



JUSTHealth Web Publication

Igniting Our Communities to Eliminate Health Disparities

Issue 01: Summer 2020

About the Web Publication

JUST Health is a community-sourced web publication hosted by the Center of Excellence at Stanford School of Medicine, dedicated to elevating the voices of the San Francisco Bay and beyond around health justice, activism, and advocacy. This publication is designed to spotlight thought, research, challenges, and inroads in health disparities, health inequity, and social justice in medicine, health and wellness.

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Letter from the Editors

Welcome to the inaugural issue of JUST Health!

We are pleased to open this issue with submissions that reflect the challenges of our time. This journal operates under the premise that our society is in need of more voices that encourage us to listen, think, and act in order to help our societal neighbors. It is with that goal in mind that we invite you to enjoy this edition as a consumer and reader; and that we also invite you to consider a role as contributor.

Please send us your thoughts about this issue by visiting us on [twitter](#). If you are ready to submit your for the next issue, [click this link](#) and share your story, research, or arts-focused expression of health disparities. This work lays the foundation for building a community of scholars, citizen scientists and researchers, neighbors, educators, learners, and activists who envision a better, healthier society for all people.

In light of the untimely and heartbreaking death of Chadwick Boseman, we would like to take a moment to highlight the disparities in colorectal cancer. Since 1985, incidences of colorectal cancer have dropped roughly 25% for Whites, while rates have only increased for Black men and stayed constant for Black women.¹ Not only are Black people 38 to 43% more likely to die from colon cancer than are Whites, but they are also more often diagnosed at later stages, suffer from better-differentiated tumors, and have a worse prognosis.¹ Fewer Black patients receive adjuvant chemotherapy for resectable colorectal cancer or radiation therapy for rectal cancer.¹

The socioeconomic and educational differences by race and ethnicity account for most of these disparities and there is little evidence supporting the possibility of genetics contributing to said differences.¹ Screening for colorectal cancer reduces the mortality rate significantly through the detection of cancer at an earlier more treatable stage. According to the American Cancer Society, the recommended screening age is 45 years old but more and more physicians are beginning to suggest individuals should start the screening process earlier.

We urge all, and especially Black men, to begin having these talks with their physicians and even start the process of screening if not already. Honor Mr. Boseman's legacy by doing this not only for yourselves but for those close to you as well.

[Click here for resources pertaining to colorectal cancer including FAQs, tests, and much more.](#)

In justice and in health,
The JUST Health Editorial Board

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Being Pre-health in the Time of COVID-19

By Marcella Anthony

Amidst a pandemic, the Center of Excellence in Diversity in Medical Education (COEDME) welcomed the 21st summer cohort and first ever virtual summer program participants in the Stanford Summer Community College Premedical Program. Lessons learned traveled beyond participants to instructional faculty, staff, and guest speakers, reminding them why pipeline programs are an essential component in recruiting a diverse health workforce committed to serving marginalized, minoritized, and vulnerable populations and reminding participants why they chose medicine as intended careers.

SARS-COV-2, also known as COVID-19, has demonstrated tremendous humanity alongside heartbreaking apathy of our global and national society. As a student development professional at a world-class medical center, it has been awe-inspiring to work alongside the talent and expertise that instantly come to mind when you hear “Stanford,” knowing that physicians, scientists and public health professionals are leveraging networks and groundbreaking science to race toward a vaccine and effective public health practices to address this dangerous respiratory virus.

To our dismay and difficulty, life and time wait for no one, and we have watched the maldistribution of resources, conflicting messages from our national leadership, and a variety of responses to this global pandemic. What a challenging and inspiring time to be a pre-health student!

This summer, amidst tremendous circumstances, the Center of Excellence in Diversity in Medical Education (COEDME) welcomed the 21st summer cohort of 35 premedical college students from across the state of California, all indicating strong interest in entering a health profession, primarily medicine. The Stanford Summer Community College Premedical Program

(SSCCPP, referred to as “skip”), in its many iterations over the years has always focused on increasing physician workforce diversity through early outreach to college students who would not otherwise have access to such an opportunity.

This first ever virtual experience that historically has relied on person-to-person contact and establishing and maintaining a collaborative living and learning community, struggled through many uncertainties: determining if participants would have the technological tools to participate in the program; assuming that under certain circumstances, sheltering at home generally meant sheltering safely at home, and that participants indeed had a home with appropriate space to spend 8-12 hours per day interacting with instructional staff, guest lecturers, and each other; using varied strategies to promote engagement.

These challenges are not dissimilar to those of the medical community when considering how to serve patients in this modified environment: access, safety, a climate conducive to the best health and wellness given the circumstances, and the opportunity to interact with people and resources that offer education, outreach, and a

network in order to have the best overall health possible.

The COE(DME) focuses on creating and sustaining an environment that fosters the development of a diverse corps of physicians and health professionals capable of addressing health inequity. Many if not all of our SSCCPP participants have been impacted by social and structural determinants; and over the summer, demonstrated their own expertise through personal narratives of institutionalized racism, discrimination, power, privilege, and oppression as members of a society that has increasingly responded with hostility and violence toward their communities.

I can say with certainty that our faculty and program staff learned as much if not more than the participants themselves given this socially and physically restrictive environment. Participant experiences have a

lesson for all of us: as societal citizens, we must consider all people as neighbors, all suffering as pain to be alleviated where we can, and all struggle as a shared burden in order to fight the many battles day-to-day that help us gain footing toward winning the war against health disparities. We must work in unison to map a clearer path toward better health and wellness.

As we embark upon this journey, we recognize that addressing health disparities is social justice work. JUSTHealth is a journey toward health justice for all - not the privileged, not the wealthy, but all of our societal neighbors, locally, nationally, and globally. We hope you join the movement, voice your narratives and join the conversation as citizen health managers, advocates and activists by contributing to the JUSTHealth web publication.

Environmental Health Justice and Equity: An Obesity Epidemic

By Chisomaga Ekwueme

Structural racism is a phenomenon referring to the institutional level policies, practices, and inequitably structured systems that result in minorities being collectively deprived of sufficient resources and opportunities to succeed. Structural racism and environmental justice intersect with food equity when analyzing the inequitable distribution of environmental burdens, such as lack of access to healthy foods, spaces to exercise, social support services, and other hazardous factors across communities and how these factors contribute to chronic, possibly life-threatening, health conditions.

Marginalized communities and people of color disproportionately face higher burdens of obesity due to the numerous exposures to obesogenic environments they encounter. With the public school system in particular, unhealthy, heavily processed, poor quality, and harmful foods are being served to school children and are, thus, fueling the childhood obesity epidemic in the U.S. Hence, there is a great need for quality, healthy, fresh, and nutritious food for these children to mitigate childhood obesity, foster greater academic achievement, and combat other adverse physical, social, behavioral, and psychological health outcomes. This video highlights a personal account of the poor quality meals served at public high schools, the health consequences that resulted, and an activism plan for pre-medical students interested in pursuing this initiative.

According to the American FoodCorps Services, public school districts currently spend only 1.19 dollars on each child's meal- a deeply saddening statistic. An envisioned large scale implication of addressing the history of racial and class inequality through this activism plan is the reallocation of federal funding towards school food programs and the emergence of policy and programmatic interventions or strategies that promote food equity in schools and communities of color. The intended launch date for the first action item, the environmental health justice leadership program, is January of 2021. The second and third action items, the food justice initiative and youth-led movement, will be implemented once the leadership program begins to accommodate the involvement of the cohort.

Video can be viewed at: <https://youtu.be/SJR4pT2gzYw>

Islamophobia: Ways to be an Advocate and/or Activist

By Setareh Harsamizadeh Tehrani

9/11 terrorist attacks changed the perception of the Muslim community to the entire world, especially in America. Government crime data suggest that Islamophobic sentiments have increased, and many Americans associate Muslims with fear-related terms such as war, violence, and terrorism. Muslims have been victims of hate crimes, and as a result, they struggle with mental health problems such as depression and anxiety and physical health problems such as higher blood pressure and preterm birth. Islamophobia: Ways to be an Advocate and/or Activist provides information regarding how Islamophobia is negatively affecting the Muslim community. This presentation goes over the visions of a first-generation Muslim immigrant student on how she thinks the American government can address Islamophobia. Additionally, this video covers five strategies that pre-health students can use to be advocates and/or activists for Islamophobia. Besides, there are different ways that pre-health students can measure the effectiveness of these strategies. This presentation introduces students to Emgage Action, an advocacy organization that helps Muslims ask for legislations that represent their rights. Emgage PAC- a national political action committee- works with candidates that support issues that are representative of the underserved communities. Emgage Action is currently working to pass Anti-Hate Crimes Resolution, H. Res. 257, which condemns hate crimes and any other form of racism, religious or ethnic bias, discrimination, or animus targeting a minority in the United States. This presentation is concluded by a quote that calls students to take action and be the change they want to see.

Video can be viewed at: <https://youtu.be/6b0OuNGhx2M>

Notes from La Clínica

By Christian Rivera Nolan

Poem: Notes from La Clínica This poem was originally penned in the Spring of 2017. It is an expression of insight and the lived experiences of individuals I had the opportunity to work with, listen to, and share space with. Certain details have been left out or changed but the nature of the stories expressed in this poem is based in truth. These are a collection of stories and experiences spread over a two year period spent working/ community organizing in a Bay Area Student-run clinic for undocumented peoples and recent arrivals. These are some of, but not all of the insightful and powerful experiences I had there. The piece is predominantly in English but does have the Spanish language intertwined throughout. The heavy use of Spanish is justified as the vast majority of patients in the clinic were Spanish speaking dominant or spoke no English at all. Many of these conversations were had in Spanish, to stay true to this and my own mixed heritage, it is reflected in the structure. The Medium of expression is Poetry. The larger poem consists of six smaller subdivisions which are marked by the use of " ____ " as a form of page break, while not interrupting the flow of language. This piece directly speaks to the lived experiences of Immigrant/undocumented populations here in the Bay Area. Through their stories, we can gain valuable and unique insight into the intersectionality of migration, health disparities, substance abuse, and the difficulties/trauma of crossing borders. To my mind, these types of stories demand to be elevated by such institutions as Stanford which will help to publicize and legitimize the struggle, growth, and realities of immigrants within a medical context.

'Notes from *La Clínica*'

Our patients are teaching me humility
They've shown me our constant reality made flesh & blood
It is not always pretty
But it is true, rooted & real.

They've touched my life in deep and impactful ways
Some days I come home and want to cry
None of it is fair.

This empire of trauma
These systems that bind us.
So many broken brown bodies.

I feel privileged to have this opportunity to work with them
A student to their struggle,
I am made speaker for the dead
Dead dreams, and dying bodies.
Today he is like a lesson
Like smoldering ash.

Homeless, self-medicating, malnutrition
Alcoholism your warmest hug.
You told me you have had this ongoing headache for two years
The pain prevents you from sleeping,
But it won't improve without sleep.
As I come to understand your pain
My heart sinks, I do not have the answers
What if I told you I cannot help you.

You drink so much that the Tylenol would
Smash your liver
More harm than good.
I asked you what a "drink" meant in your book
You admitted a drink was "maybe 12 or 15 beers"
Cases and cases of chelas
Not normal sized, the big ones.
None of this is new, I've heard this many time before
From many different faces.
We cannot give you a Motrin for the pain either
Because you never know for sure when or from where your next hot meal will come from.
The doctor in our Clínica says that GI tract bleeding is a real concern here
That it would be irresponsible to prescribe given your context.
I sit listening to the medical students and Doctor
I'm looking for answers in their faces
But everywhere I turn
I recognize a resignation
This is a failure of the system they say
Without saying,
There is no magic fix
I sit back and sigh.

You came in with a nail in your foot
We said it didn't look infected but please we are just students
Please just, just wait for the doctor to take a look
But
I could see the beginnings of withdrawal
Rocking back and forth
Anxious, tense jaw,
It was in your eyes.
You left
I pleaded with you to Stay,
Stay in the Clínica, La Doctora will see you only in a short while.
You said yes, promised, just step out for a drink to calm the nerves.

You never did come back,
Never answered my calls
Matter of fact I never did see you again
I took it home with me that day
But we are here-
La Clínica
When you're ready.

Clínica opens at 8 a.m.
It's 8:05 in our circle
Our círculo like a waiting room
Like a confessional
A safe space.
I want to make small talk
I ask about her necklace
It's beautiful
"does it have a meaning?"
I ask
"pues sí"
gazing away she says- "Mi hijo"
...he was murdered not long ago
Near his home
She explains
As she began to cry.
Su Compañera wraps her arms around her,
Her husband recently passed away too
You find strength in each other's arms
En Nuestro Círculo.

A quiet woman sits on the edge of our círculo
Mirando
Escuchando
She begins to speak.
Explaining how
She was deported
Crossed La Frontera back
How Los Coyotes held her in a room made prison cell for twenty days
She still has the same shoes on
The floors were disgusting she explains
Dark rooms,
They fed her but once a day
She could not bring herself to eat.
She's been coming to our Clínica to work through things

She cut her hair, dyed color.
As a Clínica, we bought her a new pair of shoes.
One of my favorite moments,
Her face when she slipped out of those same old shoes
She had on through it all.
Ella lanzó, llorando
It was a small thing, but to her, it meant the world.

How do I tell you?
No tengo las palabras
You did everything right
Everything you could
But I am sorry you are not Pre Diabético anymore
You have type 2 diabetes.
But I'm not the one that has to tell you that
That's the Doctor's job
Silencio
The patient room is quiet.
When your wife not missing a beat
Chimes in that things will be okay
Her smile, her warmth
Su amor por él, pero sobre todo su esperanza-
Convinces us that things will be okay.
Things will be okay.

We are sitting in El Círculo
A vigil for a patient no longer with us
We are a small group.
It's quiet
I am searching for the words
just seeming to escape me.
They talk
I listen,
Of friends and family
Of borders
Parents who passed away on the other side
While children were away
Who never could return.
These man-made walls that shut us in
They never had proper closure
To hold their fathers
Their mothers as they passed away
These stories are not uncommon.

Yet in your way, you explain that your father is still with you
Siempre.

The men speak of drink,
The comfort sought at the bottom of a bottle
It's expensive and gets us into trouble they say.
He, freshly sober
Battling with these shadows
The death of his girlfriend
Desire to drink and stop the pain
That stalks him daily.
The conversation turns to me,
They ask me if I drink?
So in my best Pocho Spanish, I tell them
Pues Sí,
Soy de una familia de alcohólicos
¿Pero los jóvenes toman mucho verdad? Especialmente los hombres.
They laugh
Pero es importante para mi, que
Siempre cuando estoy tomando
Tengo que pensar
“¿porque estoy tomando?”
¿Me entiendes?
¿ Es solo que yo quiero disfrutar un poco?
O,
¿ Hay algo mas que no quiero sentir,
Hay algo que no quiero ver?
Everything quiet
They nod their heads in acknowledgment
In understanding.

I leave it all in that room
With the Pan Dulce, El Rosario
Con Los Flores y La Vela.

Cardiovascular Disease and its Risk Factors Disproportionately Affect African Americans

By Catherine Moretto Regout

This paper reviews 10 articles to determine the association between being African American and developing or dying from heart disease in the US. The findings of this research were that there are various statistically-significant disparities among different sectors of human health that directly contribute to disproportionately higher rates of heart disease among African Americans; these include physician bias, healthcare coverage, health behaviors and more. Findings highlight the importance to address disparities on every level of the social ecological model, and discuss recommendations for community/social stressors (interpersonal level); neighborhood resources/environment (organizational level); coping mechanisms and diet/exercise (community level); and socioeconomic status (public policy level).

Introduction

African Americans in the United States bear a disproportionate burden of cardiovascular disease (CVD) cases and deaths due to heart failure, as they have the highest rates of mortality for CVD among all races/ethnicities in the US. These health consequences are due to the high rates of CVD risk factors and poor health behaviors among African Americans. Modifiable risk factors, which can be improved through lifestyle changes, have been coined by the American Heart Association as “Life’s Simple Seven” (LSS). LSS include blood pressure, cholesterol, blood sugar, activity and exercise, diet, weight/BMI, and smoking.

However, having ideal LSS behaviors only addresses risk factors on the individual level and doesn’t ameliorate those created by interpersonal, organizational, community, or public policy levels of the social ecological model (SEM). Thus, it is evident that public health interventions and policies are necessary to improve the more universal risk factors, shown in Figure 2. These factors can be targeted at each level of the SEM: community/social stressors (interpersonal);

neighborhood resources/environment (organizational); coping mechanisms and diet/exercise (community); and socioeconomic status (public policy).

Minority groups endure social stressors from discrimination, with several studies indicating that minority groups are less likely to seek healthcare because of physician bias. Organizational risk factors such as neighborhood resources and environment are linked to poor cardiovascular healthcare.¹ On the community level, trends in coping mechanisms like smoking and alcohol usage are other modifiable risk factors.² Since life course socioeconomic status (SES) is an important predictor of CVD in African Americans, it is the government’s responsibility to implement policies that decrease gaps between SES levels.

There are very few systematic reviews examining the risk factors associated with African Americans developing and dying from CVD. This is because the study exploring this, The Jackson Heart Study (JHS), will not be completed until 2024. This paper reviews significant publications of the JHS, and other supporting articles, to guide health policies

and interventions that address risk factors of CVD among African Americans on each level of the SEM.

Methods

The following electronic databases were searched: PubMed, NCBI, and library databases of both Stanford University and Santa Rosa Junior College. Within each search engine, variations of the following search phrases were used: Risk factors of heart disease, African Americans; Jackson Heart Study, cardiovascular disease; Cardiovascular disease, African Americans; Socioeconomic factors, heart disease, African Americans.

Inclusion criteria were papers that: were authored by the JHS, researched prevalence of CVD among African Americans, and studied the risk factors and social determinants of CVD among African Americans. The exclusion criteria were papers that: studied biological mechanisms and signaling pathways of CVD, focused on CVD among general minorities, studied genetic lineages of African Americans, and studied hypertension rather than CVD.

Results

Using the search terms discussed above within the databases of PubMed, NCBI, Santa Rosa Junior College Library, and Stanford's Lane Library, about 34 prospective studies were identified from keywords in the paper titles. After reviewing the abstracts of these prospective papers, this number was narrowed down to 13 studies either due to time-relevancy (studies needed to be <13 years old) or content relevancy (studies from JHS had to focus on CVD or heart failure instead of diabetes, for example). Next, taking into account the inclusion criteria that the papers had to show significant research on either the risk factors contributing to CVD or

the prevalence of CVD among African Americans, the group of 13 was then narrowed down to a reasonable cohort of 10 studies to be reviewed for this paper (see Figure 3 for reference).

Of the 10 studies reviewed, there was one literature review, one systematic review, two meta-analyses, and six cohort studies. Five out of the six cohort studies made evaluations using data gathered from participants in the JHS. The sample sizes for the cohort studies ranged from 1,115 to 5,301 African American participants, had a median of 4,323 participants, and had a mean of 3,707 participants.²

The JHS is the "largest community-based epidemiologic investigation of environmental and genetic factors associated with cardiovascular disease among African Americans ever undertaken."⁹ This cohort study takes place within the Jackson, Mississippi metropolitan area.⁹ Data was collected from 5,306 participants and the study's age range is from 35-84 years old. Study participants in this review not from the JHS were African Americans aged 45-64 years old. None of the JHS participants had all 7 ideal LSS components, and the most common number of LSS among JHS participants was 3 out of 7 ideal components.¹¹

Discussion

After reviewing JHS's publications and other articles, this review's findings highlight the consistent discrimination African Americans face in healthcare, utilizing CVD as the vessel to do so. For example, African Americans were much less likely to receive care for a heart condition or have a physician that is culturally competent and empathetic.¹ Though disparities between race and care have decreased by 50% in the last 20 years,¹

rates are still relatively high due to unconscious physician bias and insurance bias.¹ Insurance bias could be mitigated by a universal healthcare system because equivalating insurances could reduce racial disparities.¹ Also, cultural competency training could be required of physicians to improve unconscious racial biases.

Other significant findings were that socioeconomic status and age were the largest contributors to the predicted development of CVD.^{8, 12} To address these risk factors, public policy could be used to form programs supporting the elderly that decrease negative outcomes of socioeconomic disparities in low-income neighborhoods. The JHS organizes several community programs that target these risk factors: the “Healthy Housing Initiative” sends community nurses to take blood pressure screenings for home-bound elderly residents and the “Healthy Promotion” event educates low-income communities on healthy heart practices (such as LSS).⁹

This review uncovered that high-quality research addressing the efficacies of community programs in reducing cardiovascular racial disparities is virtually nonexistent. While this discussion has proposed the implementation of some JHS community programs, there is no evidence that such programs could actually reduce CVD risk factors and death among African Americans. Future studies should compare the effects of various health and policy interventions on health outcomes caused by risk factors from each level of the SEM discussed in Figure 2.

The ideal approach to improving the management of CVD risk factors would be to use organizational-level interventions¹⁶ and

monitor the effects of this approach using a longitudinal prospective cohort study. Future studies should gather high-quality data on the JHS community programs, which already aim to address risk factors on multiple levels of the SEM. Future studies could also model the JHS, testing exposures from each SEM level to determine which is most effective in reducing disparities in CVD. In order to guide public policy and health interventions, future researchers must determine which intervention methods and preventative community programs are most effective in reducing rates of CVD in African Americans.

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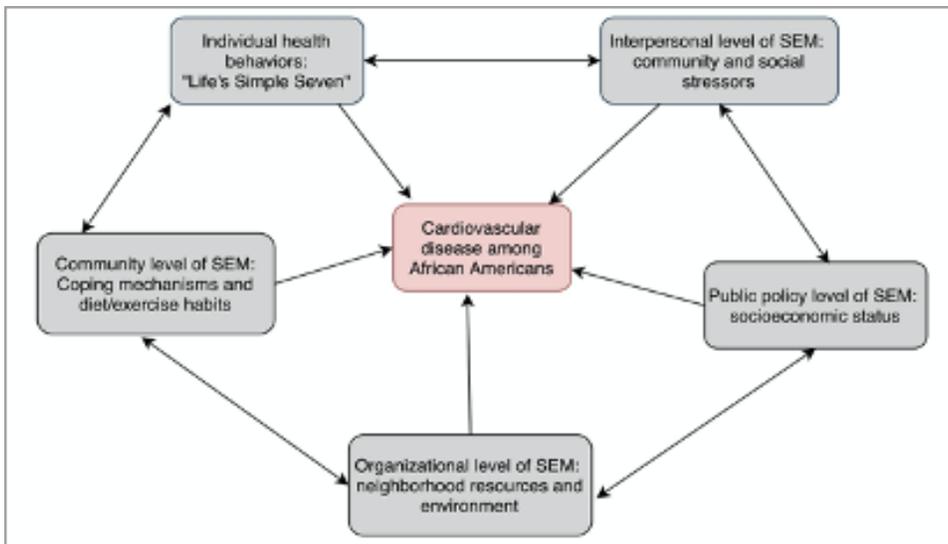


Figure 1: Conceptual diagram illustrating different risk factors that contribute to the likelihood of African Americans developing heart disease and in turn having higher rates of deaths from it. (Author’s figure)

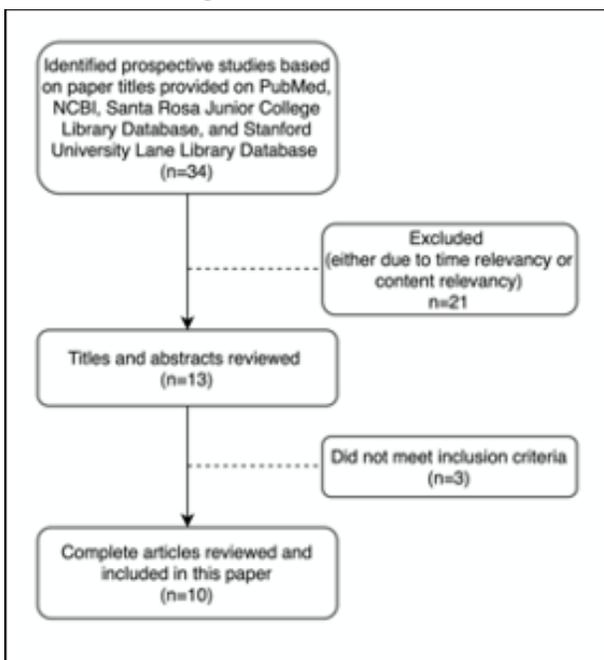


Figure 2: Flowchart summary of paper selection process for this review. (Author’s figure)

Addressing Hepatitis B Racial Health Disparities among Asian Communities

By Derek Chen

Hepatitis B disproportionately affects Asians and Asian Pacific Islanders in the United States, and it is a well documented racial health disparity. Some individuals may not have received hepatitis B vaccinations or testing due to factors that include, but are not limited to, language barriers when accessing healthcare or uneducated health literacy. Among the Asian community, 2 out of 3 individuals are unaware that they are infected with viral hepatitis B. If left untreated, the disease can progress into hepatitis-caused liver cancer; this is one of the leading causes of death among the Asian community. The policy brief aims to advocate for state legislation in favor of mandating hepatitis B testing for patients to address the gap in hepatitis B health disparities. The proposed position is to introduce mandatory hepatitis B testing for hospitals and primary care clinics, so more patients can get hepatitis B testing performed. Without governmental legislative intervention, the racial health disparity gap remains unaddressed, and disproportionate hepatitis B infections will remain unchecked in the Asian and Asian Pacific Islander communities.

Summary of Key Points

- ❖ Hepatitis B disproportionately affects Asians, with a documented racial health disparity in public health
- ❖ 2 out of 3 Asians with hepatitis B are unaware of their health status in the United States
- ❖ Chronic hepatitis B infection can lead to liver cancer and is one of the leading causes of death among the Asian community
- ❖ Legislation is necessary to mandate viral hepatitis testing to close the racial health disparity gap

Asian and Asian Pacific Islander communities

Hepatitis B disproportionately affects Asian Americans. In the United States, 1 in 12 Asian Americans is chronically infected with hepatitis B, whereas 1 in 1,000 non-Hispanic Whites are infected with hepatitis B.^{1,2} The racial health disparity is prevalent across the globe, not limited to the United States. Worldwide, 240 million individuals live with chronic hepatitis B, which leads to 60-80% of liver cancer deaths globally.³ Locally, in Santa Clara County, Asian and Pacific Islanders make up approximately 1/3 of all Santa Clara

residents, and this population growth is expected to increase by 50 percent by 2060.⁴

Living with hepatitis B

People living with hepatitis B can develop severe liver problems; left untreated, chronic hepatitis B can cause liver cancer.⁵ In fact, among Asian Americans, liver cancer remains one of the highest causes of death in the United States.^{6,7} Chronic hepatitis B often has no symptoms until the disease progresses to an untreatable stage. Fortunately, hepatitis B is a preventable disease through vaccinations, yet 2 in 3 Asian Americans with

hepatitis B do not know they are infected with the virus.^{6,7} Thus, education and awareness of hepatitis B must remain the highest priority in preventing deaths associated with liver diseases, including liver cirrhosis and liver cancer. The policy brief addresses the high need to pass legislation in the State of California that requires healthcare professionals and clinics to implement hepatitis B testing among patients, therefore addressing the racial health disparity among Asians and Asian Pacific Islanders.

Successful state precedent in hepatitis testing

There is state precedent for passing legislation regarding mandatory hepatitis testing at the state level. In January 2014, the State of New York implemented the nation's first hepatitis C testing law.⁸ The bill passed aims to protect the baby boomer generation, who are known to suffer from higher disproportionate rates of hepatitis C infection, by requiring hospitals and health service providers to offer testing for patients born between 1945 thru 1965.⁸ An evaluation performed in 2016 found that the number of hepatitis specimens tests of baby boomers increased by 275,000 tests — up from 538,000 in 2013 to 813,000 in 2014 — a 51% increase of hepatitis C tests one year after the law was implemented.^{9,10}

Policy recommendations

Mandatory statewide hepatitis B testing for all Californian patients can potentially combat hepatitis B racial health disparities among Asians. Such an act can encourage inpatients in a hospital setting or outpatients in a primary care clinic to seek hepatitis B testing.¹⁰ Under the Affordable Care Act, most

health insurance plans cover viral hepatitis B testing.^{11,12} Furthermore, many private insurance plans will cover a majority or all costs associated with hepatitis B testing, depending on the particular individual insurance plan. There is evident insurance coverage for viral hepatitis B testing, but no California law that mandates healthcare providers to test patients. Thus, without passing and implementing a law, the gap in hepatitis B racial health disparities rates will not close.

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A Public Health Crisis: Being Black in America

By Makaelah Murray

“A Public Health Crisis: Being Black in America”, was originally written on August 10th, 2020, 77 days after the murder of George Floyd. It declares being Black in America a public health crisis by definition and urges lawmakers to first declare this as the public health crisis it is, and then implement the necessary policies required to help solve the crisis. It also highlights that the only reason individuals began to believe everything Black people have been proclaiming for years regarding racial injustice was solely a result of the way COVID-19 forced many to exit their beguiled states. The date of this publication is August 31st, 98 days since the murder of George Floyd and we are back at square one with the attempted murder of Jacob Blake by police officers in Kenosha, Wisconsin. On August 23rd, 2020, Jacob Blake was shot in the back seven times in front of his three children and has since been left paralyzed. Shooting a man seven times in the back only indicates an individual's desire to kill. Seven times. He was shot in front of his three innocent children seven times. They will never be able to forget the day they saw their father, their hero, hunted like an animal and left paralyzed. Never will their father be able to run and play with them again. We all know what that officer's intentions were. He must be fired, arrested, and convicted of this attempted murder as well the murderers of George Floyd, Breonna Taylor, and the countless others. My heart aches for Jacob Blake, his family, and my Black community who continually sees the killing of their own in so many different capacities. I sincerely hope we can use this racial uprising to actually make change for the better. This commentary piece is dedicated to the Black lives lost in the hands of intolerant beings walking this Earth. #BlackLivesMatter.

“Crises are not defined by objective criteria; there is no formula with a cutoff score. Rather, a crisis is defined by the sense of urgency and importance at pivotal moments. The history of public health demonstrates the central role of crises in shaping policy”.¹ In 2020, we are living in one of the most pivotal moments we have seen throughout history, clouded by the COVID-19 pandemic but also one of the loudest racial uprisings we have ever seen as not only a nation, but as a world. It was all sparked by the killing of George Floyd in which revolts occurred across the world protesting his demoralizing, barbaric, and regrettable death. Yet why haven't public health officials deemed 'being Black in America' a public health crisis?

As a result of COVID-19, the mistreatment of Black people has been highlighted and emphasized by those outside of the Black population because we are not in our usual entranced state, consumed with work, schooling, or whatever it was that kept us occupied pre-COVID-19. COVID-19 has caused many individuals around the world to recognize they were living in a bubble and one that many other individuals could never even fathom. COVID-19 has caused the largest racial uprising in years, yet the state of being Black in America has not been deemed a public health crisis even though the sense of urgency and importance at this pivotal moment is more apparent than ever.

The mistreatment of Black people in America is a public health crisis, and it should briskly be deemed one because this mistreatment transcends the older male demographic. This mistreatment impacts Black women and children just the same, and more than any other race results in death. The heightened rate of death within the Black community at the hands of White America is a result of racism and racism, both experienced and perceived, is associated with adverse health outcomes.²

The heightened rate of death is apparent in many facets within the Black community: between 2010 and 2014, Black males who were 10 years and older were roughly three times more likely to die at the hands of police violence when compared to their White counterparts³; Black women in the United States are one to three times more likely than White women to die from pregnancy-related complications, in which these deaths are more likely to be preventable⁴; and lastly there is a breast cancer mortality gap adversely affecting Black women in the United States.⁵ A possible reason for this is because on average, Black women had a mean of 16.7 more days between biopsy and treatment and 15.7 more days from mammogram to treatment than White women⁵. These are a select few of the many adverse ways Black people in America face death at higher rates in America compared to other races.

Each of these instances of death in the Black population is a result of implicit racism present within the systems that are supposed to protect, help, and serve everybody equally. In terms of police officer killings, when analyzed it was found that the shooting of unarmed Black men was more likely to be due

to threat perception failures than the shooting of unarmed individuals of other races within the Philadelphia Police Department, just to name a small example.⁶ Threat perception failures describe the way officers assume they are in a more dangerous situation when faced with a Black suspect compared to a White suspect.⁶ However, if these same officers were asked about their biases, of course they would not be open about these biases but rather they would claim the situation was more dangerous than most.⁶ But, as threat perception failures illustrate, the influence of implicit bias can be insensible and abstruse.⁶ Similarly in healthcare, studies found a significant correlation between high levels of physicians' implicit bias against Blacks on Implicit Association Test scores and negative interactions cited by not only Black patients but also external observers.⁷

Therefore, it is a public health crisis to be Black in America. We are treated adversely in a multitude of different systems that are supposed to guard us. America must first recognize these issues, and then implement policy to address this public health crisis because it can and should no longer go on. Do not let COVID-19 be the only reason why one is fighting for justice for all. Once COVID-19 has subsided, do not surrender to the monotonous way of life once lived, only believing what is in one's own personal bubble. Remember the killings of Breonna Taylor, Ahmaud Arbery, George Floyd and the countless others who have lost their lives, and let their killings inspire one to keep fighting, keep advocating for change until one day we are all treated equally. Until the day Black people do not die at higher rates because of implicit biases. Until the day we can live in the same neighborhoods without

dissent or apprehension. Until the day we can call each other brothers and sisters and treat each other as such.

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Inequalities in Community Level Gun Violence: Impact to Approach

By Jeremy Miller

How effective and sustainable are recent calls to “defund the police” on reducing violent crime within our neighborhoods? Among adults, the homicide rate for Black Americans in all 50 states is eight times higher on average than that of White Americans. African American children have the highest rates of firearm mortality overall, which was found to be 10 times higher than white children. Gun violence, like other non-communicable diseases, disproportionately impacts inner-city minority communities and meets the classification criteria to apply the disease model to elicit a multidisciplinary approach. Approaches: The two approaches to deal with community violence are the public health approach and the criminal justice approach. The public health approach prioritizes community-based interventions while the criminal justice approach prioritizes expansion of existing police resources. Both were found to reduce victimization in high-risk communities. However, the public health approach was more efficient and cost effective. In addition, a combination of the two within the same community was found to reduce violent crimes greater than any single method alone over a shorter time frame. Recommendations: Further research to identify gun violence’s impact on marginalized populations is needed to create comprehensive interventions. In the meantime, deviation from the criminal justice approach and relocation of funds towards community-based violence prevention programs shows promising results in the reduction of gun violence in urban cities.

Over the past few months, there has been an increasing demand to “defund the police,” with the assumption that federal funds can be reallocated to community level social programs which are better equipped to deal with non-violent social issues. This talking point has garnered widespread support in the modern age of social media, but is there any data to support this idea? Despite popular belief, national rates of gun homicide and other violent crimes are strikingly lower now than during their peak in the mid-1990s, pointing to a general decline in the overall rate of violent crimes. Gun homicide rates began to rise in America in the 1960s, surged in the 1970s, hitting peak levels in the 1980 and the early 1990s.¹ Despite this decline, a Pew Research Center survey showed that 56% of Americans believe gun crime is higher today than 20 years ago and only 12% think it’s actually lower.¹ To what do we attribute this disconnect between perception and reality?

Background

Recent data shows that on average, 36,000 people are killed annually in the United States from firearms with another 100,000

suffering non-fatal gunshot wounds. To put 36,000 deaths to scale, that’s roughly 100 people shot per day. While this number is striking in itself, recent data points to an upward trend in gun death with a 16% increase seen between 2014-2017.² Over the 12 year span between 2001 and 2013, guns took the lives of more Americans than the total number killed by war, AIDS, illegal drug overdoses, and terrorism combined during that same period. With a rise in gun homicides seen between 2015-2017, gun violence remains the second leading cause of injury and death among youth and adolescents behind car crashes.³ These facts alone should warrant immediate public health investigation and policy reform, however recent politicization of gun reform has masked what it truly is: a public health crisis. While potential policies that prioritize federal regulations on gun education and safety might prove to be most effective, federal policies fail to account for the structural inequalities around gun violence that exist within our communities.

While some have the impression that gun violence is random and widespread, research has shown that it tends to follow a

distinctive pattern that public health officials have begun to track. It is estimated that twenty percent of all firearm homicides occur in the 25 largest U.S. cities.⁴ In 2015, the CDC reported 81% of firearm homicides occurred in urban areas with disparities greater than those in cities that are more ethnically and racially diverse.⁵

Inequities in gun violence

Using Philadelphia as an example, the safest district in Philadelphia is approximately 85% White and reported no firearm related deaths in the year 2014. Compare this to the most violent neighborhood which reported 189 shooting injuries and 40 fatalities, which roughly 90% of the residents identify as a Black. The homicide rate for Black Americans in all 50 states is eight times higher on average than that of White Americans.⁶ Within cities, gun violence is clustered among racially segregated, economically disenfranchised neighborhoods.³ The communities most impacted by gun violence are also known to be disproportionately impacted by an increased burden of non-communicable diseases, creating compound issues that significantly impact the health of their residents.

Media portrayal of gun violence has an impact on the way this issue is framed within society. Recently, gun violence in schools has been elevated into the spotlight with what seems to be an increase in the number of school shootings. As of August 2018, there were 56 incidents of gunfire on school grounds; however, media favors reporting only those incidents at Sandy Hook, Parkland, and Santa Fe - shootings in suburban areas with majority White populations. Outcries for help around intercity gun violence have been largely ignored, despite community leaders voicing concern for years. All too often, gun violence seen within suburban communities is believed to be due to structural social issues, whereas urban gun violence that affects minority populations is seen as an individualized community issue. Whether the

media reports it or not, gun violence on school grounds disproportionately affects students of color and occurs most often at schools with high enrollments of minority students.⁶ African American children have the highest rates of firearm mortality overall, which was found to be 10 times higher than the rate of White children and Asian American children.⁷

Recently, there have been increasing calls for comprehensive and multidisciplinary approaches to unpack the root causes of the social determinants of gun violence. The social determinants of health include factors such as social capital, income inequality, residential and racial segregation, economic segregation, non-medical social spending, and intergenerational social mobility.⁸ Key indicators that were found to have the strongest associations with gun violence were social capital, social mobility, state and local welfare spending, and income inequality, which were all associated with gun homicide rates.⁸ Welfare spending, institutional social capital, and social mobility exhibited the most robust associations, while upward social mobility showed the largest effects – with 1 standard deviation increase associated with 25% reduction in homicide rate and a 24% reduction in non-fatal shooting numbers.⁸ While the most obvious impact of gun violence is associated with loss of life, impacts on community safety often translate into the rate of community growth. Communities with higher rates of gun violence show slower growth in new retail and service businesses as well as slower home value appreciation.⁹ Property tax on homes is often used to fund education, explaining why more affluent neighborhoods are able to invest more in their public education systems and further widening educational inequalities seen between neighborhoods.¹⁰

Varying approaches to mitigate gun violence

The four characteristics used to classify diseases are etiology, pathogenesis, morphological changes and clinical significance. Given gun violence's

representation in these four categories and its impact on health and longevity, there has been a push to classify it as a disease rather than a social issue. Framing gun violence as a biopsychosocial disease engages the healthcare community to facilitate a multidisciplinary approach to address it.¹¹ While some might argue that this model is ineffective, the disease model has been applied to the prevention strategies of communicable diseases such as HIV, Zika, and Tuberculosis with great success. Much like other illnesses, we see that gun violence follows predictable patterns and, if not treated appropriately, leads to lifelong impacts on the health and wellbeing of the individual and the community.

The criminal justice and public health approaches are two competing theories on effective methods to treat gun violence. The criminal justice solution to urban violence prioritizes initiatives that increase the police workforce with a focus on “hot spots”, or small areas in a community which account for over half of a city’s crime. While some favor this approach, there is an increased concern around police abuse and racial biases which is something we’ve recently seen play out over the past several years.¹² Due to these concerns and lack of systemic improvements seen over the years with the criminal justice approach, many have turned to the public health approach as an alternative solution.

The public health approach aims to reduce urban violence by targeting at-risk youth and redirecting conflict to community agents trained in conflict management.¹² Cure Violence is an organization that has gained traction since this framework was piloted in major urban across the United States. This community-based approach uses key components to stop the transmission of violence by working with friends and families of victim to prevent retaliation and mediate ongoing disputes, changing the thinking of those at highest risk of perpetrating violence and changing group norms about violence in the broader community.¹² Compared to the

criminal justice approach, the public health approach implements the use of street outreach workers who mentor young people identified to be at the highest risk for violence, connecting them to career and educational opportunities. In addition, the deployment of specially trained staff into the community as “violence interrupters” act with the sole capacity to identify, mediate, and stop conflicts and retaliations between residents or gangs.¹²

When the criminal justice approach was applied to a representative community, policing produced a modest reduction in victimization. Doubling the size of the police force and implementing hot-spots patrol strategies for 10 years reduced annual victimization by only about 11%.¹² The results of the public health approach utilizing Cure Violence methodology were stronger in their reduction of victimization and more cost effective. The presence of two interrupters and one outreach worker in every high violence neighborhood resulted in a 13% decrease in victimization, with more reduction possible given the addition of another interrupter. When comparing the two, a 24% reduction in violent crime and homicide rates could be accomplished with 150% increase in police force for 20 years or by the work of two interrupters and one outreach worker in a high violence neighborhood for 20 years. Using New York City as an example with 36,000 police officers employed at an average salary of \$93,000 a year, the criminal justice approach would cost taxpayers an additional \$5,022,000,000 *per year* for 20 years (over \$100 billion) compared to a plan that would cost a fraction of that.¹³ Cure Violence has been rated as one of the most cost-effective community-based violence prevention programs currently available.

While the public health approach using the Cure Violence framework seems superior when compared to the criminal justice approach, the greatest reductions in violence can be seen with both approaches deployed simultaneously. Deploying two interrupters

and one outreach worker for 5 years reduced violent victimization by 7.7%, while the same intervention plus a 40% increase in hotspot policing reduced violent victimization by 10.9%.¹² The impact of the two frameworks working together means that greater reductions in violence can be achieved using fewer resources and in a shorter time frame. Over a 10-year period, a 19% reduction in violent victimization could be achieved by increasing the police force by 40% in conjunction with deploying two interrupters and one outreach worker.¹²

Barriers to Implementation

The potential benefits of prioritizing common-sense federal gun regulations should not be overlooked as a potential strategy to curb community level gun violence. States with stricter gun laws document lower gun death rates per 100,000 on average compared to those with more passive gun laws, showing the potential benefits of more stringent federal gun laws.¹⁴ Though this might be effective, the political battle that will ensue will prolong potential benefits, with time measured in lives lost and not days. Immediate action is needed but barriers to implementing these community-based programs still exist. Reclassification of gun violence from a social problem to a disease remains a major barrier to the mobilization of multisectoral approach.

Further research on the impact of gun violence on vulnerable populations is necessary. However, barriers to research have persisted since the Dickey Amendment in 1996 which stated “none of the funds made available for injury prevention and control at the Center for Disease Control (CDC) may be used to advocate or promote gun control”.¹⁵ In march of 2018, a house spending bill clarified that the Dickey Amendment did not prevent public health research on gun violence, leading to the passing of a bipartisan bill which allocated \$25 million to the CDC and National Institute of Health to research gun violence.¹⁶ While this is considered a win for those of us in public health, a 20-year lag on

data still remains and must be addressed. If we want to move forward on the issue of community-level gun violence, we must continue to prioritize gun violence research as well as community-based intervention strategies. Gun violence affects everyone in society and exacerbates health inequalities. It continues to be a public health crisis and should be prioritized as such.

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Pandemic Privilege

By Neha Krishnam

This article talks about the implications of COVID-19 on vulnerable populations, specifically Black and POC with low socioeconomic status. This article specifically touches upon the issue of income inequality in the USA and how this plays onto privileged upper class people being at an advantage, especially during the pandemic whereas those of lower SES have to suffer more. This article calls for people to start paying attention to the real issue of inequality that is causing these skewed mortality rates and a call to action for better social safety nets.

The COVID-19 pandemic is affecting lives throughout the world; however research shows that this pandemic is disproportionately impacting certain communities across America. Recently, Sharelle Barber from Drexel University's School of Public Health stated that "Black communities, Latinx communities, immigrant communities, Native American communities-are going to bear the disproportionate brunt of the reckless actions of a government that did not take the proper precautions to mitigate the spread of this disease that that's going to be overlaid on top of the existing racial inequalities".¹As Barber mentioned, these vulnerable communities are at a significant disadvantage, especially due to several health disparities such as income inequality and environmental injustice.

Income inequality is defined as the uneven distribution of income within a group of people.² These unequal societies as measured by income distribution, typically have worse health outcomes than equal societies.^{3,4} The situation with COVID 19 is exacerbated by these class gaps and while these inequalities are finally becoming exposed and vocalized, it may be too late. People with more money will find it easier to practice social distancing. They have financial resources to maintain online connection to

friends and family via technology, buy masks and necessary sanitation supplies, and be in the comfort of their own homes during quarantine.

But what about those without this advantage? Research has shown that those with lower income status, and thus socioeconomic status, generally work in occupations such as grocery clerks, gas station owners, and food workers or better known today as essential workers.⁵ Studies from Econofact show that among those who are working the frontlines, 70% of people cannot work from home and within this group of frontline workers, 39% are women.⁶ These people are considered essential workers and without them, the country would come to a complete halt. A majority of frontline workers are characterized by being people of color, low income status, and being less educated than the average worker.⁶ They are more likely to have kids or immunocompromised family members at home yet, they need to go into work as there is no online alternative and thus, are consequently placed at risk.

Worse health outcomes such as poor mental and physical health are associated with lower socioeconomic status as these individuals have less access to healthy food, education, and a good workplace amongst other things.⁷ Without proper awareness and

education about physical distancing, COVID-19 symptoms, transmission, sanitation procedures, or government rules, people with low socioeconomic status are at greater risk of acquiring or transmitting this illness. Hopefully people start highlighting these issues and the entire health care system will change. Those who are calling for universal healthcare have a strong argument and will only fight harder to get equal and free access to healthcare for all. The government needs to restructure their capitalistic and profit driven society to benefit not just those who are at the top but those who are disproportionately

disadvantaged. Economic safety nets need to be factored into plans and the allocation of money towards healthcare needs to be investigated carefully. Individuals of high socioeconomic status are less likely to become infected with Covid-19 due to circumstances and also have pandemic privilege that allows them to quarantine at home safely. This situation has certainly brought upon loss and hardship for numerous people however; it has the potential to bring real social, economic, and political change to this country. It only took a global pandemic for people to start paying attention to the real culprit- inequality.

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The Effect of COVID-19 on the Black Lives Matter Movement

By Esther Nwozo, Sarah Solomon, and Jallena Abraham

"I am sick and tired of being sick and tired." - Fannie Lou Hamer. In this piece, we as students of Howard University describe our experiences living in a global COVID-19 pandemic during the Black Lives Matter movement of 2020. Although one may think our experiences and reflections would be similar, this is far from the truth. In this piece, we showcase our thoughts on these daunting times, and these thoughts provide insight into the complexities of the Black experience. By interviewing students who have been active during these protests, we have conducted a form of research that provides insight into the different perspectives of young African Americans. We touch on the topics of mental health in the African American community, the rise of political protests and influence of social media, and the growing support of undermined issues within the Black community. Our literary submission reveals that these times have led to plenty of contemplation and action.

"I am sick and tired of being sick and tired." - Fannie Lou Hamer

There are many signs of mental deterioration, and this verbal expression is one of them. The mental health of African Americans has always suffered and continues to decline as a result of the apparent progression of the United States in regard to civil rights. The great Fannie Lou Hamer was a SNCC (Student Nonviolent Coordinating Committee) organizer back in the 1960s, who was evicted from her farm after registering to vote and thrown in jail for urging other African Americans to register to vote. As an African American woman who had faced many trials and tribulations, this did not phase her in her pursuit for both civil rights and women's voting rights.

In the United States of America, African Americans have been continuously held back from opportunities to succeed. For instance, in school, these students are over-diagnosed with learning disabilities. "...there is evidence to suggest that the gap between black and white students in rates of identification with a learning disability has increased since the 1970s, with blacks being increasingly more likely to be identified (Ong-Dean 2006)... Statistics like these raise concerns that students are identified with a learning disability according to characteristics unrelated to their cognitive processes."¹ On top of these experiences, young Black men are

told they are going to wind up in jail, or that they will never make it out of the "hood". Young Black women are constantly reminded that their hair is "distracting". Black students in general are faced with disbelief when they are told they are "articulate" or demonstrate academic excellence. With encounters like these that are instilled so young, it can only lead to the deterioration of an African American's psychological resilience.

It is without a doubt known that the rate of African Americans suffering from mental health related conditions have increased during the COVID-19 pandemic. While fighting for proper health care and treatment in hospitals, African Americans are also battling with racial discrimination in their everyday lives. The uproar of the Black Lives Matter protests occurring during this pandemic has put African Americans in a perplexing position of having to choose between fighting for their health or their civil rights, and unfortunately, both paths are risky and can potentially lead to death.

In order to conduct our own research, we first interviewed fellow Howard University student Iesha Mars, who is the newly elected Miss College of Arts and Sciences, to hear her experiences during these times. "Living in the BLM movement, protests have been both beautiful and frightening. Protests have also been a metaphor for how Black experiences are stolen in this country.

All protests are beautiful rituals of celebrations, memorials, love, and unity. These rituals always get violently silenced by police officers, by majority white men. I have been shot at with tear gas and rubber bullets. I have been laughed at while crying out the names of our murdered mxn and womxn by the people who are supposed to protect and serve. Then the police, our assaulters, are continuously protected by our government. If protests aren't a taste of the Black experience since America's birth, I don't know what is."

As if racial trauma was not already hard on us as African Americans, we now have to deal with the sudden uproar surrounding the Black Lives Matter protests amidst an unanticipated pandemic, which has only highlighted other areas where African Americans have been disadvantaged. Our health has been compromised time and time again, but not to the extent we have seen recently. While we wanted to go outdoors and protest alongside our brothers and sisters, others felt as though they could not put themselves or their families at risk of being exposed to COVID-19.

We interviewed another Howard University student for his thoughts, Peter Lubembela. Peter is a founder of 10For10, an organization that promotes cultivating social equity through service. "Along with tackling police brutality, we were forced to address the racial disparities in COVID-19 cases. The sad fact is African Americans are dying at a higher rate from COVID-19 and are at risk because of their classification as essential workers. The African American community has taken all precautions to ensure our safety and has fought political leaders for more testing centers and resources to combat COVID-19."

So, the question became how we could engage in activism without having to step outside into a hazardous environment. The power and demise of social media came to the forefront; it has become beneficial when looking for resources but has contributed to the unrest in our minds. Social media has provided an outlet for people to vent, express

their views, share important information during these difficult times, and provide solutions to issues at large. Social media has also shown that there are many ways to protest--whether it is showing up to protests, sharing information or resources, signing petitions, donating to causes that need funding, reading books by Black authors, voting in local elections, or supporting Black content creators and Black-owned businesses. There was a lack of support given to Black people prior to the pandemic, and the recent racial uprisings have taken a toll on Black people. In turn, this has pushed people — especially Black people — to pour into Black-owned businesses. More people are promoting, supporting, and employing Black people in their restaurants, businesses, music, and films, to name a few.

Social media use throughout this movement, however, has become problematic when perpetuating performative activism. For instance, "Blackout Tuesday" was a collective action that took place on June 2nd, 2020. The purpose of Blackout Tuesday was intended to allow people a day to express their solidarity with the Black Lives Matter movement via social media. Rather than bringing attention to the Black Lives Matter movement and creating an appearance of solidarity, it ended up flooding black squares on the feeds of people's pages, which ultimately ended up blocking resourceful information that protesters utilized daily. Later in the day, people eventually ceased posting useful information, which in turn limited protestors' access to information. This collective action also exposed that for some social media users, participating in Blackout Tuesday was enough-- a one-time act of support for the Black Lives Matter movement. Some users even went as far as deleting their black squares after the day was over, revealing that maintaining their social media "aesthetic" or "brand" was more significant. And of course, there were those who did not participate at all — rather, they continued posting their leisurely activities, tasteful meals, and

well-edited selfies. African Americans are repeatedly faced with the complexity of drawing and maintaining both attention and support concerning our injustices.

To be “sick and tired of being sick and tired” carries a new meaning in today’s age. As three young women sharing similar experiences as Black women in America, living in a global pandemic during the Black Lives Matter movement of 2020 has shown us that our country is not ready for the power our voices hold as one. Attending Howard University has encouraged us through its rich and expansive history of leadership, truth, and service the importance of utilizing the power of our education as voices. It does not take research to understand the complexity of the issue — rather, as we have come to learn, our research can be done through our shared experiences as African Americans in today’s society.

References

[1] Shifrer, D., Muller, C., & Callahan, R. (2011). Disproportionality and learning disabilities: parsing apart race, socioeconomic status, and language. *Journal of learning disabilities*, 44(3), 246–257. <https://doi.org/10.1177/0022219410374236>

JUST Health Artwork

By Axanti Anthony



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Corrections

Correction to Rivera-Nolan, 2020. *Poem was not published in its entirety according to the author's submission. The entire poem has been posted. The JUST Health Editorial Board regrets this error.*

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