation in [City] is just, you know? For a woman without children, the chances are minimum.
>
> Interviewer:
> To get?

> Rosa:
> Almost anything. Women with families, they do better.
>
> Interviewer:
> Can we dive into that a little? That feels really interesting and important.
>
> Rosa:
> To prioritize—it just makes sense, that priority, you know? Because of the children, absolutely.
> But then, what about the women, you know? And when you see what's available for them, it's just horrible, and even for men.
>
> And that's why I guess tents are better.
>
> Interviewer:
> Tents are better than ...
>
> Rosa:
> Going to these shelters, which is what many people say.

Here, Rosa describes the implications of a tiered system of care where, in limited resources, "family" proximity becomes a measure of need and deserving of "better" housing services. The improvement between single-adult and family shelters is relative.

Consider the following interaction from earlier in my fieldwork. A client walked into the Health Team hub while all its workers were setting up for an event in another part of the office. Since no workers were present, I asked if I could take a message for her. This client was looking for several durable goods–an infant/toddler stroller, a Halloween costume, a car seat, and maternity clothes as well as referrals for childcare, as she had no one to take care of her toddler when she gave birth in a month. She was very calm in her conversation with me, and we joked about parking and public transit woes, but I sensed that she was close to intense frustration with her case manager, if the two were not able to meet. I was able to give her several referrals for childcare and inquired with Eliza, a health educator and lactation consultant, about maternity clothes. Everything else (stroller, car seat) would need to come through the case manager, Eliza told me. The agency's policy stated that maternity clothes are "first dibs" for those attending the prenatal education classes. Since this client could not stay for class, Eliza hesitated with me about letting her take some clothes that day. Finally, she said "well she *is* pregnant—give her some clothes." In this small, significant comment, the logic of pregnancy as a deciding factor in how to apportion limited resources emerges.

In this interaction in the field, I was stuck by the layers of discretion at work–the case managers' discretion about when and how much to communicate with their client, my discretion to take the time to not just take a message for this client and defer to her case manager but actually complete some of her asks, and finally Eliza's discretion to make a soft-break with policy and allow me to give the client some maternity clothes. Decisions like this are not uncommon. Frontline workers are often called upon to asses when and how to allocate agency resources and use client family or pregnancy status to help them decide, just like PIT count. This is not to say that need does not exist at the family level, but rather to surface the ways how, when justifying need, frontline workers use "family" as proxy for neediness because of the ways in which private, nuclear families become responsible for one another in the contemporary welfare state.

When

In addition to the categorical question of who counts as a family, temporal questions around when a pregnancy constituted a "family" emerged. Like asking "who" counts as a family, asking "when" a family begins reveals that the lived experience of many clients does not fit into the firm social categories imposed by some social services. An interview with Mayra, a manager, outlines these contradictions and their potential injustices, as well as ill-effects on pregnant people.

> What I was told, and I'm going to try to say it in a way, it doesn't sound as offensive as I heard it. The city's policy - so [State Welfare Program] is much earlier, I think they're after the first trimester. That's just because that's also part of their policy, right?. But for [city's housing department] which inherited a policy, apparently that was part of human services agencies, but just in the housing and homelessness sort of portfolio side that really was focused on making sure that people weren't going to get access to the family resources, to that emergency response system, and sort of game the system and then not actually…. (pause) to get an abortion and then not have their titles one way or the other.
>
> One [administrator of a city housing program] told me they were going to terminate the pregnancy. Then the other [administrator] said, "Well, maybe they lose the baby, but either way they're no longer a family because they're just a single adult." Which was really, as a mom, it was a really hard thing to hear. I think even if that was the fear, I think the real chances of that being the strategy for a large portion of people experiencing homelessness, to try to get into the family system with a wait list of over a year for resources, are low. It just, it doesn't, I would think that the city could implement different safeguards and practices and policies around, what it means to have your pregnancy letter. What it means if later on you do choose a different path, what would be a different option to exit that you back into the single adult system?
>
> I just think you could really, if there was the political will, you could really problem-solve your way around that issue. It has just been a longstanding policy.

The pregnancy letter referenced is the formal document ultimately signed by a clinician (typically a physician, sometimes a nurse practitioner or nurse-midwife), which confirms the pregnancy and that it meets the criteria for high-risk. In her reference to this letter, and in the above anecdote in general, Mayra references a specific feature of services at the intersection of health, social services, and housing and the ways that pregnancy complicates the imposed categories of "family" at play in each of them. She also references imposition of these categories as outside knowledge that works its way into Family Center; a longstanding policy held by another agency nonetheless determines key aspects of Family Center's service provision. In

Family Center's city, a pregnant person is eligible for application for shelter in the family system at their third trimester (i.e., seven months). With a waitlist of over 100 days, most pregnant people do not enter the family shelter system until after they give birth.

One way to enter the family shelter system earlier than the third trimester is with a documented high-risk pregnancy. According the National Institutes of Health (2018), high-risk "describe(s) a situation in which a mother, her fetus, or both are at higher risk for problems during pregnancy or delivery than in a typical pregnancy," a broad definition that leaves room for worker discretion. Family Center workers are thus key actors in demonstration of high-risk pregnancies as one of several assessors, writers, and senders of the "pregnancy letter," a document that establishes eligibility for several programs including housing. Here, the shelter and housing system defers to a combination of "clinical" and "social" risk to determine eligibility and prioritize clients for entry. Clinical factors to establish "high-risk" pregnancies, verified by medical providers, include diabetes, high blood pressure, infections, complications resulting from previous pregnancies, or maternal age. "High-risk" social factors—the domain of Family Center workers—include exposure to intimate partner violence, food insecurity, poverty, and current inadequate housing or lack of housing. Risk—and therefore proximity to family shelter services—increases with gestational age. Implicit in the pregnancy letter is that the client intends to bring the pregnancy to term and parent—it is the pregnancy as part of the emerging status as a "family" that renders a person eligible for this resource.

The medical profession asserts itself most directly in the temporal construction of family more than the categorical. Both frontline workers and clients rely on medical knowledge—or, perhaps more accurately, knowledge-power—to determine the fact of a pregnancy, the degree of riskiness of a pregnancy, and therefore eligibility to for certain services. This is not a one-way exchange of knowledge-power, however. Case managers could testify to risk—and therefore eligibility for family status—by attesting that "social" factors like inadequate housing and homelessness, intimate partner violence, or food insecurity are damaging a client's health, through the pregnancy letter. While case managers can generate and weigh in on the contents of a letter, it is the clinician's medical judgement that ultimately finalizes the determination. The letter may be submitted to an employer, a shelter, a lawyer, or the welfare office in order to secure resources or services or a change (typically an increase) in resources or services. In the course of my fieldwork, I saw case managers as ready and broadly willing to suggest and write "the pregnancy letter" for clients; it was a frequent topic of discussion at Health Team meetings. I interpreted this as both a genuine desire to help vulnerable clients and exercising the opportunity to demonstrate with and to medical providers that social factors are relevant to health outcomes.

Given the broad definition of risk, it is then for frontline workers, with final approval of prenatal healthcare providers, to determine whether and which "lifestyle conditions" might create a high-risk pregnancy. Lifestyle conditions refer to a range of behaviors, resources, and characteristics recognized by the medical system as potentially impactful to maternal and child health. This could be employment status, educational attainment, and family structure (i.e., presence or absence of a partner and co-parent). By understanding social determinants such as inadequate housing as a lifestyle condition productive of medical risk, these workers document in "the pregnancy letter" information that establishes a possibility of poor infant health outcomes and therefore expedite eligibility for the family shelter system. By providing documentation that is used to determine the transformation of a pregnant person into a family, they may, in an effort to secure resources for their client, contribute to upholding a system that prioritizes norms of the private, nuclear family over the actualities of poor, unhoused pregnant peoples' lived experiences. Importantly, frontline workers and clients must both operate within a system that implicitly understands maternal health to be important in so far as it determines future infant health; the need for adequate shelter is articulated in relation to risk to a *pregnancy*, not the pregnant person.

Discussion:

At a time when families are being separated at the US border, by our carceral state, by the child welfare system, why apparently argue against the family as a site of relief and uplift? Where does interrogation of this social form ultimately take us? Given the seemingly undeniable and familiar "good" of lifting up the family as unique and uniquely deserving, I seek to unpack wider social assumptions embedded in that notion. Social assumptions around the family operate in a context of neoliberalism. A key feature of neoliberalism is the installation of the nuclear family, and not the state, as the first and most privileged site of wealth concentration, wealth transfer, debt, mutual aid, and care (Cooper, 2017). The family has sometimes been invoked as an example of the morally "deserving" subject of social welfare, as compared to the morally "undeserving" single, able-bodied adult who could work but chooses not to. Deservingness is also equated being a promising investment of resources, including case managers' time and shelter. *Biovalue* is an instructive concept here, one that links logics of deservingness and investment. If biovalue is the "yield of vitality produced by the reformulation of living processes" (Waldby, 2002, p. 310) that can then be directed toward the realization of health and wealth, then here the family is the living process that can be formulated and reformulated to produce a yield of vitality in order to realize health and wealth (therefore absolving the welfare state of responsibility to equitably distribute resources and eliminate health inequities).

An ideal type emerges. This normative version of family has value through its proximity to motherhood and childhood, its vulnerability, its reproduction of social codes around productivity and responsibility, and its deserving of relief. Co-constituting the family's social value is its investment potential. Family Center's mission of using the motivation of pregnancy and new parenthood to inspire families to engage in services that will end generational poverty echoes a neoliberal discourse around personal motivation, achievement, and success being key features of health and wealth creation. This mission rests on a logic that generational poverty can be overcome through motivation. Here, supporting the family becomes a way to foster an economic unit to such a point where it is no longer in need welfare and social services support in order to sustain itself. Then, its adult members are both expected and required to sell their labor in the market and dependents will be supported by working adults, and not the state. Here, I build on Mann's (2013) work investigating the role of community health center workers and Latina sexual health. Mann argues that "bourgeois heteronormativity," or the adherence to a life course trajectory that conforms to middle-class, heteronormative ideals such as financial independence, is an organizing principle in health center work, albeit unevenly. Like Mann, I find that reproductive, maternal and child health are contested arenas in which the definition and regulation of family is made and unmade through health and social service provision even when a setting like Family Center seeks to intervene upon the SDOH.

Taking an SDOH approach is not necessarily an equity approach. Like other ethnographers of health and social services (Bridges, 2011; Seim, 2017), I conclude that the marginalized can be both helped and hurt, in the same interactions and in the same institutions. As Family Center shows, implementing the SDOH framework means that frontline workers are reckoning with problematic social categories through which health and welfare systems organize services. This dynamic complicates historic understandings of the welfare state, where welfare is understood to be part of the soothing "left" or soft hand of the state, distinct from the "right" or hard hand, which punishes and coerces (Seim, 2017). In fact, coercion and enforcement of problematic social codes occurs in and through aid as well. Such enforcement may be obscured from workers themselves. For example, exclusionary housing policy does not originate within Family Center, nor do workers have a direct say in how it is produced. Yet, it determines many aspects of their service provision. This explains how workers can inadvertently uphold systems based on problematic and moralizing principles of the private, heteronormative, nuclear family. Like Walsh and Mason (2018), who analyze changing familial forms and everyday social work practice in England, my findings suggest that frontline service providers may recognize gaps in policy while "myriad constraints complicate the application of these understandings" (p. 603), indicating a delay between the consciousness of a frontline workforce and the policies they implement.

Taken together, these findings suggest the limits of building any or all of a health and social services system around the mainstream definition of family. Simultaneously, these findings demonstrate the potential role of frontline workers in advocacy and intervention in the wider social determinants of health–what Dahlgren and Whitehead call the general socioeconomic, cultural conditions–for defamilial approaches to maternal and child health and social services (Esping-Andersen, 1990). Because these frontline workers experience and analyze the contradictions present in contemporary US health and social services, they may be well-positioned to highlight the impacts of this system and foster the political will needed to build systems that can meaningfully address health inequities without reifying problematic social categories (Braveman et al., 2011b). For example, universal childcare, healthcare (that includes contraception and abortion services), transportation, and education could more equitably distribute the labor of care work without reinforcing women's role as caretaker. In writing about a particular definition of the family (and its pitfalls) within Family Center, I build on the scholarship and activism of Black Feminist Marxists such as Hortense Spillers (Spillers, 1987) and Angela Davis (Davis, 2019) to argue that health and social equity will require more definitions of family, not fewer. As feminist and family abolitionist scholar Sophie Lewis (2019) notes, creating social welfare systems which support the *extension* and not elimination of the bonds of kinship, trust, care, solidarity present in families can and must be the goal of a just society (Lewis, 2019). In short, "let every pregnancy be for everyone" (p. 26). Further research and theory-building must explore the role of frontline workers in bringing to life such a vision of the SDOH framework in action, as well as if and how reconfiguring agency practices regarding the family could advance more equitable health and social services systems to support myriad relationships of care and mutuality.

Chapter 4

From Apathy to Structural Competency: Implications for the Social Determinants of Health Framework

What they need, what they feel they need, is a quality of mind that will help them to use information and to develop reason in order to achieve lucid summations of what is going on in the world and of what may be happening within themselves.

C. Wright Mills, 1959

Introduction

Maternal and child health (MCH) inequities are persistent health and social welfare issues in the US. For example, across nearly every measure of MCH, Black women experience far worse outcomes than White women and children (CDC, 2019; Hoyert & Miniño, 2020; Mathews & Driscoll, 2016). Evidence suggests an economic gradient whereby lower-income women and children face poorer MCH outcomes than middle and higher-income women (Messer et al., 2008; Savitz et al., 2004; Slade-Sawyer, 2014). Notably, inequities such as those in infant and maternal mortality have not meaningfully improved over time (Murphy et al., 2018; Hoyert & Miniño, 2020) MCH outcomes are often seen as a reflection of the overall functioning of a health and welfare system and society (World Health Organization; WHO, 2018) and are highlighted as key metrics in the United Nations Sustainable Health Goals (United Nations, n.d.). Therefore, inequities in MCH may point to overall failures in the US approach to health and healthcare.

To understand the nature of health inequities, including those in MCH, scholars, policy-makers, and frontline service providers turn to the social determinants of health framework (SDOH; Adler et al., 2016; Chaiyachati et al., 2016; Exworthy, 2008; Graham, 2002; WHO, 2010). This framework outlines the layers of factors, including and above the individual, that shape health outcomes. The SDOH framework elucidates how political and economic forces and categories (e.g., racism and race, patriarchy and gender, wealth, and inequality) overlap to produce avoidable, unjust, and unfair group-differentiated vulnerabilities to injury, disease, and death (Bambra et al., 2010). However, these forces influence and produce health outcomes unevenly (Link & Phelan, 1995; Riley, 2020). Given the combination of social forces and environmental conditions, some social determinants may be more salient at a given time and place. For example, a recent study examined recent US immigration policy as a social determinant of MCH and demonstrated that Latino infants born in Iowa after an Immigrations and Customs Enforcement (ICE) raid had significantly lower birth weights than White babies born at the same time in the same state (Novak et al., 2017). Additionally, some levels of the social determinants framework may be more fundamental drivers of health status than others; in particular, economic systems and phenomena such as wealth inequality drive factors at the community, family, and individual levels (Braveman & Gottlieb, 2014).

The Frontline Health and Social Service Worker

How do frontline workers, tasked with intervening in health inequities, understand the distinctions between and within the various social determinants of health? Frontline workers have a key role in shaping what the SDOH framework becomes when it “hits the streets,” yet most extant scholarship on the SDOH has undertheorized the role and experiences of the frontline workers who are tasked with bringing this framework to life (Bandyopadhyay, 2011; Chaiyachati et al., 2016; Dean et al., 2013; Marmot et al., 2008). Previous research demonstrates that frontline workers shape and even create public social policy through their daily decisions and practices (Lipsky, 1969, 1980). This argument is extended in the present paper to suggest that frontline workers are also shaping a public health knowledge framework, the SDOH. Drawing from an institutional ethnography of frontline workers in a maternal and child wellness center in a large West Coast city, the present study examines these workers' perspectives on the etiology and origins of the interlocking health and social inequities that they see every day. Exploring the perspectives of frontline workers may improve the efficacy of education, training, and health and social welfare practice in the SDOH framework. It may also improve understanding of how to support the emerging SDOH workforce (Bibbins-Domingo, 2019).

This paper first turns to C. Wright Mills' (Mills, 1959) seminal work on "sociological imagination" to understand workers' perspectives on the SDOH framework and its implementation. Next, I argue that vis-à-vis the SDOH framework, the sociological imagination exists on a continuum ranging from apathy or burnout to possessing a sociological imagination, and finally, to structural competency (Metzl & Hansen, 2014). The latter is an emerging paradigm in health education that emphasizes the trained ability to analyze and intervene upon the upstream factors producing health inequities and shaping clinical and social service encounters. Taken together, these concepts demonstrate the range of possible perspectives that frontline health and social service providers bring to health inequity work and the SDOH.

Background

Sociological Imagination

Sociological imagination is the capacity to step outside of one's own routines and habits to understand one's immediate experiences as part of a larger whole, both structurally and historically. It is also the ability to interpret one's own and others' actions as both influencing and influenced by the social context (Mills, 1959). Developed by sociologist C. Wright Mills in the late 1950s, sociological imagination is the capacity to distinguish between "troubles"—idiosyncratic personal dilemmas—and "issues." The latter are public problems that may be experienced individually but are contingent upon connected institutional, structural, and historical forces beyond the control of any one person. By developing a sociological imagination, Mills argues, the indifference of various groups is transformed into involvement with public issues. "Neither the life of an individual," he writes, "nor the history of society can be understood without understanding both" (Mills, 1959, p. 7). Mills warns against the dangers of lacking a sociological imagination, which leads to both individual and collective apathy or burnout expressed as a dismissal of the social nature of crises and injustices, such as health inequities. Notably, Mills discussion of apathy includes an analysis of those who express pity or regret at the misfortune of others but do not consider this misfortune structurally. Individuals and whole societies may become accustomed to issues such as poverty even while agreeing that such issues are regrettable.

As apathy and burnout are key concerns for the health and social service workforce (Dyrbye & Shanafelt, 2011; Gabassi et al., 2002; Siefert et al., 1991), fostering the sociological imagination has been of interest to scholars who study health and social care (Barry & Yuill, 2016). Their work advocates the importance of seeing poor health outcomes as individually embodied, yet structurally determined (Schulz et al., 2001). However, sociological imagination is a broad and general orientation to the world, which makes it necessary but insufficient to fully analyzing and intervening upon health inequity. Informed by fieldwork with frontline workers intervening in MCH inequities, the present paper argues that relationship to engagement with the SDOH exists on a continuum ranging from apathy and burnout exist to possessing a sociological imagination to structural competency.

The Social Determinants of Health Framework

The SDOH framework understands an individual's life chances—in this case, health outcomes—as a public issue, not a result of behavior, genetics, or individual choices alone. Specifically, poor health is the embodiment of social conditions, the product of a social system that values the health of its members unequally and creates persistent unfair, avoidable, and unjust morbidity and mortality (WHO, 2011).

Researchers and policy-makers have used several models to describe the social factors that determine health (Institute of Medicine, 2003). Dahlgren and Whitehead's rainbow model (Dahlgren & Whitehead, 1991) is a common visual representation in the field of health inequities (Institute of Medicine, 2003) that comprehensively outlines the range of factors influencing health. This model (Figure 2) illustrates specific distinct layers of factors radiating from individual lifestyle through general socioeconomic, cultural, and environmental conditions. In their initial description of this model (1991)), Dahlgren and Whitehead emphasize the fixed nature of the most central factors—age, sex, and constitutional characteristics. The next three layers are those that are mutable and sensitive to changes in policy or environment. For example, lifestyle factors such as the level of physical activity may be influenced by neighborhood safety ("social and community networks"). In turn, neighborhood qualities may be determined by the income or employment status of the individuals and groups in that neighborhood ("living and working conditions"). Finally, general socioeconomic, cultural, and environmental conditions—the most outer layer—govern the ways in which all the factors contained in the rainbow model emerge and play out. Dahlgren, Whitehead, and others' subsequent work on the SDOH also addresses the need to acknowledge the interaction of these factors (Bambra et al., 2010; Braveman et al., 2011; Link & Phelan, 1995).

While there is little empirical research on health and social service providers' perspectives on specific SDOH models (Noriea et al., 2018)—including the rainbow model—a body of empirical literature on the general perspectives on social factors of providers such as physicians, nurses, and social workers (Bullock, 2004; Comfort et al., 2015; Craig & Muskat, 2013; Megaritis et al., 2018; Miles et al., 2006; Miller & Apker, 2002; Noriea et al., 2018; Park et al., 2018; Wear & Kuczewski, 2008) is available. This work suggests that knowledge and endorsement of the evidence around SDOH among frontline workers are uneven. For example, a recent systematic review of physician narratives regarding obesity found that physicians often rate individual factors (e.g., behavioral, physiological, genetic) as more influential than social ones (e.g., income, employment, food access; (Noriea et al., 2018). Similarly, as Park and colleagues (Park, 2008; Park et al., 2011, 2018) show in a review of social worker perspectives on topics such as resilience and immigration, despite social workers arguably receive more training on social inequality than other frontline workers, they tend to adopt individualizing discourses that obscure the role of the sociopolitical context in producing health risks. This paper responds to a gap in the literature around frontline worker perspectives on the SDOH in general and the rainbow model in particular.

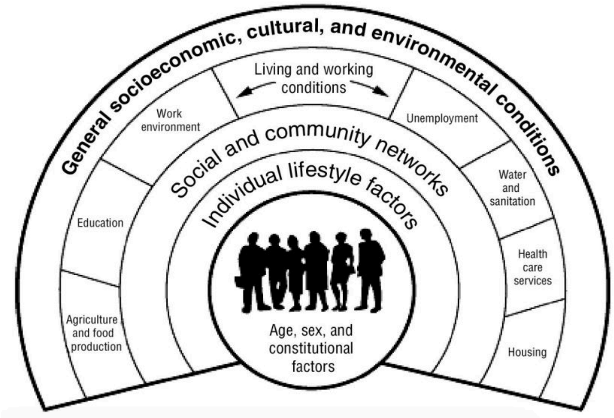


Figure 2. The Dahlgren and Whitehead model of the social determinants of health, 1991

Structural Competency

Uneven knowledge and embrace of the social factors that influence health outcomes raise concerns among public health scholars, social theorists, medical sociologists and anthropologists, and those who link lower-quality client or patient care with providers' incapacity to consider upstream factors and intervene in them (Bourgois et al., 2017; Bridges, 2011; Farmer et al., 2006; Paul et al., 2017). Out of such concerns, physician-scholars Metzl and Hansen (2014) developed structural competency as a medical educational framework to train clinicians in analyzing the systems that produce health inequities and working to change them. Structural competency has been embraced by other health professions, such as nursing (Duncan et al., 2016), social work (Downey et al., 2019), and psychology (Ali & Sichel, 2014). These professions have elaborated on the applications of structural competency in the health and social service practice. Across disciplinary boundaries, the structural competency literature argues that structural competency may mitigate provider apathy and burnout in a time when providers are leaving the health (Harris Interactive, 2011; Pathman et al., 2002) and social service professions (Gabassi et al., 2002; Kim et al., 2011) due to, among other factors, lack of ability or confidence to address the complex overlap of clinical and social need. Structural competency contains five intersecting skill-sets: (1) recognizing the structures that shape clinical interactions, (2) developing an extra-clinical language of structure, (3) rearticulating "cultural" presentations in structural terms, (4) observing and imagining structural intervention, and (5) developing structural humility (Metzl & Hansen, 2014). As I will discuss, frontline workers in the current study are already engaging with some of these elements as part of their perspectives on the SDOH framework, such as rearticulating "cultural" presentations in structural terms and developing an extra-clinical language of structure.

Structural competency calls on providers to overcome apathy and burnout by acting collectively—with one another and with patients or clients—to change the problematic structures and institutions that create avoidable differences in health status (Metzl & Hansen, 2014). Here, structural competency fills in an important gap in the SDOH framework. While the SDOH framework is a powerful analytic tool, it falls short of making and defining action-oriented commitments to systems change. It has also proven insufficient in combatting clinical and social care narratives that foster "highly advanced knowledge of the biological impacts of lived environments alongside relatively undertheorized analyses of the environments themselves" (Metzl & Hansen, 2014, p. 129). Structural competency relies on the foundation set by sociological imagination and the social determinants of health while moving providers into action-oriented, collaborative strategies at the sociopolitical level and providing more patient-centered care at the individual level. Structural competency is thus a necessary expression of the SDOH framework in action. This study explores frontline worker perspectives on health inequities to inform the development of structural competency theory, education, and practice-models.

Methods

This analysis utilizes data from nine months of participant observation in a maternal and child wellness center (hereafter, Family Center) to assess frontline worker perspectives and experiences navigating the SDOH framework as part of their occupational duties. The ethnography shows that workers possess a robust sociological imagination concerning their clients' experiences with health inequities. Additionally, workers draw upon the principles of the SDOH to explain the persistent MCH health inequities they face, such as preterm birth, low birth weight, and maternal mental health. Ethnographic work that focuses on the perspectives of frontline workers stands in contrast to the common practice in which the development of public health knowledge frameworks is the purview of scholars and policy-makers, and frontline workers are a "blank slate" relative to health equity education, training, and practice.

Institutional Ethnography

This study employs institutional ethnography (IE)—a social research method in which researchers embed with participants in their daily lives and routines. Institutional ethnography investigates contested issues in the sociopolitical world through the experiences of participants whose lives are shaped by institutional forces (e.g., health policy, social welfare programs), such as frontline human service workers (Smith, 2005). The present ethnography included discourse analysis of agency documents (i.e., flyers describing group classes, annual reports), participant observation, and in-depth interviews with frontline workers and one manager. IE was developed by sociologist Dorothy Smith to enhance social research's capacity to deal with everyday problems, knowledge, and relationships that are mediated through institutions like work and workplaces and are politically charged. Smith and other institutional ethnographers emphasize that micro forces such as worker expectations of pregnant clients are the result of wider political-economic structures; at the same time, those expectations impact on said structures. Distinct from many traditional ethnographies, IE eschews a focus on the behaviors and norms of cultures or subcultures and is thus part of a turn in ethnographic methodology away from the study of an exoticized "other" and towards Western institutions, including health and social service agencies (van der Geest & Finkler, 2004).

IE is informed by the situational knowledge provided by long-term participation, observation, and relationship, moving beyond description to ask questions about how and why knowledge is organized, enacted, and valued in a given setting. It has been extensively used in healthcare settings investigating how nurses, social workers, and other professionalized groups experience their everyday decisions from the standpoint of the group itself (McGibbon et al., 2010; Mykhalovskiy, 2008; Mykhalovskiy & McCoy, 2002; Rankin, 2003; Sinding, 2010). Compared to other ethnographic methods, IE pays particular attention to the role of texts (e.g., policy memos and flyers), which makes it an ideal methodology to study health and social service settings that heavily rely on written communication to create and share knowledge. In IE, texts serve to reinforce what is considered authoritative or ruling knowledge in a particular field site (Smith, 2005). At Family Center, this means texts that emerge both within the center (e.g., assessment protocols and annual reports) as well as without (e.g., Department of Housing policies and memos). The SDOH framework, disseminated through text, thus plays a ruling role at Family Center, although much of it is produced outside of Family Center. IE is highly attentive to knowledge and logics produced elsewhere that shape participant life, and is thus ideal for a study of the SDOH in action; this knowledge shapes worker and client experiences but did not necessarily generate from these workers and clients themselves (Smith, 2005). The present analysis assesses frontline workers' conceptions of the origins of MCH inequities surfaces possible areas of intervention to improve SDOH practice and develop its workforce.

The Field Site

Family Center is a 30-year-old non-profit maternal and child wellness center located in a large West Coast city. Since its inception, it has placed emphasis on addressing the social determinants of maternal and child health inequities in the city and the surrounding region. Compared to other similar social service agencies in the area, Family Center is mid-sized, with approximately 100 full-time employees. More than half of its workers come from a unique community health worker program that recruits staff from former clients and the wider client community (primarily poor and working-class Latinx and Black women).

The present study primarily focuses on the Health Team, which most frequently interacts with biomedical institutions (e.g., hospitals and clinics). The Health Team is also charged with tracking what are traditionally understood as medical issues and outcomes, such as contraceptive use and discontinuation, access to prenatal care, preterm birth, birth weight, or breastfeeding initiation. The Health Team's holistic approach to MCH has helped to establish the Family Center's reputation and reach. In its client community, in philanthropic networks, and among fellow non-profits, Family Center has a reputation for connecting with women and families during health challenges to create lasting and often multi-generational client relationships. It is located in a rapidly gentrifying neighborhood primarily comprised of first- and second-generation Latinx immigrants and adjacent to a growing number of tech industry employees from elsewhere in the US and around the globe. Due to gentrification and a housing crisis large enough to draw global attention, many Black and Latinx residents have been displaced to working-class suburbs and nearby cities, but often still travel to the organization to receive services. These social forces emerge in the sociological imagination of frontline workers and their application of the SDOH at the field site, as I will demonstrate.

Fieldwork

For nine months, the researcher spent two to three days each week conducting fieldwork at Family Center, primarily with the Health Team. As a participant, the researcher's initial activities included clerical work, making copies and internal deliveries, escorting clients to appointments, as well as preparing tea, coffee, and snacks for weekly prenatal education and breastfeeding classes. The researcher attended all-staff meetings and trainings weekly, as well as weekly Health Team meetings. She also attended activities outside of the agency. These included colloquia at the local teaching and research hospital where community stakeholders, such as Family Center staff, were invited to brainstorm strategies to address some of the starkest health inequities in the city and region.

As a social worker and former birth and abortion doula, I was able to build rapport and trust with frontline workers because they read her as sharing a social service approach to maternal and child health and well-being. As she gained more familiarity in agency practices, I began to take a more active role in agency life, particularly prenatal and breastfeeding groups. For example, in one prenatal session, after being asked by health educators who knew my experience as a doula, I led a question and answer session on the role of birth doulas in hospital settings and demonstrated the use of a scarf (*rebozo*) in labor. The agency's architecture also influenced my participation. While the front door was heavily monitored by the staff, once clients were in the building, they had relative freedom to move between spaces, excluding the executive team floor. Otherwise, open doors and free access to rooms and hallways were the norm. Clients often walked into the area where I was stationed and approached me for resources (e.g., diapers, clothing), to inquire about getting a referral for certain services (e.g., doula care, prenatal massage), or to find their provider (e.g. case manager). I became acutely aware of my role as a frontline actor myself, a sort of gatekeeper to gatekeepers as I fielded questions. This provided me with a level of understanding of the frequent requests made by clients at Family Center and provided enhanced participant observation.

Interviews

Participant observation assisted me in identifying the relevant participants for semi-structured interviews, which in turn provided insight into my experiences in the field. In my fifth month of fieldwork, I began interviews with frontline workers on their daily work routines, experiences, and perspectives on health inequities. I also interviewed one member of Family Center's executive team who served in a managerial role over all frontline participants. Overall, a purposive sampling approach was utilized. Given the study's focus on health inequity, I began by interviewing a sample of Health Center workers. Interviews ($n = 21$) were conducted in-person at a mutually agreed upon location within Family Center and averaged 67 minutes in length. Upon completing the interview, each participant received an incentive of a $25 gift card. The semi-structured interview guide probed for workers' daily routines and practices concerning client care, collaboration practices, and workers' reflections and explanations for client health inequities (e.g., "What makes it hard for some clients to be or stay healthy?"). Perspectives on the SDOH framework were elicited at the close of interviews when participants were shown an image of Dahlgren and Whitehead's (1991) rainbow model and explicitly asked to describe and analyze it. This model was selected because it balances a comprehensive overview of SDOH with clarity and brevity. It was also selected because of its citation in seminal work by major health organizations such as the WHO (2010).

Analysis

Data analyzed for this paper include field notes, interview transcripts, and agency documents. I qualitatively analyzed participants' descriptions of their daily work routines, reflections, and explanations for health inequities. An iterative process was implemented based on an integrated approach. The latter combined a priori codes with codes derived inductively through a close reading of the transcripts (Bradley et al., 2007). In informal interviews conducted during participant observation, all participants spoke of a social origin of the health inequities faced by their clients, emphasizing factors beyond individual behavior or genetics while differing in the specific details and SDOH framework level. This initial observation informed the subsequent full coding and overall analysis. All data (interview transcripts, agency texts, field notes) were read repeatedly to achieve immersion and a sense of the whole. Next, two types of content analysis were employed—directed and conventional (Hsieh and Shannon, 2005).

For directed content analysis, terms from Dahlgren and Whitehead rainbow model (e.g., “living and working conditions: housing”) served as a priori directed codes and were applied to interview transcripts, agency texts, and field notes. Conventional content analysis was applied to the same data to achieve inductive category development whereby data were read line by line to capture emergent codes and sub-codes (e.g., “origin of health inequity”). Sociological imagination and principles of structural competency emerged as broad themes that informed the development of codes. Overall, I employed a “*sort and sift, think and shift*” method, in which I created analytic memo profiles of each interview transcript and of groups of similar field notes to capture important emergent themes (Maietta, 2006). These memos informed the iterative development of codes, which were completed after all analytic memos were finalized. Interview transcripts, agency documents, and field notes were coded in Microsoft Word and subsequently organized into a matrix. For subsequent analysis, I focused on codes regarding work routines, reflections, and explanations for health inequities, alongside directed codes drawn from the Dahlgren and Whitehead rainbow model.

In the following results, I describe workers’ general perspectives on the origins of health inequity and subsequently, their reflections on the of the SDOH framework (i.e. instances in which workers located the causes of health inequities in a specific tier of the rainbow model or responded to a specific facet of the framework). I also outline how workers described the possibilities for intervening in the social factors that shape health inequity beyond the individual level. Finally, I describe these results in terms of a continuum of possible frontline worker perspectives on the SDOH, ranging from apathy and burnout to sociological imagination and finally to structural competency.

Results

In interviews and participant observation, all workers spoke of the social origins of their clients’ health outcomes, including the MCH inequities that they encountered as part of their daily lives within the agency. Notably, analysis from interviews and participant observation stood in contrast to agency documents (which framed services as healing, soothing, and empowering for individuals and families while not directly challenging or analyzing systems of inequity). In contrast, frontline workers and the two executive team members saw appropriate social services in their setting as necessarily engaging with factors beyond the individual or family unit. Workers also discussed the high stakes of a lack of commitment to seeing health outcomes beyond the responsibility of the individual client. In contrast, agency documents emphasized client responsibility in engaging in services. Blame and bias on the part of health and social service providers were seen in interviews and participant observation as barriers to ethically engaging with clients and genuine SDOH-informed practice.

I begin by describing how worker interview responses and fieldwork recall Mills’ sociological imagination and address the problematics of apathy and burnout. Next, I describe the how worker responses and fieldwork fit into the SDOH framework, specifically which factor in the SDOH framework workers foregrounded. Finally, I describe how structural competency can be understood as an expression of the SDOH framework in practice and can support the growing SDOH workforce, such as that of Family Center, in grappling with health inequities.

Against Apathy: Sociological Imagination at Family Center

Workers’ responses can be understood as evoking sociological imagination. The responses surface an endorsement of a worldview in which health inequities are understood as reflective of and exacerbating social problems. Furthermore, workers were aware of their own place in the social structure. Mills (1959) refers to this as being "imaginatively aware of the promise of their own work" (p. 6). Consider Sam, a social work case manager on the housing tea who stated in an interview: "Of course health is more than your genetics and your lifestyle choices, right? I mean, anyone with a lick of sense understands that, right? It's just common sense," demonstrating how, for her, possessing a sociological imagination was a practical, common-sense part of her approach to intervening in health inequities. She went on to reflect, "I probably see things differently since I've worked here than I did before that because it does open your eyes to what people have to struggle with, which I might not have had that same kind of struggle, you know, within my own life." Sam linked her experiences as a frontline worker with the development of a sociological worldview. By understanding her clients' health status as more than a personal struggle and her professional role and work in a broader social context, she demonstrated the uses of sociological imagination in a workplace where intervening upon health inequity is the goal.

Mills (1959) describes sociological imagination as a remedy against apathy or the lack of valuing any higher social ideal to the point of total indifference, detachment, and an end of curiosity, which may also be understood as a form of professional burnout or "cynicism and loss of commitment" to improving client or patient lives (Maslach, 1976, p. 16). Like Sam, Family Center workers spoke of professional apathy and burnout as a key barrier to truly addressing health inequity, supporting Mills' assertion that social apathy in the form of blaming those who are suffering from health inequities for their plight contributes to social problems. As noted by Eileen, a mental health clinician, "it's much harder to make changes when you have lots and lots piled up on you. And also when you've got a society that is also making you (a pregnant person) at fault."

Ali worked as a prenatal and postpartum engagement coordinator in the Health Team, focusing on outreach and service initiation for pregnant clients, as well as clients who had given birth in the last six months. Ali was also a first-year medical student at a local teaching hospital. During our interview, in response to a question about how her early education and training around MCH impacted her daily work at Family Center, she threw up her hands and stated:

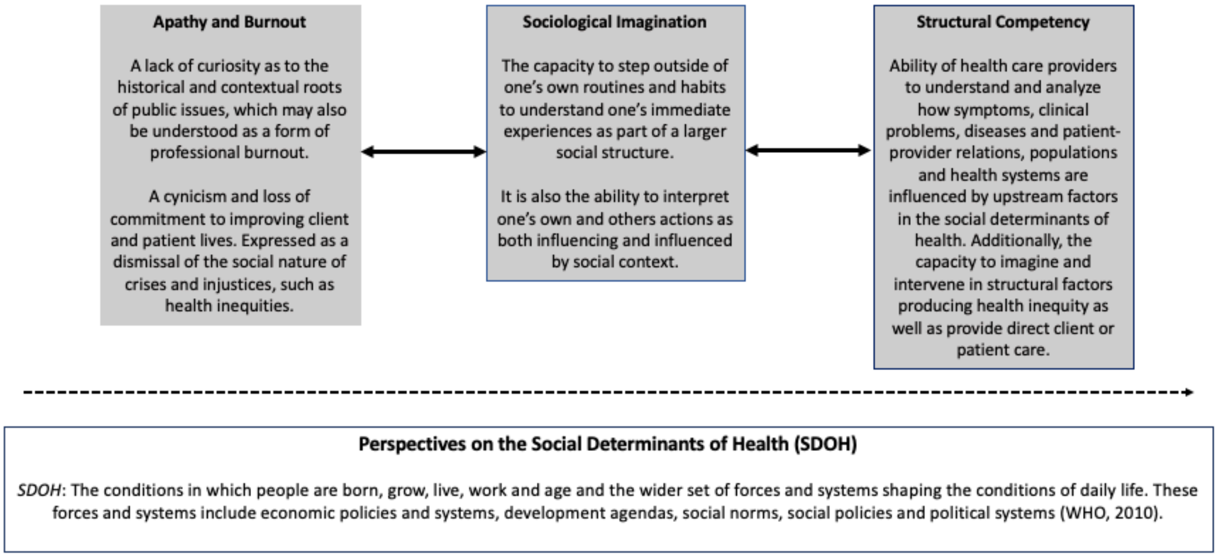
> In the classroom, the material has historically been presented as like without any structural context on, like, why are people injecting drugs? Why might somebody experience homelessness? There just, like, isn't really any context. It's part of just like, in many cases, race-based medicine, like give African-American patients this medicine, or like Asian populations are more likely to be subject to this disease. Instead of like, well, what an anti-racist care would look like, "Okay, let's look at the structural reasons for why some of these things might be true. How are people ended up in more marginalized positions, and how does that affect their health? What can we do about it? How are we changing it? Okay, if this disease is endemic to this region, why is that? Are we using race as a proxy for genetics? If so, how good of a proxy is that?"

She went on to express frustration at health and social service providers outside of Family Center who were content with a "race-based medicine" approach and who, consciously or unconsciously, relied on racial, ethnic, or class stereotypes to make health and social care decisions. She described Family Center as a counterpoint to her medical education and a broader culture in health and social services in which individuals are blamed for their health failures. Ali portrayed these providers as lacking a sociological imagination around how patients and populations come to be disproportionately impacted by poor health.

Similarly, Anne—a health educator on the Health Team who focused on breastfeeding and prenatal education—reflected on the broader culture of health and social services, which she saw as ethically problematic and detrimental to patient or client care:

> There are core elements that sometimes get placed on a level of unimportance, when in fact they should be the primary. So, let's say this person comes in, and they could be disregarded because, oh, they're drunk. Or they're really very poor. Let's see this person here because they look like they're dressed better, or something like that…Some people are there just to put in their eight hours, they only have four hours to go. Is *that* how you're measuring your day, or are you measuring your day by how you can influence health in your clients or in the patients?

Anne describes the apathy and burnout that emerge in the clinical or social service encounter, which may be understood as a lack of sociological imagination around the connections between a client and their presentation, socioeconomic position, or health status. Exploring how to foster sociological imagination in health and social service settings may involve addressing provider apathy or burnout and improving client care. Figure 3 presents a novel framework developed from these findings to understand the range of provider responses to their own role vis-à-vis health inequities. Apathy and burnout are common challenges in the allied health professions (Dyrbye & Shanafelt, 2011; Gabassi et al., 2002; Kim et al., 2011; Siefert et al., 1991; Spickard et al., 2002), and often emerge in beleaguered and under-resourced settings that serve populations impacted by health inequities. Expressed as a cynicism, detachment, and loss of commitment to improving patients' lives, apathy and burnout are barriers to patient care and the delivery of health services (Gabassi et al., 2002; Metzl & Hansen, 2014). Borrowing from Mills' view on how to engage with individually experienced social phenomena, sociological imagination is a counterpoint to clinical apathy and burnout. Next, the SDOH framework presents a specific application of the sociological imagination to the particular sociopolitical problem of health inequities. Finally, structural competency advances the sociological imagination and the endorsement of the SDOH and provides a framework for collective action and direct health services that challenges narratives of blame, bias, and individualization of social problems. Importantly, these are not fixed perspectives, nor is structural competency a level of permanent mastery. Rather, this continuum suggests that provider perspectives can shift between these core lenses on the social world; therefore, frontline health and social services work require consistent reflexivity.



Apathy and Burnout

A lack of curiosity as to the historical and contextual roots of public issues, which may also be understood as a form of professional burnout.

A cynicism and loss of commitment to improving client and patient lives. Expressed as a dismissal of the social nature of crises and injustices, such as health inequities.

Sociological Imagination

The capacity to step outside of one's own routines and habits to understand one's immediate experiences as part of a larger social structure.

It is also the ability to interpret one's own and others actions as both influencing and influenced by social context.

Structural Competency

Ability of health care providers to understand and analyze how symptoms, clinical problems, diseases and patient-provider relations, populations and health systems are influenced by upstream factors in the social determinants of health. Additionally, the capacity to imagine and intervene in structural factors producing health inequity as well as provide direct client or patient care.

Perspectives on the Social Determinants of Health (SDOH)

SDOH: The conditions in which people are born, grow, live, work and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (WHO, 2010).

Figure 3. The Apathy-Structural Competency Continuum

Worker Perspectives on the SDOH

Workers identified the most relevant aspects of the SDOH framework for their work in improving clients' health status in in-depth, semi-structured interviews. In this section, I describe how responses fall into three levels of the SDOH in Dahlgren and Whitehead's rainbow model: 1) social and community networks, 2) living and working conditions, and 3) general socioeconomic, cultural, and environmental conditions (see Figure 2). Importantly, workers also highlighted a key aspect of the SDOH framework, namely, the fact that these issues may overlap or influence one another. Their responses indicate the possible range of conceptions under the SDOH framework when applying it to MCH as well as the need for potential research and education to further clarify the causes and drivers of MCH inequities to frontline workers and improve practice.

Social and community networks

Five workers endorsed social and community networks as the most relevant tier concerning the MCH inequities that they tackle as part of their daily work. For example, Marilyn—a health educator and program coordinator on the Health Team—noted:

> We know that (social and community networks are) the protective factor, specifically for our work with trying to change outcomes for children who are raised in the environment, in the family, that is a protective factor, to have parents who are supportive in social networks. There's a limit to the amount that we are able to change, the overall social world and community that clients operate within, but, to the extent that we create new communities within our clients, there's some level of an influence there.

Similarly, Gabriella, a social work case manager on the Housing Team, stated:

> Healthy pregnancy is a lot of things. The first thing I think of is support and not being alone in the pregnancy. It's nutrition. It is being housed. It is having the education to know how to take care of your body, access to prenatal care. I think the biggest part of having a healthy pregnancy is not being completely alone in that experience, and being able to have a supportive community or at least supportive people to be able to hold someone from that process.

These comments reflect and reinforce two fundamental dynamics observed in the course of fieldwork. First, workers could shift their practice focus and analysis between different tiers and facets of the SDOH framework before settling on one as the most salient. This suggests both mutability in their understandings of the SDOH and opportunities for the worksite to clarify its theory of change around health equity using the SDOH framework. Second, the social and community factors were more a core part of Family Center's public-facing image than other aspects of the SDOH endorsed by workers. Annual reports directed at funders, flyers advertising group classes and services directed at clients and, to some degree, frontline workers, and Family Center's web content emphasize the agency's health and social services as part of a mission to strengthen the family and to give clients a positive experience of prenatal care and childbirth. In a context where overtly addressing sociopolitical aspects of Family Center's work such as the provision of housing and health services for oppressed and marginalized people may be alienating to funders, partners, or clients, emphasizing social and community networks may be a strategy to ensure maximum reach.

Living and Working Conditions

Most (12) interviewed workers endorsed living and working conditions as the primary tier concerning MCH inequities. Within these responses, four defined housing as the most relevant aspect of this tier. This may be due to the marked lack of affordable, safe housing in the city in which Family Center has operated for the last three decades. Consider the response of Layla, a social work case manager on the Health Team. She connects housing access to income, linking this factor to the broader socioeconomic tier of the rainbow model while focusing on housing as the most salient factor, for her, in Family Center's work:

> I think that it's just really hard to stay healthy when you're not housed. So, I think housing is a human right, and I think that really, if we want a healthy society, we need everyone inside. And so being able to be housed is the biggest barrier. And the barriers to being housed, a lot of times, is income. Where we live it is extremely difficult to find market-rate housing that a client or that any person can afford who is not making an upper-level salary at a job.

Michael, another social work case manager on the Housing Team, also brought up housing as a social determinant of MCH. He immediately connected housing (and another living and working conditions factor, water and sanitation) to unemployment: "If you're unemployed, you're not going to have access necessarily to sanitation and water because you're not going to have a house over, a roof over your head, which is the housing part right? And then of course you're not…so it's almost like the unemployment leads you to this (points to water and sanitation), and the work environment leads you to this (points to housing).” Here, Michael’s response is an example of how workers may also understand the interaction of social determinants.

General Socioeconomic, Cultural, and Environmental Conditions

Other workers described the broadest tier—general socioeconomic, cultural, and environmental conditions—as the most relevant. General socioeconomic, cultural, and environmental conditions may refer to a range of concepts, including economic systems and distributions of wealth and resources, norms and values, or governance structures. As with other tiers, participants were not directed on how to convene these concepts. Four workers identified this tier as the most relevant set of determinants and located their work as shifting dynamics at this tier. Anne, a health educator on the Health Team, endorsed socioeconomic conditions—specifically naming capitalism and contingent wealth inequity—as the main driver of health inequity.

> Well, we look at the government that we have now, and we know that we are a capitalist society, that we have 10% or two percent of the population takes 90% of the money, of what we make here, so when there's that much of a disparity with income there's always going to be people at the lower echelon, and the middle class is getting shrunk, so you get a few more richer but a lot more poorer, and the middle class has quite shrunk. Not that I'm promoting a middle class per se, that’s not what I’m saying; we all should, we could have a classless system, but we don't.

One worker, Andrea, a deposit coordinator for the Housing Team, noted policy as the most important aspect of the general socioeconomic tier: “I’m just thinking of policy. That's really going to make or break a community, I feel like, which is hard to explain. Just because of the people in power that have so much of a say for communities that they know nothing about.” Similarly, Mayra, an executive team member, described policy as a specific expression of “general socioeconomic conditions” in action.

> Yet there's still a major disconnect between what we know to be true and our continued policies and practices that just continued to perpetuate that even though we say that we're really committed to not continuing those negative policies, or having that same disproportionate impact on communities of color or poor communities. Yet we continue to have practices in place or limiting resources in a way that automatically excludes certain populations…I think for the Department of Housing in particular, it's very important that there be more individuals on their staff that reflect the population that they serve and or have lived experience with, having experienced homelessness or housing insecurity. That's not currently the case, and so it makes for policy that sometimes can feel nonsensical to those that are experiencing homelessness or housing insecurity because the people who are making the policies don't necessarily understand the realities of what it means to actually go through.

Other workers endorsed the broadest tier of the framework as most important to their work by describing it as an orientation towards who is valued and who is not. For example, Sarah, a social work case manager on the Health Team, connected wealth inequity to a problematic social worldview and value system, as opposed to the presence or absence of income or access to employment: “It's (the socioeconomic tier) so important because, well, in the US, maternal mortality is actually not very low. It's fairly high, and similarly with infant mortality. Being able to have a healthy pregnancy and a healthy birth is something that our society doesn't throw all its resources at like some other societies, and it's so segregated by wealth.” Here, wealth inequity is understood to be a driver of healthy pregnancy and birth. Distinct from individual-level income or employment status, which other workers described as part of living and working conditions, wealth segregation is understood to be a wider issue of socioeconomic, cultural, and environmental conditions to which an increase in income or a change in employment is secondary.

Innovations on the SDOH framework

Three respondents proposed, unprompted, changes to the Dahlgren and Whitehead (1991) SDOH model, suggesting that frontline workers have practice knowledge to contribute to the SDOH framework’s development or that the SDOH framework can be adapted to specific worksites as part of workforce development. Jessica, the social work case manager in the Health Team, responded to the visual of the SDOH framework in terms of its limitations. She ultimately found the framework useful but too static to capture the complexity of social forces that she considered as relevant to health inequity:

> I think what stands out to me about this is that there is no active blame, it's not calling out the actual structures. It's just saying like “housing, health care, water, and sanitation.” Like “socioeconomic, cultural, and environmental conditions” are such a general blameless term as opposed to like oppressive structures that actively hold people down. What if that were like in this beautiful rainbow? I think a lot of social determinants models can remove blame and make it sound like it's like this yeah, it's just listing things. I like how it moves inward toward the individuals, but there is no mention of racism or interpersonal violence or anything like that, capitalism, White supremacy, like any of those things. It's just like conditions, which is great. This is a great “101.”

Marilyn, the Health Educator and Program Coordinator in the Health Team, shared that she would add a level to the SDOH visual between its living and working conditions tier and its general socioeconomic tier to describe her clients’ experiences:

> I think that a lot of the really big things that our clients are up against fit in between the outer and the second to outer category, in the intersection between how do we view poverty, how do we really think about that as a society, and how do we think about people in situations of poverty? How do we structure our society to take care of people or not? All of those things, it's kind of right in between the systems level and the community philosophy level.

Finally, Eleanora, an operations manager, described an interpretation of the SDOH framework that also addressed a need for a more dynamic visual—one that could capture relationships between factors. The following quote suggests similar themes in the work of

Breihl (2008), Krieger (2008), and others who have attempted to advance a more dynamic model of the social determinants of health—one that captures the direct impact of structural forces on people's lives and survival.

> I think general socioeconomic, culture, environmental conditions, I would put that much closer (to the individual). Because I think those conditions include racism, and what kind of services are being given to the people in general as opposed to, you know, social services.

Overall, participants displayed rejection of apathy and burnout, strong sociological imagination, and the endorsement of the SDOH framework as necessary knowledge forms to their work in intervening upon health inequity. They also displayed several components of structural competency as outlined by Metzl and Hansen, as discussed below. Moreover, some frontline workers innovated on the Dahlgren and Whitehead rainbow model, suggesting that frontline workers have potential contributions to this public health knowledge framework.

Discussion

In conclusion, this research reveals insights into the relationships between frontline health and social service worker apathy and burnout, the sociological imagination, and structural competency vis-à-vis the SDOH, particularly those determinants of maternal and child health inequities. Workers in this study contrasted apathy and burnout with embracing the SDOH. The perspectives of such workers inform the SDOH framework at a key era in SDOH research and practice, when scholars and policy-makers are calling action and implementation (Braveman et al., 2011; Kelly et al., 2007; CDC, 2017; WHO, 2010). To summarize the results of this analysis, social/community networks, living and working conditions, and general socioeconomic, cultural, and environmental conditions emerged as the most common aspects of the Dahlgren and Whitehed model of the SDOH highlighted by frontline workers as most salient to the production and organization of MCH inequities. Additionally, frontline workers also proposed innovations on the framework, highlighting the need for knowledge and practice frameworks to capture the relations of power, social hierarchy, oppression that contribute to health inequities. Frontline workers also problematized the idea that general economic, cultural, and environmental forces are distal and therefore far from clients in line with critical public health scholarship on the politics of causation (Krieger, 2008). This work states that instead of focusing on a framework where proximal "biological" factors (such as birthweight) are given causal strength and distal "social" factors (such as racism or poverty) are considered far and removed from individuals, those seeking to intervene upon health disparities should turn their gaze to the relationships, "levels, pathways, and power" that produce pathologies in the first place.

Fieldwork, including workers reflections on the SDOH framework, revealed that workers are invested in cultivating a sociological imagination regarding health inequities because they feel that understanding clients' suffering in terms of social forces and historical context is a counterweight to apathy and burnout, which in turn impede client services and professional duties. Workers also displayed the capacity to develop a general sociological imagination into an analysis of specific social forces such as racism and poverty and MCH inequities. Moreover, as workers are engaged developing extra-clinical language for health inequities and rearticulating "cultural" presentations in structural terms, they are engaged in several elements of structural competency, as discussed below.

The current study provides an in-depth, textured portrait of a difficult to capture construct, i.e., the enactment of public health framework in a contemporary MCH services setting. By highlighting the perspectives on frontline workers on their daily work attempting to address health inequities, this work offers a novel approach to studying the emerging SDOH workforce and its needs, perspectives, and experiences.

In the tradition of critical, post-structuralist ethnographers, I also harness my own social position as a data point (Bourdieu, 2015; Goodson & Vassar, 2011; Holmes, 2006; Mykhalovskiy & McCoy, 2002; Smith, 2005). Relationships between myself as the investigator and participants informed all stages of the project from design to analysis. In this case, for example, my identity as a White, middle-class, professional student who moved to the region during a wave of gentrification perpetuated by similarly situated White, middle-class professionals may have influenced the way participants spoke to me about the economic and racial inequities they observe and experience. My positionality in this sense may have positioned me as an outsider. On the other hand, my health and social service-related training (as a former doula and social worker known to frontline workers) may have positioned me as insider, which in turn may have helped participants' trust my presence in the agency as well as give me an autonomy over my time, allowing me access to people and spaces within Family Center unescorted. Finally, I have participated in several structural competency trainings myself as part of my home institution's working group, which influences my knowledge and investment in applying this particular educational paradigm to this data.

The current study also has several limitations. By excluding managers and clients and focusing solely on frontline worker perspectives and experiences, I limited my data to one subset of agency life. Including managers and clients could enrich the analysis of the perspectives on the SDOH framework at Family Center. By limiting my study to one agency in one city, I Even so, this element of the ethnographic study did allow for rapport building and depth of understanding, beyond self-report, of frontline workers experiences. Participant observation with frontline workers at the agency itself inevitably limited my access to those workers whose duties occurred primarily outside of the agency, which may have limited my understanding of how frontline workers applied their perspectives in other contexts or settings. This gap is an opportunity for further scholarship. For example, additional research should explore the perspectives of health and social service workers in biomedical settings such as hospitals and clinics on the SDOH framework.

In the course of my fieldwork, I found that all workers described the origins of health inequities as social, thus indicating strong sociological imagination. Nonetheless, there was variation in their diagnosis of which social forces were the most important in their work and in determining aspects of their clients' lives. While engaging in structure, their responses did not necessarily offer a coherent analysis of how to address any given MCH health inequity structurally. This is understandable given the lack of consensus on how to implement the SDOH framework in real-world practice (WHO, 2010) and the complexity of health inequities. Responses ranged from seeing family as the primary social determinant of health to housing access and quality, from environmental conditions, such as air, water, and soil quality, to community agency, and from social welfare policy to sociopolitical forces, such as racism and capitalism. Within the same conversation, some workers toggled between different tiers of the SDOH framework to explain the same health inequity. Such language reflects a broader discussion in the SDOH literature around which factors or set of factors drive health inequity and how to discuss complex social forces (Tull et al., 2005). For example, while some SDOH research continues to examine factors at the "living and working conditions" level of the framework, Link and Phelan (1995) discuss the need for analysis and practice to reflect an understanding of "fundamental causes." Similarly, Braveman and Gottlieb (Braveman & Gottlieb, 2014) call for the recognition of a "cause of causes," with Braveman and colleagues (Braveman et al., 2011) arguing that harnessing "political will" is required for any SDOH intervention to truly eliminate and not merely tinker at the edges of health inequities.

These results also indicate that frontline workers in Family Center are already engaging with many of the key elements and questions of structural competency, such as recognizing the structures that shape clinical interactions or developing an extra-clinical language of structure (Metzl & Hansen, 2014). For example, Family Center workers demonstrated an ability to understand racial inequities in health as inequities, or the physiological impacts of racism on pregnant people as socially contingent, and spoke of racism itself as a social force. Family Center workers also connected this with the ability to empathize with clients and de-stigmatize the need for social services. Additionally, some workers added innovations and interpretations to the SDOH framework when the Dahlgren and Whitehead model was presented to them, indicating that frontline workers have valuable insights concerning this popular public health framework. Examining and understanding their perceptions and experiences will inform education, training, and development of an expanding SDOH workforce.

Therefore, their perspectives on the SDOH framework and its application to MCH practice informed this author on the development of a continuum of perspectives on health inequities, with apathy and burnout on one end and structural competency on the other. Advancing the notion of a continuum of perspectives vis-à-vis the SDOH and health inequities may help foster provider self-reflection and shift from an emphasis on the linear achievement of mastery that dominates health services education (Metzl & Hansen, 2014). Frontline workers' insights may also inform the development of structural competency trainings, education, and curricula to teach frontline workers how to collaborate and intervene to end health inequities meaningfully. To date, few studies have empirically investigated the sociological imagination, perspectives on the SDOH framework, or structural competency of frontline health and social service providers—including MCH providers. Further research should examine whether and how to incorporate their insights into health and social services theory, curricula, and praxis.

Sociological imagination is a necessary but insufficient step towards structural competency. By cultivating the sociological imagination emergent in health and social services providers, we may foster empathy with clients, guard against burnout—a key concern for the health and social service workforce—enhance provider buy-in to the SDOH framework, and inform the implementation of structural competency curricula in multiple settings. I offer the preceding framework to understand the continuum from apathy or burnout to sociological imagination, specifically related to an endorsement of the SDOH framework (a specific application of the sociological imagination to health inequities) through to structural competency. The continuum represents the shift and fluctuation in frontline worker perspectives; adequately addressing health inequities requires continual reflection on praxis. By demonstrating that the frontline workers of MCH are poised to uptake structural competency and put it into practice, researchers can motivate future developments of this promising educational paradigm. Additionally, by understanding structural competency in relation to apathy and burnout, sociological imagination, and the SDOH framework, it is possible to develop a richer insight into the perspectives of those with the most intimate knowledge of service delivery.

Chapter 5

Conclusion

The SDOH play an indelible role in shaping individual's life chances, to the point where one's zip code tells us more about one's outcomes than one's genetic code (Slade-Sawyer, 2014). In the face of avoidable inequity, scholars of the SDOH advocate for shift from issue or disease-specific thinking to research and practice that motivates the political will to end all forms of exploitation and create social, political, economic resources and equity (including health) for all (Braveman et al., 2005, 2011; Spiegel et al., 2015). As the frontline workers and managers in this study indicate, those with the most intimate experiences of service delivery in the MCH (these "street-level bureaucrats") have valuable perspectives to share on key aspects of this conversation. For example, their specific collaboration strategies inform a broader discussion of interprofessional collaboration at a time when frontline workers are increasingly called upon to work together to eliminate health inequities, often without specific training or the support mechanisms to truly follow through on this task. Next, these frontline workers are making, remaking, and reinforcing definitions of the normative, private family in a welfare state that delivers social reform as well as social control through "family" services. Finally, the perspectives of frontline workers offer a means of considering the uses of the sociological imagination as applied to the SDOH and ultimately, a promising health education framework, structural competency. Health and social service workers are a potentially transformative sector of the broad SDOH stakeholder community. Fostering their ability to analyze and intervene in health inequity is essential to any equitable redistribution and restructuring of resources.

As I have demonstrated in these three different aspects of frontline health and social service work, the terms of the SDOH framework are ripe for revision, particularly with regards to how and why they are engaged in clinical and social service settings. Future research should explore, empirically as well as theoretically, the ways frontline workers are shaping what this framework becomes in the daily labor of health and social care. This scholarship must attend to several relations of power. First, this scholarship must attend to the fact that addressing the SDOH requires the collaboration of myriad professionals, whose collaboration may stir existing disciplinary boundaries and social hierarchies. Second, this scholarship must also attend to the fact that relations of power shape health and social categories in the first place, such as the normative family. Frontline workers are often implicated in this categorization process on their patients or clients. Finally, this research must acknowledge that frontline workers' endorsement of the SDOH exists on a continuum and is a necessary but ultimately insufficient step towards adequately conceptualization of SDOH intervention. I argue that structural competency (Metzl & Hansen, 2014) advances the SDOH framework by taking its explanatory power and given workers' the tools to analyze the upstream, institutional, and seemingly invisible factors that produce the inequities they tackle every day. As Michael Lu (2019), former director of the MCH Bureau, US Department of Health and Human Services, states: "the future of MCH will depend on our effectiveness in bringing about social and political change in the coming decades." The results presented in this dissertation can thus serve as fodder and motivation to rethink systems of health and social care where frontline workers are given the proper training, resources, and consideration commensurate with their vital role in our society.

Appendix 1:

Comprehensive List of Services at Family Center

Comprehensive List of Services at Family Center

Internal Services	**Description**
Case Management Services	Longitudinal support for families facing various challenges related to poverty, including domestic violence, substance abuse, parent-child-separation and immigrant status. Divided in case management (CM) and Intensive Case Management (ICM; for clients experiencing or at risk of homelessness, mental health crisis, clients with active CPS cases, and clients with medically high-risk pregnancies)
Health Team	Prenatal education classes, alternative health services, post-partum and parenting groups, with a specialized program for women with high-risk pregnancies, including doula care.
Housing Team	Limited, short-term financial assistance and workshops that help families obtain and retain safe and stable housing.
Childcare Team	On-site quality childcare for children while their parents participate in services. Family Center also has an outdoor Wellness Garden for young children with specialized curriculum led by child development teachers.
Emergency Support: Basic Needs	Assistance with food, clothing, diapers, baby and children's items, hotel and transportation vouchers in crisis situations.
Mental Health Team	On-site individual, couples, family and group therapy for Family Center clients.
Community Health Worker Team + Training Program	A one-year job training program that prepares economically disadvantaged women for careers in the nonprofit sector.
Family Economic Success Program	Tax preparation services, one-on-one financial education support, as well as support in accessing public benefits.

On-site Partners	**Description**
Teaching hospital research program	Specialized therapy for families with children 0-6 who have experienced domestic or community violence.
Financial Literacy	Individualized financial coaching for budgeting, debt management and building credit.
Charter School	Onsite education services to help clients complete high school diplomas and GEDs.
Project Legal Aid	One-on-one legal assistance, resources and referrals.
City and County Food Bank	Assistance with Supplemental Nutrition Assistance Program onsite enrollment; food bank on-site
Public Hospital	Onsite prenatal care and childbirth education classes led by nurse-midwives.
Teaching Hospital-affiliated clinic	Reproductive health center, primarily serving youth and young adults, co-located with Family Center.

Appendix 2:

Interview Guide

Interview Guide

1. Tell me a little bit about yourself.
    a. Probes
        i. Where are you from?
        ii. Where did you go to school?
        iii. What got you interested in the work you're doing now?
2. Tell me about your job - what is your role here?
    a. Probes
        i. How long have you worked here?
        ii. Why FAMILY CENTER? What led you to work here?
        iii. How did you come to be employed?
3. Take me through a typical workday.
    a. Probes
        i. What do you do when you first get here?
        ii. How does the rest of the day go?
4. What are your feelings about your work?
    a. Probes
        i. What do you like about your work?
        ii. What's an example of a time you felt successful or enjoyed your work?
        iii. What helped you feel successful/enjoy?
        iv. What is challenging about your work?
5. At work, what types of fellow workers do you collaborate with the most and why?
    a. Probes
        i. What qualities do you look for in a collaborator?
        ii. ii. What qualities do you look for in an innovator?
        iii. Do you think collaboration is valued here?
        iv. Why or why not? How would you describe the training you received to do what you do now?
    b. Probes
        i. What types of professional development classes did you take/are you taking related to your job?
        ii. What were the most memorable? Helpful?
        iii. What were the least helpful?

6. Tell me about your clients.
    a. What is a typical day like in the life of one your clients?
        b. Pick one client you feel has a life that may represent the population you work with. Let's give them a pseudonym (or something that signals not to use their real name).
        c. Probe:
            i. Why are they coming to FAMILY CENTER?
            ii. What could help your clients achieve their goals?

7. Can you tell me about a time when a client succeeded in meeting their health and wellness goals? Let's give them a pseudonym.

8. What do you want clients to walk away with after interacting with you?
9. What do you think are the biggest facilitators to health for FAMILY CENTER clients?
10. What do you think are the biggest barriers to health for FAMILY CENTER clients?
11. Some people believe that people's health is related to individual choices and even genetics, and others say that it is factors beyond the individual that shape health. What do you think?
12. I understand that FAMILY CENTER works with people during pregnancy and early childhood - why does your organization do that? How does your work impact people's lives [Preface with description of life course (some people think that there are key moments in our lives that impact health most)]?
    a. How are these events linked?
    b. Some people say that pregnancy and early life play a role in people's overall health throughout their lives – What do you think? How do pregnancy and early life events play a role in people's health?
13. Professional differences...what is the role of [social work/public health/counseling/program evaluation] in addressing health disparities between groups?

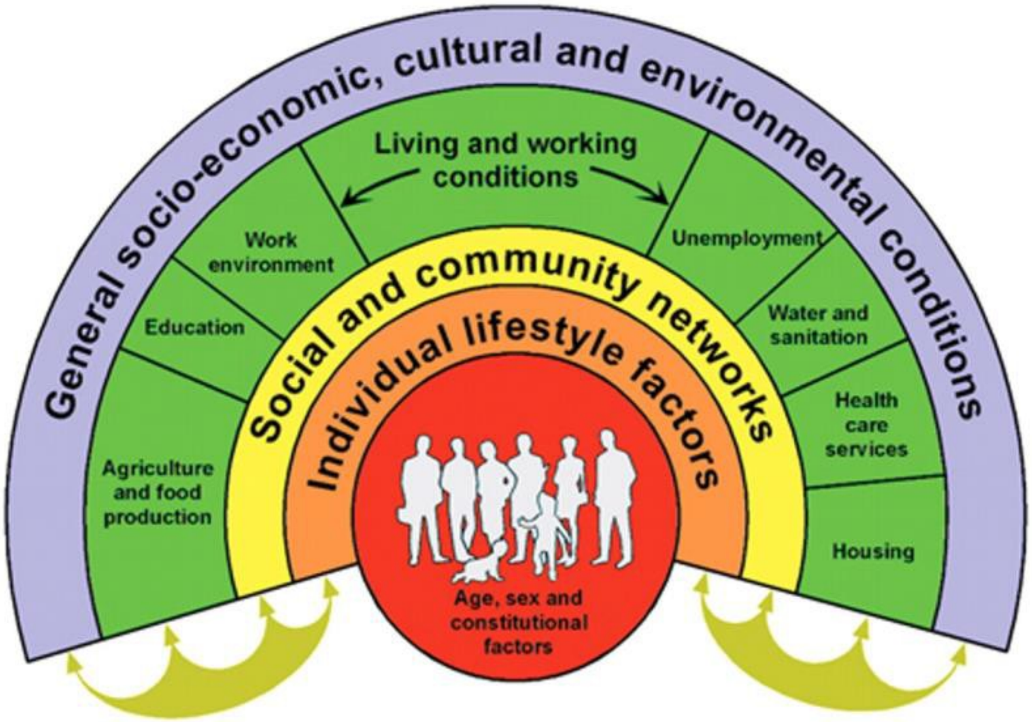
Role of health workers in general, support for health workers

14. What do you think the ideal (program in which they work) would be like?
15. Has working here influenced your own development as a person/clinician/practitioner?
    a. Probes
        i. Why or why not?
        ii. How?

16. FAMILY CENTER seems really unique. Does anything support you in the work that you do?
    a. Probes
        i. What supports you?
        ii. What doesn't support you?
        iii. Tell me about a time when you felt [supported OR unsupported].
17. *Present visual of the SDOH and the Life Course:*
    a. Probes
        i. What do you think of this image?
        ii. How does this apply to your work?

Visual of Social Determinants of Health

b. Source: Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies


General socio-economic, cultural and environmental conditions
Living and working conditions
Work environment
Education
Agriculture and food production
Unemployment
Water and sanitation
Health care services
Housing
Social and community networks
Individual lifestyle factors
Age, sex and constitutional factors

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