150th Anniversary Video

Throughout our nation's history, APHA has been there. We've been on the ground fighting for the public's health since 1872, taking on diseases, poverty and sanitation at the turn of the century. We were there when Rosa Parks and Martin Luther King Jr called for equal rights and continue today fighting to end racism and counter all of its devastating health effects. We were there encouraging auto safety standards and calling for seat belt laws. Since then, we continue to support work to make our cars and roads safer and reduce injuries. APHA was there when women made their voices heard and supports their ongoing fight for equality and control over their own health. We fought for access to care as AIDS spread across the country and continue working to ensure easy and equal access for all to vaccines for COVID-19, the flu and other infectious diseases. We've been sounding the alarm about climate change's impact on human health by raising awareness and the world is listening.

Change is happening, but these next years are so important. We need your help to shift the tide. By advocating for safe work, home and school environments, access to care, nutritious food and reducing gun violence, we've strengthened our nation's public health and APHA continues to develop and advocate for policies and programs that support the public's health and the public health workforce. We were there and we're here today and together we are moving forward. Join us as we celebrate APHA's 150th Anniversary and look to an even brighter future. Together, we will continue to improve health and achieve health equity for all.

Jynx Frederick:

Welcome everyone to the Student-Led Forum reflecting on health inequities in a global pandemic, hosted by the American Journal of Public Health's 2021 Student Think Tanks Cohort. My name is Jynx Frederick. I'm a current member of the AJPH 2021 Student Think Tank and a second year Master of Public Health and Tropical Medicine student at Tulane University. The five other members of the Think Tank behind me are [Sabrina Butler 00:02:22], [Lauren Carol 00:02:23], [Jenny Chen 00:02:23], [Sussana Park 00:02:24], and [Taylor Van Dorian 00:02:28]. They'll all introduce themselves in the chat when they get a chance. We ask to all guests, please also introduce yourselves in the chat to be considerate and respectful. The panelists today, all attendees are muted and we ask that you also turn your cameras off if you've not already done so. We'll be monitoring the chat throughout the event. So please add comments questions for the panelists or the Think Tank in the chat and will respond during the end of forum, 15 minute Q and A session.

Jynx Frederick:

This forum is intended to provide a platform for students to reflect on their lived experiences and perspectives on the newer preexisting health inequities, highlighted by the COVID-19 pandemic and to offer solutions. We're excited to provide an opportunity for a diverse group of students from a variety of backgrounds to candidly discuss the current state of public health. Let me introduce you to the mission of the 2021 AJPH Student Think Tank. We're composed of six graduate students from across the US collaborating to promote student engagement and public health, improve student fluency and science communication, support equitable resources for present and future public health leaders and endorse intersectionality in public health practice. The eight panelists joining us for the forum today represent a variety of health related fields and specialties. Each of the eight panelists have been invited by the Think Tank to bring attention to their thoughtful responses, to our recent call for papers reflecting on health inequities in a global pandemic, each to appear in an upcoming issue of the American Journal of Public Health.

Jynx Frederick:

The panel will answer pointed questions specific to their article submissions, as well as their thoughts on the current state and future of public health. Each panelist will provide a two minute response per question. The panelists will have an opportunity to answer audience questions and any additional questions from the Think tank in the end of forum Q and A session. I'm pleased to introduce you to the panelists. They are Carolyn Fan. Carolyn Fan is a PhD student at the University of Washington

Department of Health Systems and Population Health. She wrote Beyond #StopAAPIHate expanding the definition of violence against Asian Americans. Which seeks to expand how violence against Asian Americans has been conceptualized in news headlines over the past two years to include the historical and structural roots of violence and how those roots lead to the ongoing inequities and marginalization experienced in the United States by people of color. Welcome Carolyn.

Jynx Frederick:

Noel Green is manager of outreach, I apologize at the University of Chicago Center for HIV Elimination. Noel wrote Getting to Zero leaving HIV testers unemployed, which discusses the importance of prioritizing the HIV workforce in getting to zero efforts and a call to action to prioritize the employment and translatable skills of the HIV workforce during and beyond the COVID-19 pandemic. Welcome Noel.

Jynx Frederick:

Prinyanka Mathur is a medical student at the Northwestern University Feinberg School of Medicine. She and fellow author Natasha Dolgin wrote addressing inequities, working at state level public health policy during COVID-19. Which focuses on state level vaccine distribution strategies among vulnerable populations during the pandemic. And the lessons learned that can inform and improve future public health initiatives for vaccination among homeless populations. Welcome Priyanka.

Jynx Frederick:

Erin McCauley is assistant professor in the Department of Social and Behavioral Sciences at the University of California, San Francisco. She and fellow author Kate Lemasters wrote COVID-19, a wake up call to incorporate mass incarceration as socio structural determinant health into public health teaching research and practice. Which describes how the COVID-19 pandemic has illuminated the role of the criminal justice system in engendering health inequities and the interconnection between the health of incarcerated individuals and the general public as a catalyst to incorporate mass incarceration into health determinants curricula.

Jynx Frederick:

Ankita Patil is an undergraduate student at the College of New Jersey and research assistant at the Brigham and Women's Hospital. She and fellow author Marjorie Nyla Gully wrote how the pandemic further isolated the incarcerated, which highlights the importance of recognizing and acting on the differential disease burdens experienced by incarcerated individuals during the pandemic. Welcome.

Jynx Frederick:

Jayati Sharma is a Master of Science student in Genetic Epidemiology at the Johns Hopkins Bloomberg School of Public Health. She and fellow author [Gayatri Menon 00:06:43] wrote serving the public of public health, student reflections on community involvement during the COVID-19 pandemic. Which highlights in deed for the field of public health to invest in community based interventions, education and partnerships. Jayati and Gayatri offer discussion on the lack of requisite representation of community involvement in public health curricula and recommendations from two masters level epidemiology students who matriculated at the height of the COVID-19 pandemic.Welcome.

Jynx Frederick:

Lydia Smeltz is a medical student at Penn State College of Medicine. She and fellow author [Sandra Carpenter 00:07:18] wrote reflecting on health inequities in a global pandemic, the need for disability conscious public health strategies. Which highlights the issue of ableism during the recent public health crisis and the need for robust disability conscious public health strategies in public health practice. Welcome Lydia.

Jynx Frederick:

And last but not least Nneoma Ozoukwu is a Master of Public Health and Epidemiology. A student at the University of Pittsburgh School of Public Health. She wrote we're all in this together. A public health reflection on global health inequities, which provides perspective on current health inequities in the United States and Nigeria exposed by the COVID-19 pandemic, as well as a call to action for public health officials to respond to these inequities. Welcome.

Jynx Frederick:

Let's begin the discussion. So, we'll start off Carolyn, we'll ask you a question first. Can you describe the importance of expanding the conceptualization of, and vocabulary pertaining to violence against Asians and Asian Americans as historical and systemic, and the role that the field of public health should play in addressing the individual and population level social and health effects of historical structural and systemic racism against Asians and Asian Americans, especially during a public health crisis like COVID-19.

Carolyn Fan:

Yeah, of course. So I think it's really important to expand what we think of as violence because so much of society is violent even beyond hate crimes and hate incidents. So I would argue that having to live in substandard housing is violent, that not having enough to eat is violent and our immigration and healthcare system can be violent. And of course research and prevention and awareness on hate incidents and interpersonal violence is extremely important and it's crucial that it's in the national dialogue. At the same time I also want other parts of the Asian American experience to be in the conversation. So in my article I mentioned things like the history of highways being built through China towns resulting in environmental health concerns or how green card holders can only access Medicaid and CHIP after a five year waiting period. So these are deeply entrenched aspects of our society and policy that have been going on for ages and causing issues and causing harm in our communities.

Carolyn Fan:

So this is about what we might call slow violence or systemic violence. And we know from public health theory that all these upstream things inflict physical, mental and emotional harm and affects the health of not only individuals but also families and communities. So that's why in my article I call in the public health field to broaden our conceptional violence in order to have a fuller understanding of Asian American health equity and just health equity in general. And overall, I think the public health field is really uniquely suited to understand these concepts and to do this type of work to the Center Health Equity. We've seen a much needed change in mindset and just, the past five years is around structural racism and policing, and we need to make sure a response to the health equity needs of Asian Americans are rooted in the same principles. So critical race theory, intersectionality abolition and of course making sure to share space and share power with Asian American community organizations and activists.

Jynx Frederick:

Thank you Carolyn. This next question is for you Noel. Can you please explain for the audience what the Getting to Zero Initiative is and why investment in the HIV workforce should be an important consideration of this initiative and how COVID-19 has illuminated the necessity for that consideration?

Noel Green:

Yes. Well first, Getting to Zero is the tagline for the strategies purpose to end HIV epidemic and, or achieve the threshold of new diagnoses that will ensure an end to HIV. During the COVID-19 crisis, we saw locally a lot of issues around how organizations, health departments are utilizing the social determinant of health and priorities as far as data collection and funding, yet not in program design for the benefit of peer navigators. This is indicative of an inability to dismiss equity or a social change

framework that upholds oppressive power dynamics and embrace liberation, a social change framework that deconstructs oppressive power dynamics.

Noel Green:

What I have seen is that when organizations are not understanding how a lack of focus on how programming is impacting the health, the livelihood, where people stay, where they reside, not just for the programs recipients before the workforce. What happens is, as we're getting closer to zero, there is no focus on how our workforce will live after we achieve zero. A lot of this was seen during COVID-19, where we had a lot of organizations which either closed their doors or reduce their workforce, which equated to people that were a part of communities highest impacted by HIV and, or most vulnerable to HIV/AIDS and other STIs being without employment, which we know employment is necessary in order to ensure one that you can have a certain standard of healthcare in a certain quality of life.

Jynx Frederick:

Thank you so much Noel. Next question is for Priyanka. In your paper, you describe your experience working on the Illinois Department of Public Health Homeless Vaccination Initiative, providing COVID-19 education, outreach, support and resources to homeless shelters in Cook County, Illinois. Can you explain the lessons on health inequity and building successful public health interventions that you took away from that experience?

Priyanka Kumar Mathur:

Yeah. Thanks for the questions. I want to address the second part of your question first, which is the key lessons I took away from building successful public health interventions. The first key takeaway is that you really have to understand your population needs. And Illinois's a big state, it's 60,000 square miles from Michigan to Kentucky. So we began by understanding our population needs by mapping CDC social vulnerability, COVID-19 burden, homeless population density and shelters across the state to highlight key areas of focus. And we also sent out service to shelters, to understand challenges and barriers to vaccine distribution.

Priyanka Kumar Mathur:

The second key takeaway was the need to facilitate communication at the local regional state and federal level. As we developed this intervention we came to realize that a lot of this infrastructure to facilitate communication and communication between all of these partners still needed to be developed. And what we found is that when we brought all of these stakeholders together, it allowed strategies, resources, and ideas to be shared. In the same vein, it was really important to develop our relationships between community stakeholders, including local health departments, shelters and local clinics, to allow us not only to provide vaccines but also other services such as STD, HIV testing, mental health services and resources such as food and shelter that address some of these other social determinants of health. Facilitating all of these partnerships has a real potential to create lasting collaborations that will empower the community to address public health needs beyond this intervention.

Priyanka Kumar Mathur:

And my third key takeaway and perhaps the most important one is that public health interventions require the work with community partners and community based organizations. Working with organizations has that key aspect of facilitating trust and allows these interventions to be [inaudible 00:15:37] less than equity which address that first part of your question, is how limited and unequal access to healthcare is for this population. Especially how dependent they are on available at fragile support systems and infrastructure that still need to be developed.

Jynx Frederick:

Wonderful. Thank you so much. Next question is for Erin. In your paper, you and the co-author note that the US is experiencing simultaneous epidemics of COVID-19 and mass incarceration. Stating that the US has the highest number of both incarcerated individuals and confirmed COVID cases in the world. Can you explain the interconnectedness between correctional facilities and the broader communities in which they reside observed during the COVID-19 crisis, and how that interconnectedness should expand our social determinants of health vocabulary, both inside and outside of academia?

Erin McCauley:

Well, thank you for this question. I want to begin by defining the scope of the criminal legal system. So the US leads the world's incarceration. And during 2020, there were 2.3 million Americans detained in correctional facilities and 4 million Americans under the supervision of the criminal legal system in the community. And the criminal legal system also disproportionately affects black populations. For example, one in three black men will be imprisoned in their lifetime. And importantly, the negative consequences of incarceration extend beyond incarcerated individuals. Family member incarceration has negative health impacts as well. Overall, about 45% of Americans experience incarceration of a loved one. In one and three young adults experience parental incarceration. And the risk of family member incarceration is also unequal with more than 60% of black individuals experiencing the incarceration of a loved one. And beyond impacting the individuals who are incarcerated and their families, correctional facilities are also embedded in communities and incarceration reduces the population of communities that erodes political power and can disrupt social networks.

Erin McCauley:

And so COVID-19 raged in correctional facilities since the pandemic. And research has found that COVID-19 spread in correctional facilities, contribute substantially to community spread and vice versa. And this really demonstrates the connection between the health of individuals who are in correctional facilities and the health of individuals in the broader community. And I want to stress that this connection exists outside of COVID-19 as well. And a dedicated group scholars have long argued that mass incarceration is a public health risk, which contributes substantially to racial disparities in health in the US and disparities between the Us and our peer nations. And so we hope that this newfound attention that's been focused on correctional facilities during the COVID-19 pandemic, can act as a catalyst for us to view the criminal legal system as a central health determinate, in kind of as a stratifying health institution which must really be considered. And this means considering a criminal legal system along other central socio structural determinants of health like education and housing and healthcare in the training of the public health providers and researchers of the future.

Jynx Frederick:

Thank you Erin. And next question is for Ankita. In the same vein of the criminal legal system, can you give an overview of the differential disease and workplace burdens experienced by incarcerated individuals during the COVID-19 pandemic and how those differences compare to the experiences of an incarcerated frontline workers? And can you also explain more about the neglect of society's reliance on incarcerated workers during the pandemic?

Ankita Patil:

Yeah. Thank you for your question. So the differential disease and workplace burdens that a lot of incarcerated individuals face during a pandemic lie in difficulty in filing OSHA complaints. With many incarcerated individuals being the frontline and working in hazardous conditions, OSHA complaints are a big tool in advocating for themselves and getting better working conditions. However, as we've seen in nearly all workplaces, there have been less inspections because of COVID. And as a result, we have less workplace safety protections. Inspections in prisons and jails, if they do occur, they can also happen virtually. And regardless of in person or virtual, the facilities are notified beforehand, which then gives these facilities ample time to change or hide what they don't want inspectors to know. But even before

having an inspection, there's so many barriers to just filing that complaint. Including internet access being controlled or phone use also being controlled.

Ankita Patil:

But I think that the biggest barrier is the right to know. This is especially relevant during the pandemic when incarcerated individuals were working in morgues and working with contaminated hospital laundry which could place them at risk. But did they know about this risk and did they know the extent of it? Did they get a mask? If so, which type of mask? How often did they get a mask? What about for those who don't know English that well and it isn't their first language. And the paper documentation that's provided, it can be super difficult to read. And overall we as a public can ensure that these workplace protections are being followed when incarcerated individuals are not really seen as employees.

Jynx Frederick:

Thank you. This next question is for Jayati. How do you see epidemiologic curricula integrating theory and practice with the social sciences, which can be well equipped to engage with social epidemiologic inquiry when interfacing with communities, for example, engaging with public to combat misinformation or disinformation or conducting disease investigations? How do you see your current epidemiologic curricula and experiences as a public health student during the COVID-19 crisis benefiting your future practice as an epidemiologist?

Jayati Sharma:

Yeah, that's a really great question. So I think integrating mandatory community oriented public health increase and projects into all levels of public health education not just at the MPH level is really imperative, to ensuring that we strengthen and our current and next generation of public health professionals. And to respond to both our current crisis of the pandemic and the impending crisis of the future. We think that there should be a significant emphasis on the past, present and future of social epidemiology as it interfaces with the social sciences. And would definitely help us better understand the public that we're crafting these recommendations and guidelines and policies for.

Jayati Sharma:

This can come in a couple different forms. I think there should definitely be structured community oriented courses for students that let them interface with these communities one on one, and in groups that provides the value of working with individuals that are directly facing diseases and crisis, but also courses that integrate these community based projects with theory that we're learning in the classroom. I think a lot of community based practice is relegated to the sidelines of epidemiologic curricula. And my co-author and I think that incorporating that more into the mainstream of our curricula would have a much more long lasting implication on how we conduct epidemiology and public health in the real world. Throughout the pandemic I think social scientists have been pretty united on the front.

Jayati Sharma:

Throughout the pandemic, I think social scientists have been pretty united on the front that things that people have said were unpredictable were actually quite predictable from a social science perspective. For example, the rampant rise in disinformation around COVID vaccines and the related low levels of uptake in certain communities were unforeseen by certain members of public health communities. But in social science people definitely saw these things coming so building relationships with communities in epidemiology and public health broadly would help us bridge that gap between things that we think are unforeseen and things that social science knows are going to happen in our current and [inaudible 00:23:43] crisis. So I think as epidemiology students ourselves, we see the current COVID-19 crisis as something that really will shape our relationships with our own communities and the communities that we work for in the future and long term.

Jynx Frederick:

Great. Thank you, Jayati. Next question is for Lydia. Can you describe the barriers that people with disabilities experience when accessing health systems and social programs and how COVID-19 has exacerbated the often unrecognized disparities experienced by people with disabilities? How does the failure of recognition within healthcare, education and research perpetuate those disparities?

Lydia Smeltz:

Yeah. So there's a lot of well-documented and extensive literature on this topic. In two minutes, I can't cover all the barriers that people with disabilities experience, but I think that the CDC groups these barriers into seven categories which are helpful for us to think about as we think about the barriers that people with disabilities experience. So they group these categories into attitudinal barriers, communication barriers, physical barriers, policy, programmatic, social barriers, and transportation. I'm briefly going to touch on two of those. So the first is attitudinal barriers. And so these are the stereotypes, stigma, and prejudice that people with disabilities experience in their everyday life. So there was a landmark study published in 2021 which surveyed practicing US physicians in a variety of specialties and the survey found that 82% of these physicians stated that their patients with significant disabilities had worse quality of life than their non-disabled patients which is discordant with how people with disabilities self-report their health. So already we're seeing that the way the biases that these providers have have a direct effect on people with disabilities' healthcare quality and healthcare access.

Lydia Smeltz:

So this has only been exacerbated during the COVID-19 pandemic, as we've seen a lot of beliefs about quality of life, about people with disabilities and allocation of resources, specifically with ventilators. And I just want to highlight the case of Michael Hickson, who's a 46 year old man with quadriplegia who died from COVID after doctors denied him potentially lifesaving care because they assumed he had poor quality of life. Neither he nor his family were consulted in this decision. And so shifting gears to different type of barriers, we have physical barriers. The Americans with Disabilities Act or ADA mandates that everyone has full and equal access to care, meaning people with disabilities should have full and equal access to healthcare, but ADA compliance can be inconsistently enforced and the burden often falls on people with disabilities to advocate for their own care.

Lydia Smeltz:

So even if we take a step back from is the physical healthcare environment accessible, we are then ignoring all the barriers that present to the patient getting to the healthcare clinic. So did they have accessible transportation? Were the appointment instructions accessible and available in a variety of formats? And last week, the New York Times published an article related to this about at home COVID tests and how they're inaccessible to blind people. So while it's great that you can get an at-home COVID test and that might be more accessible to some people who don't have access to transportation, if you can't read that test, then it's introducing a new set of barriers. So people with disabilities have been experiencing healthcare disparities and barriers for a long time and they've only been exacerbated during the COVID pandemic. And if you'd want to learn more about this, the National Council on Disability published a great report and I would encourage you to look at that. Ultimately, we must look at these barriers in order to devise solutions so we can't ignore them but we can learn from them.

Jynx Frederick:

Thank you so much. Next question is for Nneoma. You've experienced the COVID-19 pandemic in two countries, the United States and Nigeria and as such have been able to observe not only the differential control measures enacted by each country but also the differential social and health inequities experienced by each country. Can you describe the differences that you saw social and health inequities between the United States and Nigeria and the importance of prioritizing health equity, not simply equality when pursuing health justice?

Nneoma Ozoukwu:

So during my time in America, I saw that people of color faced a higher mortality rate from COVID-19 compared to their white counterparts. This difference in mortality mainly stem from multiple factors, one being that people of color were the frontline workers and had increased rates of comorbidity such as heart disease, obesity, and asthma. That also contributed to this [inaudible 00:28:37] mortality rate. So on the other hand, in Nigeria I saw that people were more impacted by the indirect effects of the COVID-19 pandemic and really saw that globally as we compared COVID-19 rates across America versus in other countries in Africa. So I actually spent the past summer working at this cancer clinic in Nigeria, and there I really saw firsthand the negative impact that the pandemic has had on preexisting health challenges Nigerians face, which resulted in negative patient outcomes. So these negative impacts I observed include reduced access to care as well as reduced community outreach screenings because of lockdown and social distancing restrictions. The pandemic has also had extremely negative economic impact and disrupted much of the global supply chain of necessary clinical resources.

Nneoma Ozoukwu:

So to me, my experiences in both countries really showed that nationally and globally we need to prioritize health equity. I stress equity and not equality because to me, there are very different things. While equality calls for equal treatment and interventions, equity calls for action [inaudible 00:29:40] focuses on giving everyone the tools they need to be successful. Understanding why COVID-19 disproportionately impacts people of color in America is just really recognizing the social dynamic elements that contributed to this issue. Understanding why Nigeria was impacted by the indirect effects of COVID was really recognizing the [inaudible 00:29:58] challenges that Nigerians face regarding the healthcare system. So in these two countries, I witnessed how economic and social environmental inequities really intersected to affect health outcomes in minorities in America as well as Nigerians in general. So prioritizing health equity just involves recognizing and understanding these factors then taking tailored actions to the target these barriers individually.

Jynx Frederick:

Thank you. We're going to start a next round of questions starting with Carolyn. In your paper, you noted that in addition to recognizing oppressive systems, it's also important to recognize the role of institutional involvement in perpetuating anti-Asian violence and racism against people of color. As a student, what role do you see academia playing in ensuring the health and safety of its students and the broader communities of which it is a part? What role do you see students playing in holding academia accountable and beginning conversations with their universities or institutions?

Carolyn Fan:

Yeah, so this is definitely a tricky question because I think one main thing that needs to be acknowledged is that academia has long been a perpetrator of racism and it still is to this day. That being said, there's many things that academic institutions can do to improve and support the wellbeing of their students. I think the main thing is really to invest in equity efforts and by invest, I mean money, time, space, and things that run the gamut from funding for research, hiring diverse faculty, course offerings, paying your student workers fairly, paying folks for doing equity and diversity work on campus and offering spaces for folks who do that. I think for promoting Asian American health in particular, all of the above things apply and I think offering Asian American health classes would be a really great place to start. Plus recognizing that many Asian American ethnicities and subgroups are still very underrepresented in the health field; I think that's a common misconception. I think students who want to hold their institutions accountable should know that they hold a lot of power as a collective.

Carolyn Fan:

Students are really the change makers at universities and things like grad student unions are really important. But one big realization for me that I wanted to share as a student who was really involved in a lot of and equity work on campus is that it's okay to step back from that work if you need to. You don't need to feel indebted to join a diversity committee even if there are many things wrong with your

institution, just because you're a marginalized student. Especially if you're a marginalized student, doing health equity research work like a lot of us are and then doing institutional equity work in your spare time, it's really easy to become burnt out and exhausted. It can be very isolating to have a predominantly white institution be the centerpiece of your life. So I also recommend getting involved outside of academia. So joining a local community organization where you can find support in community and do really great equity work there in your local neighborhood. I joined a local Seattle organization of Asian American women and that's been really rewarding and healing for me.

Jynx Frederick:

Thank you. Noel, hypothetically with unlimited budget and resources, please outline or describe a plan for what you think needs to be done to prioritize the HIV workforce to limit unemployment among workers and ensure translatable skills. Do you see any components of this plan currently being prioritized in the Getting to Zero initiative?

Noel Green:

Thank you for the question. First, I'm going to define what I'm mean by translatable skills. This is an occupation and/or professional certification that is useful in one field and translates into a useful provincial in another for people that have been historically marginalized and or recipients of systemic question. As far as the plan goes with unlimited resources, I think the first step is for the Centers for Disease Control and Prevention, health departments, and foundations that are focused on HIV/AIDs to prioritize in their planning and funding programs and/or interventions with translatable skilled development for staff that are members of the communities that are most impacted by and/or vulnerable to HIV/AIDs. I want to say that for example, programs or interventions that pay for HIV testers that are part of the local population for health department with the highest incident of HIV to receive phlebotomy licenses and the plan to pay those newly licensed phlebotomists market rate once they are licensed. At the height of the COVID-19 crisis, some programs did start moving in the right direction by cross-training staff as COVID-19 screeners and a lot of the plants and agencies inherently prioritize promoting from within.

Noel Green:

However, the power dynamics that cause harm and vulnerability in our society are not being addressed with these models. I'm a little bit of a soapbox preacher when it comes down to talking about a transition from equity to liberation. I say that because the power dynamics that we embrace today still situate [inaudible 00:35:44] has been historically and that is with a class of people that are educated including myself and others that are here and more so creating strategies that are homegrown and community defined led so that we accomplish something that is sustainable rather than is resource driven. So there's still work left to do. As a second part of that plan, I would say in a perfect world that we transition from equity. And as I said, strategies that are embracing this as an outcome to say that we have to go and find out and then create for other people and create strategies that say we need to come to the table and bring resources.

Noel Green:

And as an educated class and/or educated people come to the table and say here are applicable solutions, and allow the communities that are underserved, underrepresented to pick and choose, if you will, what is necessary to meet the need as they define it as what is most useful to them. This will take us to abandon the idea that those in need do not know how to solve their need. So that context with abandoning that context of our thoughts and our process and our programs, we can accomplish a [inaudible 00:37:12] ideas, these strategies that individuals that are part of groups that have been marginalized historically, recipients of systemic oppression to really say they have not just a seat at the table but they are defining change on their terms, which is more sustainable versus basing all of our solutions on resources that are limited.

Jynx Frederick:

Thank you so much, Noel. Next question is going to be for Priyanka again. How long did the Illinois Department of Public Health's Homeless Vaccination Initiative last? Are there elements of the initiative that are ongoing? What were the metrics for program evaluation that the Illinois Department of Public Health Working Group established to ensure sustainability of the initiative? Are there any improvements to local vaccine initiatives that you believe could be made outright to increase vaccination coverage among homeless persons in Cook County and beyond?

Priyanka Kumar Mathur:

So the IDPH Homeless Vaccine Initiative began February 2021 and ended in May 2021. The metric we used was a number of shelters that we were able to reach and have adequate resources to allow their clients to access the vaccine, whether that was through education resources they need from us or whether that was actual events that IDPH helped put on. So the unit of observation is at the shelter level and not necessarily at the individual level. The intervention created a sustainable set of recommendations and processes for making sure that large public health interventions include vulnerable population. And some of these key insights to ensure sustainability of homeless populations receiving care was one, knowing where all the homeless shelters were, who had oversight on them and who had connections to the shelters which is critical because a lot of this had not been previously established. The other key insight was learning how to support local resources as I mentioned in my first question, and doing so at a state level.

Priyanka Kumar Mathur:

This means taking a local approach versus a top down approach or setting up sites that are overviewed by the state rather than local community, which is we ended up doing sites and events that involved the local community. That was critical in moving forward, using that in public health interventions. The third part of this step touches on sustainability, [inaudible 00:39:43] populations to healthcare beyond just vaccines, what we called wraparound care. That included access to mental healthcare, STD, HIV testing and access to food. And finally, one of the biggest points in developing sustainability was developing these relationships between local health departments and shelters at the state and federal levels, which lays the infrastructure for future health initiatives. What we found is we got a lot of gratitude from these local health departments and shelters for bringing everyone together and that was important and will have a long lasting, sustainable impact. Additionally, our work in terms of sustainability in a small way helped inform and nudge the state towards appointing a state homelessness chief, which was recently done this past fall.

Priyanka Kumar Mathur:

A lot of it was in the works but our work definitely helped nudge that initiative. And finally, talking about local vaccine initiatives and improvements that can be done. Obviously this is very contingent on resources and money available but in an ideal world, we'd like to see some of the elements that we were able to implement, including having additional services like STD, HIV, mental health, having health education and community leaders come in to answer questions, especially if they're trusted members of the community. Another key thing that we saw was having street outreach. A lot of these populations are unsheltered and often don't trust these larger organizations so having local outreach would be really important. Then again, as I keep emphasizing in my responses, working with these community based partners is critical.

Priyanka Kumar Mathur:

Finally, a couple of perhaps one of the biggest takeaways we found is that it was really important to bring the vaccine to the population. It's very different than having it at a pharmacy or somewhere else. These places are unfamiliar. They're often daunting and there's often a lot of mistrust. So being able to bring the vaccine to places that homeless populations are familiar with or know is critically important and it really develops trust and a sense of security in taking this vaccine, especially in this population that's had a lot of valid medical mistrust.

Jynx Frederick:

Great. Thank you. Next question for Erin. As you described, incarcerated populations are often thought to be isolated or separated from the general population and have historically been subjected to inhumane practices that have spilled over into how these individuals are treated during the COVID-19 crisis. Can you talk more about the collateral effects of incarceration on incarcerated individuals themselves and on their families since the implementation of COVID-19 control measures as well as the general effects on families with loved ones who are incarcerated [inaudible 00:42:24] COVID-19?

Erin McCauley:

Thank you for this question. Basic mitigation and prevention strategies for COVID-19 are really difficult to implement carceral spaces. Incarcerated individuals have little or no ability to social distance. There are limited or controlled access to things like self sanitizers, personal protective equipment. Since the start of the pandemic, there has been some moderate declines in prison and jail population, but these have been quite moderate. So for example, there was a 4% decline in the state prison population and a 10% decline in the federal prison population by August of 2020. We know that facilities that have less crowding also have less COVID-19 but for the majority of incarcerated people, they were still incarcerated and remaining still incarcerated in fairly crowded facilities. So it's important to note that the incarcerated population is also at a higher risk of severe COVID-19 infection because this population is aging, has a disproportionate of burden of chronic conditions and is disproportionately non-white. So groups like the COVID Prison Project have organized a really large effort to collect and make public data about the pandemic in carceral facilities.

Erin McCauley:

And so we now know that as of today, prisons have reported around 500,000 confirmed cases of COVID-19. The confirmed case rate in prisons is five times greater than in the general population and nearly 2,750 individuals incarcerated in prisons have died from COVID-19. So the mortality rate is three times greater in correctional facilities at least in prison than in the general population. So first and foremost, the toll of the pandemic in carceral facilities has been a loss of life. As the pandemic raged in these carceral facilities throughout 2020, there was really a lack of testing, there were extreme movement restrictions, and solitary confinement was used as medical isolation. Solitary confinement is considered torture by many and is associated with an increased risk of death in the year following release compared to incarcerated individuals who are not put in restrictive housing. And these movement restrictions barred many from communicating or having contact with their families, led to the shuttering of many educational arts and academic programs and kept incarcerated individuals from accessing yard time or any outside time.

Erin McCauley:

These measures have likely had a substantial toll on the physical and mental health and incarcerated individuals and their families. And so I want to emphasize that decarceration is really pivotal for managing COVID-19 and achieving health equity more broadly. In October, APHA called for decarceration in a divestment from incarcerated systems. Decarceration would reduce crowding which could lower COVID-19 rates and releasing older individuals and those with chronic conditions could reduce the threat of infection. But beyond COVID-19 decarceration would also improve health equity through diverting funds to bolster other structural determinants of health like toward housing and education and keeping families and communities together.

Jynx Frederick:

Thank you, Erin. Next question for Ankita. In your paper, you described being dispatched as an EMT to a local prison in a hidden part of town. You and the papers co-authored then go on to state that the criminal system engages in violent inaction. What are the hidden conditions experienced by incarcerated individuals and how has both the hidden and violent nature of these conditions been perpetuated by COVID-19?

Ankita Patil:

Thank you for your question. I think that the hidden conditions that incarcerated individuals face happens on two levels. So there's a visible [inaudible 00:45:52] and research has shown that a disproportionate shared prisons are located in rural areas while a disproportionate number of incarcerated individuals are from urban areas, which

PART 2 OF 4 ENDS [00:46:04]

Ankita Patil:

Incarcerated individuals are from urban areas, which kind of goes back to the reference that I made to the local prison I was dispatched to as being in a hidden part of town. So it goes by the saying, if it's out of sight, it's out of mind. Then for the other level, we have this incredibly huge, lack of data transparency, which has further been perpetuated by the pandemic. For example, the COVID-19 incorrections data transparency act was presented back in August 2020 and reintroduced half a year later in February 2021. So also just considering that gap to mandate standardized and transplant reporting from carceral settings, by the bureau of prisons, the US marshal service, and state and local governments by demographic factors, this COVID-19 data is really critical for unearthing and documenting the disproportionate burden of COVID-19 on black, Hispanic, and indigenous people of color.

Ankita Patil:

Yet, here we are with numerous amounts of COVID-19 outbreaks in these systems, which continue to still withhold its COVID-19 data. I think it's also worth mentioning that prisons and jails who were reporting, they stopped reporting, or now they report much less frequently ever since vaccines and boosters became available. Despite the risk of omicron, the pandemic isn't over, and this battle capacity and lack of accountability facilitate violence and racism.

Jynx Frederick:

Thank you. Next question for Jayati. What successful community-level interventions have you seen in your own community? Have you observed unsuccessful community interventions? How might improving Community level public health interventions aimed at reducing health inequities benefit national and global health inequities or benefit from reducing national and global health inequities?

Jayati Sharma:

Yeah, thanks for these questions. My co-author guide through she's from Calgary Canada as well. So I'll take a successful intervention example from there that we also mention in our piece. A specific area within Calgary was facing a really low vaccine uptake, a kind of disproportionate high burden of COVID-19 cases in that specific region. So to combat both of these issues, the local community health officials kind of garnered the community and created these mobile vaccination sites. They extended vaccination hours. They partnered with community organizations to provide translation services for public health messaging and vaccination information. And they remedied the lack of transportation for people living in these communities to get more people to become vaccinated and protect themselves from COVID-19. These measures had a very tangible impact on COVID-19 rates and vaccination uptake in this community, particularly in that the members of this community almost all became vaccinated once they were eligible to about 99% of the population were vaccinated when these measures were implemented.

Jayati Sharma:

So addressing, the COVID 19 pandemic through a very culturally competent lens that really meets the needs of the community, I think is a prime example of successful community intervention. However, there have been, as I'm sure everyone watching and all the panels, there've been several unsuccessful community interventions throughout the pandemic as well. So I'll take an example from my home state of Arizona, where our governor in 2020 passed laws to prevent the implementation of public health

measures, such as mask mandates and vaccine mandates, particularly in schools and universities in the state. No one was allowed to implement a mass mandate vaccine mandate. It was outlawed. So some universities tried to combat this by encouraging, despite not being allowed to encourage very strongly to use the masks and vaccines. And they thought to do this through a community-centered lens.

Jayati Sharma:

However, one particular university, for example, in Arizona, thought to do this by using college athletes, as ambassadors for COVID-19 vaccination, without recognizing that these are not necessarily community leaders among undergraduates in college. So this was kind of a community-centered approach. They took that wasn't successful and didn't really lead to vaccination uptake because they hadn't considered the needs of their student community and what they needed to promote public health.

Jayati Sharma:

So I think community-level public health interventions need to improve and need to focus on the actual people that they're working to serve and doing this would really benefit the production of national global health inequities. I think in public health, we tend to see a broad picture of the public that we're serving, but I think it might be better to visualize these as smaller individual communities that we should be serving one on one rather than issuing guidelines that apply to a very, very broad populous. So as some of the other panelists have said communities know what they need and it's our job in public health to take their needs partner with them and get them to a public health standpoint that really serves their interests in an equity focus.

Jynx Frederick:

Thank you. Next question for Lydia in your paper, you noted a stark statistic that pup with disabilities report, lower rates of vaccination compared to their non-disabled counterparts, despite reporting lower rates of vaccine hesitancy, what are the strategies that students can engage in to assist the people with disabilities community and partners in holding public health leaders and health educators accountable for implementing recommendations aimed at improving equitable access for people with disabilities to healthcare services like COVID-19 vaccinations and what strategic barriers might you expect to see?

Lydia Smeltz:

So I think that students can set the example of what inclusive, inclusive public health planning looks like. And I think that we can do this in two key ways. The first way is through universal design. And the second way is through forming equitable partnerships, which many of the other panelists have mentioned as well. And so it really starts with universal design and you can't have those equitable community partnerships without universal design. And when I say universal design, I mean the idea of planning for things to be accessible from the beginning and not trying to adapt things later on and just kind of make them work and put the pieces together. And so while a lot of COVID planning, especially recently, accessibility has been a larger priority. It feels a little too late. So what I mean by this is that when we look at the different COVID vaccination websites in different states and territories, we see substantial variability and suboptimal compliance with accessibility guidelines.

Lydia Smeltz:

And part of the problem of this is that there's just inconsistent enforcement of what we think is accessible. So while the ADA mandates accessibility, there's not a clear delineation. And so accessibility means very different things to different people. And if it doesn't say you need to have a sign language interpreter at your COVID vaccination site. If you didn't think about that from the beginning, then you don't have one there. One way to combat this is through forming these equitable community partnerships and the ADA mantra, nothing about us without us reminds us that this is so critical. We need to include people with disabilities throughout all stages. This includes planning, implementation, and evaluation. I also want to stress that it's not enough to have one person. The disabled perspective is diverse and low experience of disabilities, very diverse. And so we need to make sure that we have a variety of perspectives that are also intersectional.

Lydia Smeltz:

So I would encourage everyone here, the other panelists, and the people attending to think about the work you're doing, are you including the perspectives of people with disabilities, and are you including diverse perspectives of people with disabilities? And did you start off by trying to include those perspectives? Or is that something you thought about later on? Because I think a lot of these barriers can be mitigated if we take that universal design approach and start with an equal access goal. And so addressing access needs is really hard and it's not something that most people think about in their day-to-day lives. So I always say that it has to be intentional until it becomes automatic and the more you practice it, the easier it gets, but being intentional is a key first step.

Jynx Frederick:

Great. Thank you so much, Lydia, next question for Nneoma, can you give an example or more than one example of a strategy to reduce health inequities that you believe could be successful in both the United and Nigeria?

Nneoma Ozoukwu:

So to reduce health inequities, I believe that strategies should focus on healing communities and correcting injustices. And I say this, especially because health inequities arise from factors influenced by social-economic environmental disadvantages. So one strategy, in particular, is using a community perspective before thinking of a solution. To get an example of this, I mentioned this in my paper during my time in Nigeria, I was really troubled to see originally it gave a proportion of cancer patients at the clinic I was working at, dying weekly at the clinic. Originally I thought it was due to issues with treatment or care. However, I soon came to learn that was attributed to the COVID-19 relay restrictions, which prevented free community cancer screening outreaches. So these outreach programs are really essential in catching early-stage cancer because most Nigerians cannot afford annual screenings. And additionally lockdown restrictions between states in the country, a nightly cure for you just really prevented people from traveling to receive cancer care because with very limited cancer sites in the whole entire country, I think there's about two or three.

Nneoma Ozoukwu:

So this resulted in a great proportion of patients presenting with late-stage cancer, thus worsening in patient outcomes. So for me, what may have seemed to be an easy solution just revealed itself to be a web of social problems. So gaining that community perspective in that situation that allowed me to understand underlying problems that were occurring in the healthcare system over there and welcoming the community perspective can just allow public health officials to create impactful and sustainable intervention initiatives.

Nneoma Ozoukwu:

I want to mention another strategy that can be used, is also engaging communities in decision making or create in creating solutions. So one issue in America was vaccine uptake, and this is a prime example of how that strategy engaging communities can be used. So in America, among people of color, there's a deep distrust in the medical system, stemming from historical injustices between the medical community, people of color. So this is stress has given much rise to vaccine hesitancy. We see today, especially among people of color, so working to engage disadvantaged communities and decision-making can help really help heal these historical wounds and address these public health problems.

Jynx Frederick:

Great. Thank you so much. So that marks the end of our two-minute lightning responses. We're a little early ahead of schedule on the Q and A session. So I'm just going to jump into some additional questions. So we'll do this first additional question for Jayati right off the bat. You noted in your paper that public health graduate students have been inundated with scientific research misinformation and disinformation since matriculating during the COVID-19 pandemic. Do you have any personal

experiences that you would like to share about what it has been like to navigate an environment where research is always evolving by nature and perhaps more quickly due to the pandemic and then misinformation and disinformation may also be evolving in reaction to the fluid nature of scientific research?

Jayati Sharma:

Yeah, thanks for the question. So I think it's an interesting time to be a public health student, particularly because, and I'm sure a lot of the panelists related to this, is that we're serving kind of as the public health consultants to our family members, our friends in our communities, especially when guidelines are coming out, that sometimes aren't very intuitive to the public and we're automatically being tasked with explaining these things that sometimes are hard for us to even understand ourselves. And this is one layer of the problem, but then there's a second whole layer of the rampant misinformation and disinformation that spreads on social media and on the internet, which I personally have been trying to combat on a small level through my own social media platforms and in conversations with my family and friends. But I think it's, it's a very important skill to learn to balance the knowledge that we learn in a very active and very education-focused realm and balancing that with communicating with the general public, telling them what the most important part of public guidelines are for them, what's applicable to them on a daily basis.

Jayati Sharma:

And I think it's, it's just been a really challenging time. Trying to balance both of those things is been a real learning experience for me and for all public health students. I'm sure. But yeah, I guess that's kind of what I would say is that we're being inundated by all this research and new information from a public health standpoint, but really conveying that to the public is really important and people need that and there's definitely a space for that. So I encourage students to take up that mantle if they can and demystify a lot of public health guidelines.

Jynx Frederick:

Great. Thank you. Next question. I'm going to move on for Ankita. So let's see here. What are some ways that incarcerated and UN incarcerated individuals have advocated for equitable conditions among incarcerated populations?

Ankita Patil:

Yeah. Thank you for your question. So I think speaking from a personal experience, I have seen advocacy work be done through a data-driven approach, including public health professionals who work towards releasing people from prison, writing letters to mandate vaccines, and even filing lawsuits to release thousands of people. But I think the biggest way to advocate is to simply listen. I'm incredibly grateful for my mentor, Dr. Monique Mendes for providing me the opportunity to sit in her class mass incarceration and help in the US at the Harvard T.H. Chan School of Public Health, because in this class, formerly incarcerated folks shared their raw accounts of their experiences and their hopes were just to vocalize their stories and really provide insight into the conditions that they've faced. And there's just so much power in listening. And I feel like sometimes we collect this data and we collect some more and we keep collecting, which of course is really important to make informed decisions, but it's also just as important, if not more important to provide platforms for incarcerated individuals to speak and share what they've gone through.

Jynx Frederick:

Thank you. Next question for Erin. So I was going to ask a little bit more about decarceration. If you want to speak more on the topic, please do my question for you was, but just to explain a little bit more about what it means, why it's important and what makes it successful, if you feel comfortable with that. Otherwise, I can throw another question at you.

Erin McCauley:

No That's great. Thank you. A question. So decarceration is a response to the system of mass incarceration and it aims to eliminate or reduce dramatically the number of people involved in this system and kind of beyond this physical reduction, it also entails a reinvestment in healing, the trauma restoring civil rights, and combating the enduring stigma associated with criminal legal involvement. Funds diverted from the criminal legal system could be reinvested in other socio-structural determinants of health, like housing and education. And decarceration is really important in the fight against COVID-19. So it would improve the effectiveness of standard prevention measures, incarceration facilities, but more broadly decarceration would also begin to dismantle the historic legacies of structural racism and improve the health of entire communities.

Jynx Frederick:

Thank you. Next question for Lydia. So considering that the COVID-19 crisis has exacerbated existing disparities experienced by people with disabilities, what strategies to address ableism, do you believe may be the most promising and sustainable after COVID-19 has been declared over the best way to say that, I guess.

Lydia Smeltz:

Thank you. So ableism is the discrimination or prejudice against people with disabilities. And this often comes up when people make assumptions about people with disabilities, quality of life, wishes, goals, or barriers that they experience. And so similar to a lot of the other panelists, as we keep mentioning, the key here is really to center the disabled community and center their testimony. And so I think that it can really be in some facets, as simple as just asking the disabled community what they need, what they want, what barriers they've experienced. And I often feel like ableism comes up when people are afraid to ask. And so this fear we have about asking is really just because we feel uncomfortable, but the disabled community, they already know they have a disability. And so this is not new and information to them. And so when we give them that equitable platform to talk on, then we can learn from that experience.

Lydia Smeltz:

And when I say equitable, I mean that we're not just including them, but we're paying them. We're respecting their time. And we're truly forming a longitudinal relationship to learn from their expertise and limited experience. And so we just need to ask and we need to listen and similar to what we were talking about earlier. Listening is great, but then we need to take action because if you put someone in a place where they're sharing their testimony and you just listen and you don't do anything that then you just continue to perpetuate that mistrust. So when we gain that valuable knowledge, we can use it and implement it together and we can come to that positive solution together. So I really think it starts as we've been saying by listening and then working together to actually create true change.

Jynx Frederick:

Great. Thank you. So I see that we've, so we've entered essentially the time allotted for the Q and a session. So we do have some audience questions. There's one in particular here that says, is there an opportunity for a mask culture to develop post-COVID similar to Southeast Asia where citizens wear masks when the risk of infectious diseases increases if the universal mailing of at-home tests is a success, can that inform how we screen and treat other infectious and communicable diseases? Is there anyone that would like to address this question in particular, or have any thoughts on it?

Nneoma Ozoukwu:

I want to answer the second part about the universal mailing of at-home tests. So, currently, right now, I don't think it's very successful because we're only sending out four tests per household. And that really comes back to the conversations. When we talk about equity versus equality, like equity would be making sure you're sending the right amount of tests per household, because you're missing a lot of

important groups when you're only sending four tests out and then ask for mass cultures. I do see a greater mass culture where especially when it comes to schools and hospitals, I don't really see much in like the general public and general events, but I do see a greater mass culture where though that would sustain post-COVID.

Erin McCauley:

Yeah. I want to kind of jump on that and echo some of the sentiments you said in terms of mailing. I agree it's right now, it's accessible for people who have an address. If you look at the homeless population, it's not necessarily a good solution to just have something that's mailed. I think having it publicly accessible or even given to shelters is a better solution or ways to bring those tests to the community so they can distribute it. So I think that's one of the key failures with these delivery of at home tests. It's a great first step, but there's so much more that needs to be done.

Erin McCauley:

In terms of mass culture, I do agree. I see it a lot in hospitals. And when I work in the clinic of, I think there's a lot of politics, especially in the US, unfortunately, behind wearing masks. And it would be great if we could develop that culture because even last year, during what we call flu season, there was almost not a very few reported cases of the flu. And I think wearing masks, especially when you're sick, could really help prevent that communicable spread of disease. It's just really unfortunate that it's become such a political thing. And my hope is that it will, we will be able to be in a culture where that is acceptable, but right now it's very politicized.

Noel Green:

I would like to respond just as well, I guess, in terms of the first response of the first part of the question, is there an opportunity for mass culture to develop post-COVID? I think in my experience of working with different populations and with masks, just getting access to masks, using them, it's not something that people are readily embracing already. And so to think in the future that we would be at a place where it would become at least a cultural norm for us to say, we will wear a mask. If there is a pandemic, people are more apt to stay home or to isolate rather than put on a mask. Also, the availability of masks in that just like our screening technologies, it's difficult for people to access. So to say that we would give to a place where our culture would be more accepting of it, I think is, is a little farfetched.

Noel Green:

And also I think in terms of just American individualism, that is different between our culture and Southeast Asia, where people are okay with connecting and, and embracing things as a group, whereas more so in America, we think of each other as I am different from you, even if we are a part of the same community, endorsing racial group, in terms of like the universe of mailing at-home test kits, in terms how that translates into other infectious diseases, our present strategies with just mailing test kits for HIV screening is not successful. We have embraced it in a large way across Chicago and different states I know. But the issue is even just doing an INSTI test requires a level of knowledge about infectious disease and biology.

Noel Green:

... About infectious disease and biology to even know how to ensure or prevent contamination of the kit and then having to send that back somewhere is a little lack of concern for the fact that most people don't have resources to buy a postage stamp to send things back, alone pay for shipping.

Jynx Frederick:

Would anyone else like to comment or we can move on to another question if no one has anything else they'd like to add?

Lydia Smeltz:

I just had one thing to add about when I'm thinking about these questions, I'm just thinking what new barriers would be introduced. So to speak to the mass culture, this is great from an infectious disease perspective, but if we just continue to only use the surgical mask, a lot of people who are deaf and hard of hearing rely on lip reading to help them understand and so even in the hospital setting, I've yet to seen the accessibility of mask with a clear face panel to help with lip reading. I look around the hospital all the time, I don't know where I would find one if I needed one and that worries me greatly. So if this culture were to develop here, I wonder what downstream effects we would see of new barriers being introduced. And so if it were to develop, I would hope that it would look a little bit different than the way I'm imagining it currently, and that we would be able to come up with new solutions to mitigate the new barriers as they pop up.

Jynx Frederick:

Great. Thank you. So another question that just popped up in the chat, there's sometimes a disconnect between public health research and what is actually practiced. How have you seen this disconnect manifest in your field of interest or your work? And this is addressed at anyone.

Noel Green:

I can jump on this. I think the biggest disconnect, I've been working in the field of HIV prevention and treatment for several years before now becoming the student, and what I thought was a large failure of our system was the diffused effective behavior interventions. The idea to test an intervention with several populations and four or five different states and then mass produce it so that people in every state working with similar populations would have the same amount of success was not thought through well. And even though there was some level of applicability in terms of the population and similarity of the groups, to say that the same success that was seen during the analysis of those interventions to be determined as effective and the actual implementation of those interventions, insights that were not a part of the evaluation phase was not, that did not happen.

Noel Green:

I'm just going to say it like that. How it was implemented, how it was cared out across the board changed. A lot of people had issues with fidelity of the interventions. And a lot of people did this thing where they were calling, they were freely doing things in the name of an intervention, and then calling it adapting without any level of a researcher involved to understand like how do we adapt while also ensuring the integrity of the intervention.

Jynx Frederick:

Great. Thank you, Noel. Anyone else have any comments on that?

Nneoma Ozoukwu:

So I have a comment. So, I definitely see this a lot in the field. If we do health equity research, I feel like there's just so much reporting on "okay, this disproportionately impacts, blah, blah, blah" and it's like okay, we know. We've been talking about this for years, where are the interventions? So that is one thing I really see. I would love to see the public health field focus now, like now we know certain things now let's focus more on how can we make interventions and evaluating possible interventions.

Jynx Frederick:

Yeah. I feel like that's a very relatable concept for all students.

Erin McCauley:

Yeah, I wanted to make a comment as well. I think we know that the criminal legal system has really devastating consequences for individuals and families in terms of their health, in terms of social stratification and inequality, and in terms of things like crime and the safety in our communities. The

more someone is involved in the criminal legal system, the worse their position is and the more likely they are to kind of engage in the type of activities that the system seeks to stop in the first place. And so, the goal of the criminal legal system is not to promote community safety and so, I think we know that yet there's been very little will to move away from the criminal legal system and to keep kind of families and communities intact.

Jynx Frederick:

Thank you. So we'll move on to another general question for all of you from the chat. So I know that we've kind of already discussed quite a bit of collaborative or the importance of collaborative efforts and intersectionality. This question is how important is collaborative department and professions in the work of health equity in the role of public health? And so if anyone has anything extra they'd like to add on this, please do. Otherwise we can move on to another question.

Priyanka Kumar Mathur:

I'll make a quick comment on this. So I worked on an interagency team with IDPH and we had public health students, we had my medical students, we had people within IDPH, we had residents, and I think creating that diverse team really created different perspectives and allowed people from different professions and different backgrounds and research and areas of interest to highlight important parts that eventually did go into our intervention and allowed just different perspectives to come in and inform decisions we made, which is really critical to kind of having a diverse kind of frame of thought.

Priyanka Kumar Mathur:

And so, for example, I wish we'd had somebody who was really informed on disability like Lydia. I think that would've been a really great perspective to have and could have also changed some of the interventions we made. So having more people on a team with different perspectives can bring in different things. Like I'm just hearing our panelists talk and I'm like, wow, I can add so many more things to some of the initiatives we did. So I just like to say that would be a great thing to have in any intervention.

Nneoma Ozoukwu:

I like to add-

Erin McCauley:

Oh, sorry.

Nneoma Ozoukwu:

No, you can go ahead.

Erin McCauley:

Sorry. I'll be quick, I promise. Just along those lines, I just want to point out that formerly incarcerated individuals face substantial barriers to gaining employment in the field of public health research and practice. And so I think we really should collectively work to reduce those barriers that those folks can be involved in this important work that we all do. So I would encourage everyone to look at the employment policies at your institutions and organizations, and then to try and preference formerly incarcerated individuals when hiring to do this work.

Nneoma Ozoukwu:

Also just want to make a comment on just the importance of collaboration, especially when it comes to health equity, because we really saw this when it comes to vaccination campaigns. We saw that scientists made the vaccine. I remember I was, [inaudible 01:16:39] has a background in biology. I was like, oh my God, it's so exciting. Okay, time to distribute the vaccine and it was not as great as we thought it would because we needed the voices of different perspectives and people to really show,

okay, what is it to vaccine, what's the purpose of vaccine, what does it do. So I think it's just really important that we're collaborating with other communities and different perspectives just to we're making interventions to promote health equity.

Ankita Patil:

I just, I'd reinforce that point. I think even beyond vaccines, and that's a really good point, but in addition we've currently seen a lot of these tests being ordered and I think in the coming days and weeks, we're going to see a lot of N95 masks being freely available at pharmacies and other institutions. And I think the general public maybe doesn't have the resources to understand all of these non-pharmaceutical interventions, how they should be used, what's the optimal way, when, where, and how to use them. And I think collaborating, especially with social scientists, but also with community leaders could generally promote more equity in public health. And I think that's something that public health people talk about a lot in academia and outside of academia, but don't necessarily champion when it comes to implementing these interventions. So I think that's also another area to focus on.

Noel Green:

I'd like to further emphasize that point, that collaboration between departments and professions in this work is necessary. An example of this that I can think of is in recent years, we have seen a lot of conversation around interventions and program design that prioritize teaming and, or bring people into a client's support planning that are part of their social networks and or informal supports. This has been a standard practice for the field of child protective services for over 20 years. And so public health is now developing this, but however, if we would've invited cross sector partnerships to really talk about how we could approach an issue of this nature, we could have probably realized this 10 years ago. And so in terms of how we accomplish things in the populations that we serve is necessary because there are tools and resources and knowledge that are not at our disposal because public health acts in silo across the country and will at later stages make collaboration important when it should be a priority at the beginning.

Jynx Frederick:

Thank you. In the interest of time, I'm going to end our Q and A session and then move on to our final remarks. So we're just going to have each of the panelists go through and give a one minute final remark. We'll start with you Carolyn, if you want to go ahead?

Carolyn Fan:

Yeah, of course. Yeah. I just wanted to say a huge thank you to the AJPH thing tank for holding this event and to other amazing panelists, I'm so looking forward to reading all of your articles. And so for my closing statement, I just want to say that during the COVID 19 pandemic, this country has just seen an immense rise in anti-Asian violence and it's been almost two years and we've seen all of this in the news, and I know we've been dealing with more reports just this past week. However, stopping anti-Asian hate goes beyond just stopping violent hate incidents. To allow ourselves to fully address the effect of hate, violence, racism on the health of the Asian American community, the public health field must realize the long legacy of anti-Asian racism in the US. There's a myriad of forms of this from historical violence, state violence, colonial violence, and more, and each must be acknowledged, contextualized, and addressed by public health students, researchers, and practitioners to fully achieve health equity for Asian Americans. Thank you.

Jynx Frederick:

Thank you, Carolyn. Go ahead Noel. Your one minute final remark?

Noel Green:

One, thank you, thank you, thank you for allowing me to be a part of this meeting of the minds of such great people. It has been an honor. But my point that I want to drive home as I close is what's happening

in our field in regards to HIV prevention and treatment is that funding is decreasing as we get close to zero. What that translates into is less employment options for the people that are highest impacted by HIV/AIDS. And so what needs to happen in the future? This needs to be a systemic priority that CDC, foundations, health departments need to prioritize programs, initiatives, projects that embrace the idea of translatable skill development for those people that are on the front lines of the work. Because if we don't, as we closer to zero, they will be left with zero jobs.

Jynx Frederick:

Thank you. Priyanka, we'll give you an opportunity to give your final remark.

Priyanka Kumar Mathur:

Yeah. First thank you to AJPH Think Tank for letting me come on here and kind of bring my perspective and it was really great to meet all the panelists. I really look forward to reading your guys' papers as well. So I just want to say this COVID 19 pandemic, really highlighted how much work our healthcare system needs, especially for marginalized populations and including them in public health initiatives. This initiative showed me how much of an impact working in public health and policy can have. And that's something I personally want to incorporate into my future career as a physician, as a lot of these issues will directly impact my patients. I want to say my biggest takeaways from working on this is that, and for any public health intervention, is the importance and value of working with community partners and bringing the vaccine or whatever public health initiative is to the population.

Priyanka Kumar Mathur:

Talk with community organizations, and I really found that they have a very large depth of knowledge about their community and what works with the community and resource available. I encourage students who are interested in public health to reach out and work with your public health officials. And I encourage the panelists and those who are watching, the audience who are going to develop these future public health initiatives to include vulnerable populations in your work. Work with community partners to ensure that these vulnerable populations have access to these initiatives while bringing it to them. I also really want to thank my co-author Dr. Natasha Dolgin, who played a huge role in this, and also IDPH for putting vulnerable populations on the forefront of our thought and accessibility to vaccines in Illinois.

Jynx Frederick:

Great. Thank you. Priyanka, Erin, your final remark?

Erin McCauley:

Well, I just want to thank my fellow presenters so much in a AJPH Think Tank. It's been such a privilege to be here and discuss the broader consequences of mass incarceration. I also want to thank my co-author Katherine LeMasters, who's a PhD candidate in epidemiology at UNC. She was integral to this work. And really the COVID 19 pandemic has drawn attention to the role of mass incarceration in population health and its centrality to health equity research. Efforts to promote the teaching, research, and interventions around health equity must focus on the role that mass incarceration plays in efforts to improve data transparency and the need to really, truly dismantle our criminal legal system.

Jynx Frederick:

Great. Thank you so much, Erin. Your final remark, Ankita?

Ankita Patil:

Yeah, first of all, I just wanted to give a huge thank you to AJPH Think Tank and everyone who is here and everyone who contributed to the development of this program. I also wanted to give a huge shout out to my co-author, Nyla, she is also very integral to this whole process, my undergraduate institution, as well as my incredible mentor, Dr. Monique Jimenez. She is the one that has truly brought me to this

kind of work and has really helped me develop this passion. And I guess the last thing I wanted to say was that I urge all of you regardless of the domain of public health that you work in, even after this pandemic, which hopefully dies down soon, please continue to do your work and don't forget that these people will still continue to face problems and to make sure that we amplify their voices and really provide them a platform to make sure that they get the help and equity that they deserve. Thank you.

Jynx Frederick:

Thank you so much. Jayati, your final comment?

Jayati Sharma:

Yeah. Thank you again to the AJPH thank thank for this really great opportunity to be on this panel. And thank you also to my co-author [inaudible 01:25:40] and our mentors in public health and epidemiology who drive us to do this work. We're in the midst of a really challenging time and environment for public health, but I'm especially inspired by my fellow public health students here and leaders who are reimagining what it means to have an equity focused view of public health. Because I think this is what's really going to drive the change in our current and impending crises in public health, including climate change and other infectious disease pandemics in our future.

Jayati Sharma:

We've seen so many really great perspectives on public health here today. And I hope that we see more of these insights implemented in future public health planning. I think public health is only as strong as the people that are championing it. And I hope that through a community based perspective, we create many, many more of these public health champions within our communities that help us cultivate a more centered mindset. For the public health students on this panel and watching, I hope that we all can stay mindful of why we chose a career in public health, why we chose our training in public health, and stay mindful of the people that we serve and that they should be at the center of everything that we aim to do. Thank you.

Jynx Frederick:

Thank you. Lydia, your final comment?

Lydia Smeltz:

Thank you to the AJPH thank tank for allowing me to be here today and to elevate the voices of the disabled community and thank you to my co-author Sandy Carpenter and our mentor, Dr. [Lunsford 01:27:06] and the entire disabled community and all the disability activists I follow on Twitter who have been so vulnerable in sharing their stories and allowing me to learn from them and shape my advocacy accordingly. And I'd like to thank all the other panelists too, for being so vulnerable and for forcing me to consider how my advocacy can be even more intersectional as we move forward.

Lydia Smeltz:

I just want to encourage everyone here to take some time and reflect on this panel afterwards. We covered a lot and it can be really overwhelming when we're talking about all the work we need to do. And as I said earlier, our efforts have to be intentional and being intentional requires taking a time to reflect and guide your efforts accordingly. So ableism is an imminent public health issue and we need to be intentional and we need to be to be disability conscious in order to make feasible strategies and forward progress, and we need it now more than ever. So thank you all.

Jynx Frederick:

Thank you, Lydia. And Nneoma, your final remark.

Nneoma Ozoukwu:

Okay. First, I also want to say thank the Think Tank for allowing me to come on. I had a really good time meeting everyone. And for my final remark, I just want to say that what really has driven me to the field of public health is just my sincere belief that healthcare is a human right. And I really see that public health is just a form of social justice. And to me being a public health leader is to be, it's a form of activism. And a job of public health officials and for those watching should not only show people that inequity exists, but all also call them to action. And just my hope that inequities revealed during this pandemic has really driven the public health communities and officials just to think about actual steps and how we can alleviate them moving forward.

Jynx Frederick:

Great. Thank you so much, you all. This marks the end of the forum. A warm thank you to all of the panelists and guests who attended. To the panelists, I just want to tell you, it was of course, very humbling to listen to this conversation for you all to give the insight that you have. It's very incredible. The Think Tank wanted to pass on to you that we truly enjoyed reading all of your pieces and it's a testament to our abilities as students and public health practitioners, our abilities to work within the communities that we are passionate about. So thank you again so much for that.

Jynx Frederick:

I also want to thank my talented colleagues at the AJPH 2021 Think Tank cohort. We are almost done with our tenure, which is very exciting. Thank you to the American Journal of Public Health and the American Public Health association for sponsoring the event. You can follow the AJPH student Think Tank on Twitter at our handle, @AJPHThinkTank, and the American Journal of Public Health, @AMJPublicHealth. Please be on the lookout for the upcoming 2022 AJPH Think Tank cohort. And yeah, thank you all again. We really, really appreciate your time. It was a real pleasure. Thanks.