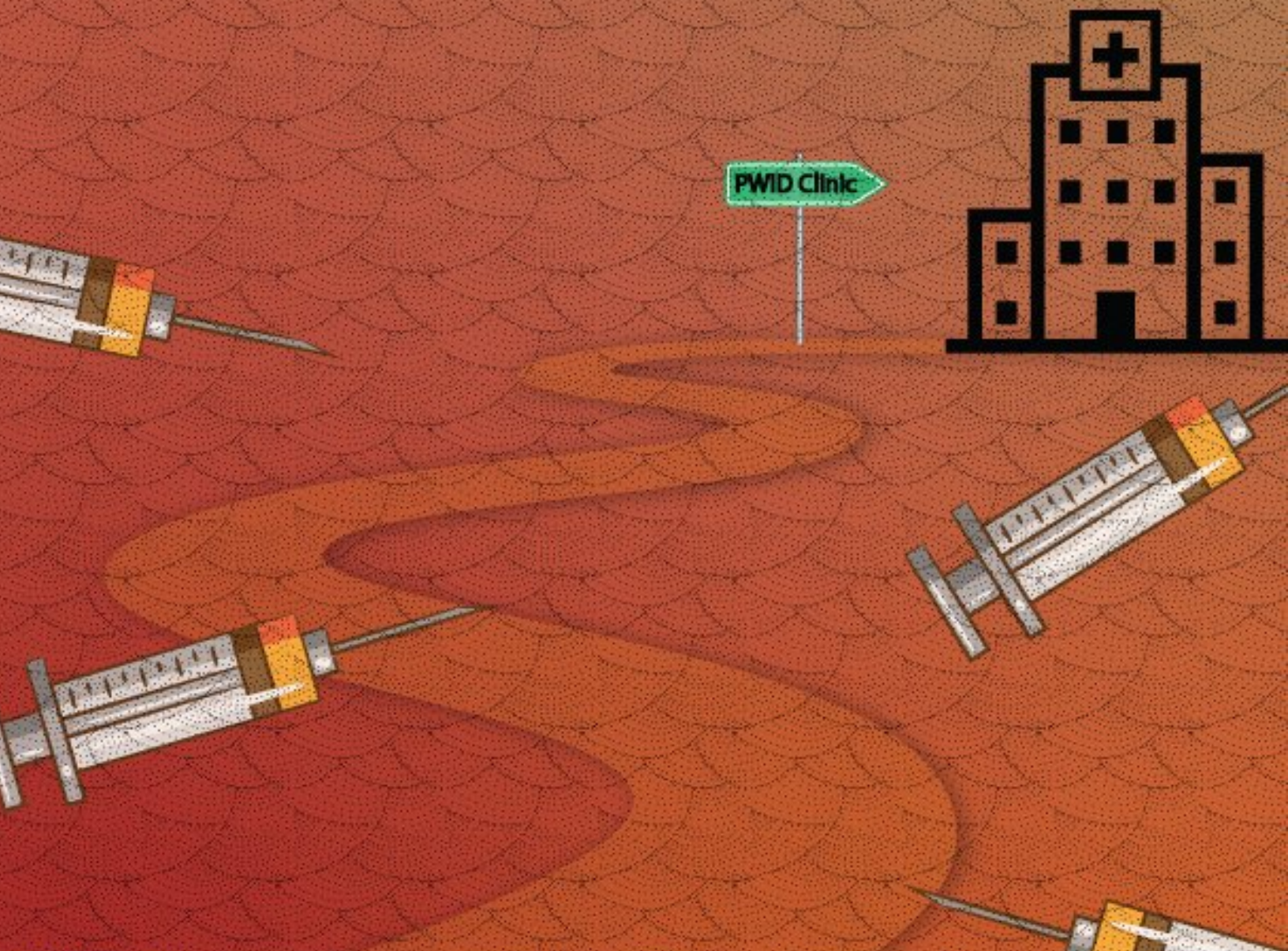


JUSTHealth

Issue 03 | Fall 2021



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About the Web Publication

JUST Health is a community-sourced web publication hosted by the Stanford Medicine Office of Diversity in Medical Education, 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 3rd 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 needs more voices that encourage us to listen, think, and act to help our societal neighbors. With that goal in mind, we invite you to enjoy this edition as a consumer and reader; we also invite you to consider a role as a contributor.

Please send us your thoughts about this issue by visiting us on [Instagram](#) or [Twitter](#). If you are ready to submit your piece 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, citizens, scientists and researchers, neighbors, educators, learners, and activists who envision a better, healthier society for all people.

Nearly two years since the pandemic first started, we finally have vaccines. Vaccine uptake is, arguably, widespread. In California, about 60% of the population is fully vaccinated which aligns with the near 57% of the nation who are fully vaccinated.^{1,2} While this number can and should increase further to reach herd immunity, there are many reasons preventing that — many of which can be traced to politics. As a result, we may be at a standstill in terms of getting more Americans fully vaccinated. However, there is now an FDA-approved booster shot available for those who have received the Pfizer-BioNTech vaccine and are 65 & older, immunocompromised, or front line workers.³ Many of these individuals have taken advantage of this opportunity to additionally protect themselves from COVID-19, and rightfully so. But, what does this feel like to countries who haven't received even one dose of the COVID-19 vaccine?

Well, in America, we have many vaccines sitting in doctor's offices, pharmacies, and hospitals that other countries could have surely benefited from. With the addition of booster shots to doses already available in our local medical care facilities, the chances of doses being wasting will grow should we decide not to use them.⁴ We recognize the perplexity that comes with shipping our 'leftovers' to various countries and therefore believe our government should do more to ensure global citizens have access to their first vaccination. Permitting richer countries to maintain or 'hoard' vaccine supply will only delay less advantaged countries in receiving theirs.⁵

Should the government have ordered boosters so preemptively without thinking of our brothers and sisters across the world who haven't even had their first dose? We don't believe so. But the reality is that we in America now have access to boosters and we cannot let them go to waste. The United States can accomplish administering booster shots domestically while also facilitating better vaccine allocations abroad.

Let's not forget this is a GLOBAL pandemic and many people are being significantly impacted — especially outside of America. Additionally, we cannot just send vaccines to these other countries without infrastructure support for the administration of these preventatives. We cannot, as a nation, choose to be oblivious to other countries' exigencies — instead, we as global leaders need to be facilitators in developing countries which requires the generation of a truly bottom-up initiation.⁶

We encourage our readers to partake in their civil duty to get vaccinated, prevent wasting booster shots (if eligible), and advocate for individuals around the world who do not have access to the vaccine. For more information, visit the W.H.O.'s campaign for vaccine equity at: <https://www.who.int/campaigns/vaccine-equity>.

In Justice and in Health,
The JUST Health Editorial Board

* Please find references on pg. 31

Implementing a Hepatitis C Testing Center and Wound Care Clinic at the Only Syringe Service Program in Orange County

By Meleeka Akbarpour

I currently volunteer at the Harm Reduction Institute (HRI), the only syringe access program in Orange County, which provides safe injection supplies, referrals, and naloxone to people who inject drugs (PWID). After hearing from our clients, I've identified two unmet medical needs among PWID: the prevalence of blood-borne infectious diseases, and soft tissue infections. Many of our clients require medical attention but are reluctant to go to a hospital or doctor's office due to past stigmatizing experiences. Therefore, I implemented a clinic within HRI that tests and treats Hepatitis C and provides wound care to clients. The clinic's goal is to decrease HCV transmission rates and improve the quality of life of patients. I want to give power back to them and create a safe place where their autonomy is respected. The clinic has been running every Monday since June of 2021. At the clinic, I take patient histories and do the appropriate physical exams. I then present the case to my physician mentor, and we see the patient again together to do Hepatitis C testing, and incision and drainage procedures. Since the clinic started in June of 2021, I have seen an average of 4 new patients every Monday, and the patients that we are currently treating also check in every week. Many of our patients are now on medication-assisted treatment, and others have quit taking certain drugs, which has resulted in finding housing and jobs. We are also treating one patient for HCV, and another recently got his wound drained. We also support patients who currently have no plans to quit, by doing blood work and providing counseling. The clinic has become a place that upholds the human dignity of people who use drugs. We put power and resources in the hands of people who use drugs because they are every bit capable of improving their life circumstances as anyone else, as evidenced by these patients' stories. I hope to expand this clinic by recruiting more medical, nursing, and physician assistant students. I also want to raise awareness about the HRI clinic so that other syringe access programs can potentially implement similar clinics.

Background

Orange County is often viewed as a symbol of Californian wealth, however, the region is not immune to income inequality or the opioid crisis. Reports document that 1 in 200 Orange County (OC) residents experience homelessness each year,¹ and the opioid overdose death rate in OC is higher than the statewide rate.² People who inject drugs (PWID) have unique and often unmet medical needs including a high prevalence of blood-borne infectious diseases and soft tissue infections.

In August of 2020, I began volunteering at the Harm Reduction Institute (HRI), which is the only syringe service program in Orange County. Being a first-year medical student during the COVID-19 pandemic was isolating, so the weekly shifts at HRI became a welcome break from Zoom and studying. Directly interacting with individuals and providing them with safe injection supplies, referrals, and naloxone was fulfilling because I could immediately see the positive impact on each client. I built rapport with clients, the majority of whom were unhoused, and discussed their

needs with them. One conversation that stood out to me was when a client mentioned that their partner recently passed away from gangrene due to a wound infection. This story soon became one of many, as I noticed a pattern of clients asking how to care for abscesses and other wounds. I then identified that approximately 20% of our weekly clients had active abscesses.

A group of medical students and I began to address this gap in care by creating wound care supply kits and educational handouts. Since January of 2021, we have given out 820 wound care kits and over 1,000 educational handouts. When I was giving clients these kits, they often asked for advice on treating their wounds, many of which were visibly infected. However, clients were reluctant to visit the Emergency Department, claiming past experiences of stigma from the medical community. Studies have shown that stigmatizing experiences of PWID in formal healthcare settings contribute to negative attitudes toward seeking health care in the future.³ On the other hand, many PWID describes syringe service programs (SSPs) as accessible sites to receive high-quality medical care, which may limit stigmatizing interactions and their consequences on PWID health.³ Therefore, it was not surprising that HRI had become the only place many of our clients felt safe seeking medical attention.

I saw this as an opportunity to expand our wound care services by establishing an on-site clinic that would also treat Hepatitis C (HCV). Transmission of HCV in the US is primarily through non-sterile injections. Over 70% of people with new HCV infection in 2018 reported injection drug use.⁴ There are multiple treatment regimens of direct-acting antivirals available, which can successfully

eradicate viral load. Reports from a syringe services program (SSP) in New York found that 89% of patients achieved sustained virologic response to treatment.

Additionally, 46% engaged in treatment for opioid use disorder during HCV therapy.⁵ A subjective survey on HCV testing and treatment provided by an SSP in New York City concluded that patients are more likely to comply with treatment received from their local SSP.⁶ There are also notable psychological benefits of HCV treatment for PWID, as one study found over 75% increases in reported physical and mental wellbeing scores.⁷ After learning about these successes at other SSPs, I presented my idea of a clinic to the physician at HRI, and with his help, I began taking steps to implement a clinic at our SSP.

Objectives

The HRI clinic's goal is to decrease HCV transmission rates and improve the quality of life of our patients. I want to give power back to our patients and create a safe place where their autonomy is respected. I, along with the rest of the medical team, provide trauma-informed care, ensuring that we are sensitive to the cultural backgrounds, preferences, and values of people who inject drugs.

Methods

In March of 2021, I began working with Dr. Banimahd, who is the clinical director and founder of Zephyr Medical Group, which operates in tandem with HRI. We first located a room at HRI that we could designate as our patient examination room, and we ordered the necessary supplies to test for HCV and provide wound care. Clients who already had Medi-Cal and who were interested in coming

to the clinic registered to Zephyr Medical Group. I also helped interested clients who did not have insurance sign up for Medi-Cal.

In June of 2021, I started to see patients under the supervision of Dr. Banimahd. Patients have 40-minute initial visits that take place on Mondays from 12-7pm, which is concurrent with HRI's hours of operation. Follow-up visits are scheduled for 20 minutes. During these visits, I take patient histories and do appropriate physical exams. I then present the case to Dr. Banimahd, and we see the patient again together to do ultrasound-guided blood draws and incision and drainage procedures. Patients with positive HCV tests begin treatment during subsequent visits.

Outcomes

Since the clinic started in June of 2021, I have seen an average of 4 new patients every Monday, with current patients maintaining follow-up visits. While patients are supported regardless of their desire to decrease substance use, many patients have been initiated on opioid use disorder medication-assisted treatment such as suboxone. Others have tapered or quit amphetamine use, which has resulted in improved housing and jobs.

Conclusions

In the short time that the clinic has existed, it has become a place that upholds the human dignity of people who use drugs, especially in a society that has few welcoming spaces for PWID. We have not only helped people with their physical ailments, but also with their struggles in finding jobs and housing. The recovery process is not linear for most, but the HRI clinic is a place that people can always come to – regardless of where they

are in their disease and recovery process. Harm reduction means putting power and resources in the hands of people who use drugs because they are every bit capable of improving their life circumstances as anyone else, as evidenced by these patients' stories. My biggest accomplishment has been to help protect these patients' rights, as the use of drugs does not mean people forfeit their human rights.

Recommendations

Concurrently run SSPs and clinics are uniquely positioned to facilitate care to PWID by providing wound care and HCV treatments that will reduce morbidity and mortality. These clinics also decrease health care expenditures by reducing the number of soft tissue infections that require hospitalization. SSP clinics are a point of access to the health care system for this vulnerable population that has limited engagement with health care services due to past stigmatizing experiences.

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Contributions and Consequences

By Ashley Washington

The clenched fist is a gesture that Blacks have used in efforts, as well as solidarity, to demand equality and equity. But, I wanted to draw this fist as the body in order to expose health injustices as it symbolizes the health inequities that Blacks hold tightly to, whether it be from the past, present, or the future.

The blood-stained cloth is the hospital gown worn by black women and the stain is located at the uterus. Modern-day gynecology was built on the experimentation of Black female slaves by the father of gynecology, J. Marion Sims, who performed surgeries without anesthesia. This gown also symbolizes Henrietta Lacks' experience in the hands of surgeons that created the immortalized HeLa cells used globally. Blood represents the pain and the droplets below (uncolored) symbolize their contributions from the body to the world. Unfortunately, with all the improvements in women's reproductive health, Black women lead in postpartum mortality despite frequent consultations with their physicians. This long history of injustice shows that people (some physicians) believe Black women are immune to pain.

The index finger has a "95-83" tattoo. Those numbers are from the pulse oximeter that clamps onto the index finger. Recent medical articles and research studies have discussed the racial bias in pulse oximeter measurements. The darker the skin, the less accurate the readings. This is problematic because it is a commonly used medical device that can be inaccurate because of color absorbance ability.

On the upper-right side of the sketch is the Covid-19 virus being squeezed by the pinky finger. This is the stronghold. Blacks are struggling to let go of past experimentation for medical use without consent or full knowledge of the research. The mishandling of in-patient treatment towards minorities is a prime example. Below in the artwork, there is a needle piercing through the hand and a blue droplet at the tip of the needle acknowledging the Tuskegee experiment and historically poor patient-physician interaction. This needle symbolizes the use of Blacks for experiments, yet Blacks are not represented in a plethora of research studies.

If the healthcare industry of the United States wants to bridge gaps and make amends, then the hospital should be a safe haven for all, not a clear reminder that Blacks have no other place to seek medical help.



Horrific Healthcare Violations Against Uighurs

By Sarah Siddiqui

One of the worst events that occurred in 2019 was the incarceration of nearly one million Uighurs. In 2019, The Human Rights Watch reported that Chen Quanguo won the election as secretary of The Chinese Communist Party (CCP), and the government created a new agenda -“The Strike Hard” policy. CCP began its crackdown on the region of Xinjiang in an effort to combat religious extremism. Starting in 2019, CCP is closely monitoring Uighurs and is using the “Strike Hard” campaign as a witch-hunt for Uighurs, Kazakhs, and Hui Muslims. Those who practice Islam by reading the Qu’ran or praying at the masjid are taken to the internment camps. Men who have beards and women who wear the hijab are targeted and sent to the camps as well. CCP is masking the genocide of Uighur Muslims by simply stating they are eradicating extremism. As part of the “Strike Hard Policy,” Uighur Muslims have been stripped of their healthcare rights as they are victims of organ trafficking and forced sterilization. The austere conditions of the concentration camps are also a violation of healthcare rights. Impure water and stale food are served only a few times a day. In addition, about 50 prisoners are placed together in a small cell, making it a breeding ground for infectious diseases. As Americans, we take our healthcare rights for granted and we don’t value healthcare as an essential human right. In China, the CCP has deemed healthcare to be a privilege for everyone except for Uighur Muslims. The purpose of this paper is to raise awareness about the horrors in healthcare for Uighur Muslims. The Chinese government has not only imprisoned the religious beliefs of Uighur Muslims but also their bodies.

Organ trafficking is the process of illegally obtaining organs from an individual without his or her consent. In September 2019, the United Nations accused China of engaging in organ trafficking from Uighur Muslims. The Chinese government has subjected Uighur Muslims to undergo organ examinations and forced blood tests. The results of the organ examinations for each Uighur detainee are recorded in an online database. The UN reports, “Forced organ harvesting in China appears to be targeting specific ethnic, linguistic or religious minorities held in detention, often without the reasons for arrest or given arrest warrants, at different locations. We are deeply concerned about reports of discriminatory treatment of the prisoners or detainees based on their ethnicity and religion

or belief”.¹ The UN has acknowledged the fact that Uighur Muslims are deprived of their healthcare rights as they are imprisoned in concentration camps. In addition, forced organ examinations, blood tests, and organ harvesting are administered without the consent of the patient. This news has shocked human rights activists down to the core as they received proof of this horrific act from the China Tribunal. The China Tribunal is an independent international tribunal composed of lawyers and healthcare professionals. The investigation conducted by the China Tribunal stated that the most common organs removed from Uighur Muslim prisoners are the hearts, kidneys, livers, corneas, and even skin.¹ Hamid Sabi, a lawyer from the China Tribunal, investigated the matter and stated

that China was committing “crimes against humanity”.² Sabi also mentioned in his report that China has forcefully harvested organs from prisoners, a practice that has long been continued. The prisoners were alive when the incisions were placed on their bodies. The harvested organs were used for organ transplants and were prized black market commodities. Unlike the United States, there is a short wait time for organ transplants in China because the organs have already been harvested through the mass “killing” of Uighur prisoners. After hearing the report from China Tribunal, the Chinese government denied these findings and claimed that it only harvests organs from prisoners facing capital punishment. Sabi concluded the report by making a distinction, “Organ transplantation to save a life is a scientific and social triumph, but killing the donor is criminal”.²

In addition to organ trafficking, the Chinese government has permitted forced sterilization techniques upon Uighur Muslims. In the eyes of the Chinese government, Uighur Muslims are viewed as a plague that they wish to eradicate. In an effort to accomplish this, the Chinese government has imposed a child policy in which Uighur Muslims can only have two children.¹ If parents have more than two children, then they are placed in concentration camps. At the camps, Uighur Muslim women experience many violations of their healthcare rights. Uighur Muslim women are subjected to rape, STDs, intravenous injections, and forced implantations of IUDs. The forced sterilization techniques are part of the demographic genocide carried out by the Chinese government. According to AP News, the birth rate of Uighurs dropped almost 60% from 2015-2018.¹ Many Uighur Muslim women have recounted their traumatizing

experiences in the concentration camps on how they witnessed other prisoners being raped and undergoing abortions when they became pregnant. One of these women, Mihrigul Tursun, spoke up against the cruel treatment of Uighur Muslims and the several violations of ethical and healthcare rights by the Chinese government. In 2018, Tursun spoke at the Congressional-Executive Commission on China in Washington D.C.. She was imprisoned and her triplet children were taken away from her. She experienced multiple beatings, electric shocks, forced injections and was forced to take other medications. One of her children died at the camp and the other two survived, but have scars on their necks due to the feeding tube that was inserted. Tursun says, “I would rather die than go through this torture. I begged them to kill me”.³ She experienced the loss of her child and has been told that she can’t conceive again due to the pills and intravenous injections that she was forced to take at the Uighur concentration camp.

China is charged with violating a few human rights, including the tissues of organ trafficking and forced sterilization techniques. The United Nations plans to hold the Chinese government accountable for its healthcare violations and genocide against Uighur Muslims. These are important issues in global healthcare because Uighur Muslims and their bodies are imprisoned by the draconian laws of the Chinese government. The United States should also take action and raise awareness about the plight of Uighur Muslims in ethics and healthcare rights. UN Human Rights Chief, Michelle Bachelet, stated that she will be visiting Xinjiang to examine the situation of Uighur Muslims and demands “unfettered access”.⁴ Unfortunately, she hasn’t been able to

visit China yet, due to the COVID-19 pandemic. Hopefully, Bachelet will be able to visit Xinjiang soon so that China can once again be exposed for its unethical standards of the internment camps and healthcare violations against the Uighur Muslims.

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What Can We Do to Better Provide Personalized Medicine for Underserved Communities?

By Ellaine Arroyo

Personalized medicine is known for overcoming the limitations of traditional medicine since it is catered to each patient's unique genetic makeup. Although, some precision health advances lead to disadvantages that affect underserved communities at high rates. This community health project aimed to gather findings on the local population's insight on personalized medicine and determine next steps for providing more inclusive healthcare.

Video link:

<https://drive.google.com/file/d/1Ic3fgZNBBgdIOb7yJwEJK4XWeySGtR6J/view?usp=sharing>

Addressing the Educational Gap of Latinx Youth Due to COVID-19 Through Access and Mentorship

By Humberto Baquerizo MBA Ed, Zain Khawaja, Noah Sinangil

Latinx communities throughout the United States have suffered disproportionately from the social effects of the COVID-19 pandemic. Data shows that Latinx youth have fewer resources to accommodate virtual schooling. We developed a virtual, 13-week program to address this inequity in the Newark, New Jersey Latinx community. The objective of this study is to assess educational and personal characteristic outcomes from the virtual program. The program had professionals from various fields talk about their careers, paths, and answer questions from the participants. A detailed survey was sent out after completion of the program to assess outcomes. We observed significant improvements in critical thinking, career guidance, well-being, and teamwork. 65% of students stated the program increased their resilience, 75% discovered potential career choices, and 73% said that they felt like role models after interacting with those of similar cultural and personal backgrounds. Future studies should attempt to collect more longitudinal data in order to determine a causal effect.

Introduction

Latinx communities have suffered disproportionately from the social and academic effects of COVID-19, largely due to various social determinants of health.¹ During the COVID-19 pandemic, Latinx youth suffered from a lack of digital accessibility, social connections, educational spaces at home, and an increased prevalence of mental illness.² Mentor U, a Newark, New Jersey-based non-profit, recognized these inequities in the Latinx community. “Mentor U Chats” is a virtual program that was created to alleviate the negative academic effects of the pandemic. The program focused on science, technology, engineering, and mathematics (STEM) fields, but included sessions regarding business and law. 58% of participants in our program came from underserved communities, and 35% were Hispanic/Latinx. The objective of this manuscript is to assess the impact of our program on students’ personal characteristics and skills.

Methods

Mentor U Chats was a weekly, virtual program held for 13 weeks. The program utilized the Zoom video platform. Each session featured a panel of professionals and students that discussed their field of work and their respective paths. These panelists began their presentation in an informal lecture and ended the session with an interactive question and answer period. To assess educational and personal outcomes, we administered an in-depth, online questionnaire. The post-program survey assessed personal impact in the following areas: critical thinking, career guidance, well-being, cultural identity, and teamwork. These areas were chosen as they directly related to grit and resilience, as well as the social determinants of health.

Results

Critical thinking: students gravitated closer to potential career choices.

There were overwhelming positive outcomes with regards to students discovering potential career choices (75%), learning more about specific careers (64%), and the benefit of having a career plan (62%).

Career guidance: students gained an increase in confidence when searching for internship opportunities.

Our students narrowed their career focus (63%) and now feel that they can reach out to presenters for internship/work opportunities (66%).

Well-being: resilience improved despite COVID-19 pandemic setbacks.

The program increased students' ability to navigate stressful situations (65%) and develop their personal/professional networks (61%).

Cassidy et al. (2015) found that resilience and grit can be discussed in terms of inner strength, competence, optimism, flexibility, and the ability to cope effectively when faced with adversity. The development of these attributes minimizes the impact of stressor factors.³ Attributes of resilience enhance protective factors, such as optimism, social support, and active coping that increase people's ability to overcome life's challenges and adversity.

For many students, this was the first time meeting a professional. Participants discovered the power of diversity in the workforce and managing their well-being. Presenters shared their journeys and showed how negative stressors can have adverse impacts on their well-being. Students shared that the program increased their ability to navigate stressful situations (65%). This revealed positive impacts on mental health

outcomes through mentorship on students of color. A well-established sense of cultural identity plays a role in the health and psychological functioning of minorities who are often misrepresented or discriminated against by society.

Our program resulted in the majority (73%) of students indicating they too could serve as role models for others due to their experiences with professionals with whom they share cultural identity and life experiences. Studies have shown that resilience-focused interventions, such as our program, are conducive to supporting the student development of positive mental health and reduce mental stress.⁴

Discussion

The program had an overwhelmingly positive impact upon students as seen in the results. We noticed greater improvements in critical thinking traits compared to career guidance traits. This could possibly be explained by the students not having one-on-one attention with the panelists. It should be noted that a causal impact cannot be determined until more data is collected. A future study could be longitudinal in nature, and follow these students into higher education and observe continued outcomes from Mentor U Chats and other Mentor U virtual programming.

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The Hole of Poverty

By Cyrus Hajian

I'm the first in my family to be born in the United States, my mom is from the Philippines, and my dad, from Iran. Their understanding of the U.S. was limited and I ended up having to figure out the nuances of the culture, social dynamics, and social issues on my own. This provided a different perspective from what I was taught; rather, the development of my perspective revolved heavily around my experiences. I have friends throughout the United States that I talk to often, some of who I've known for more than a decade. These are strong, smart individuals who are bogged down by their personal circumstances. We talk about social justice, and health issues quite often. A theme that often comes up is our perpetual lack of resources and how that affects our daily lives. We speak about what limits ourselves and the people we know. We speak on the effects of a lack of education, and the subsequent manipulation of uneducated individuals and communities by those who orchestrate policy that negatively affects our lives. Although poverty is caused by a multitude of issues, poverty itself causes a plethora of problems; most of which are perpetual as those in poverty tend to lack the resources to deal with them. I write this as there are individuals out there who believe that all are born equal, who don't understand the trials and effects of escaping the hole that is poverty. As of 2020, there were over 37 million people living in poverty across the U.S.¹

Throughout my life, the most common issue I've seen affecting people's health is poverty. Although poverty is considered a social issue, I, among others, believe that poverty is one of, if not the biggest detrimental influence on our health. When I say "our health", I speak of my community. My community includes individuals who live paycheck to paycheck, who avoid healthcare and education due to fear of acquiring debt, and who have no future plans because they must work constantly to survive. It is filled with those who dare not dream of social equity, knowing that by acting in that direction, they risk losing everything; in turn, they keep their heads down and their voices low.

We live in a society where if we suffer a major injury, the resulting debt from remedying it could mean losing our living situation and livelihoods.⁵ The mental anguish

and stress of constantly living on the brink of homelessness is enough to break anyone.^{6,7} I have seen too many people broken from the traumatic effects of poverty. The perpetual stress of wondering whether we can afford all the basic necessities makes it nearly impossible to advance due to the constant fight for survival.

There are large communities of us throughout the San Francisco Bay Area and the United States. Although there is a disparity of those affected in regards to race and skin color, I truly believe that the thing that brings us together into one group is not our race, but rather our socioeconomic position. Put simply, if you are poor, you've likely experienced the hardships that other poor people have faced. This mutual understanding creates an underlying sense of camaraderie in most cases, and through this understanding, a community is formed.

Although the lines of this community are not limited by geographic location. I've met people throughout the United States with the same perspective as me. I have friends from Iowa, Arizona, Texas, Tennessee, and Oregon that understand the pain of poverty. As much as some people want to deny it, these impoverished lives we were systematically granted are damaging to our mental and physical health, even worse, it's a cycle. It is widely known that if your family is poor, you are more likely to stay in that socioeconomic class throughout your life, save a few hard-working or lucky exceptions.^{2,3,4}

For the majority of people, the climb out of the hole of poverty is too steep. I believe that one of the worst parts of poverty is the fact that it doesn't just affect one's health for a set period of time; it can be a permanent ordeal. It can detriment the health of one's children and anyone who needs to rely on you. The stress and ordeals that come with poverty are limitless. If you get sick you need to choose between trying to tough it out, or getting a medical bill that you know will eventually be sent to collections because you can't afford to pay it without forgoing aspects of your survival. That medical bill is food for a month, it's rent, it's opportunity. But as someone in poverty, you need to choose between your health or your livelihood. It is no wonder why those in poverty are commonly regarded to have more physical and mental health problems. These problems tend to be left untreated, as they don't have the means, nor the time to address them.

Where do we draw a line between what is a health issue, and what isn't? If there is a predisposition of a circumstance causing a community of poor people to get more sick than their richer counterparts, is the

circumstance the health issue? I think so. I firmly believe that poverty is one of, if not the biggest health issues in the United States (if not the world). It affects generations alongside individuals. Poverty is a deep hole that is exceedingly difficult to get out of, and in the process of getting out, one must experience a multitude of social and financial barriers trying to halt their progress. A single slip up, and it's back to the bottom of the hole. Trying to claw one's way out of poverty is an ordeal, I see people around me trying with every fiber of their being to make something out of the scraps they were given at birth. I also see how the climb out of the hole affects us. The stress is crushing. I've seen smart, strong-willed, hard-working people with so much potential collapse under the weight of poverty. Sometimes the weight becomes too much, and it is easy for depression and other ailments to take hold. People snap, as there is only so much one can take. It makes me sad to think about how many great minds born in low-income communities will never be able to realize their potential because of their socioeconomic status. I have yet to see a health issue for my community that affects our health worse than poverty. I see the suffering it causes nearly every day. For the few that make it out of the hole, we can only hope that we can get to a point in life where our loved ones won't have to experience the stressful pain we've endured.

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Bettering Mental Health Outcomes for At-Risk LGBTQ+ Youth

By Danissa Barrios Coffey

This opinion piece addresses mental health disparities for queer youth and offers insight into how to transform outcomes for LGBTQ+ youth at risk of suicide and mental health crises. This piece articulates and educates about why suicidality is more common in queer youth than their straight counterparts and begins a dialogue to recognize this health disparity and implement initiatives to prevent suicide attempts. Educating family members about disparities, stigma, and supportive avenues for their loved ones can save lives by encouraging help-seeking in at-risk populations. There is also a discussion about the need for healthcare professionals to practice trauma-informed care and for systemic change within academic institutions and workplaces. A few resources are also shared at the end of the piece to support LGBTQ+ youth struggling with suicidality which can significantly help mitigate the health disparities discussed. This piece serves as a call to action and is more relevant than ever during the continued devastation of the COVID-19 pandemic.

LGBTQ+ youth are three times more likely to seriously contemplate suicide — and five times more likely to have attempted suicide — than their heterosexual counterparts, according to [The Trevor Project](#), a national organization providing crisis intervention to LGBTQ+ people under the age of 25.¹ Likewise, the COVID-19 pandemic has exacerbated mental health symptoms for young people across the globe and made it impossible to ignore the profound suffering experienced by LGBTQ+ youth.

Why do these mental health disparities exist for queer youth? The American Psychiatric Association suggests that health disparities for people in the [LGBTQ+](#) community stem from stigma and discrimination, complicating the process of seeking healthcare and finding social support.² As many of us have witnessed in our own communities, rampant homophobia and poor understandings of mental health have compounded the challenges that queer youth face as they confront adolescence and young adulthood.

We have a responsibility to remedy mental health disparities and prevent suicide in LGBTQ+ youth. Here is how practitioners, family members, and community-minded citizens can help.

Establishing Family Support And Addressing Community Stigma

As a National Alliance on Mental Illness (NAMI) volunteer and advocate for a Spanish-speaking family support group, I realize the transformative power of educating parents, family members, and friends about mental illness and the mental healthcare system.

Ultimately, I've found that engaging family members about the challenges their loved ones face is the first step in creating comprehensive support networks for youth. When parents fully understand the intersection of mental illness and identity, they are better equipped to recognize LGBTQ+ health disparities and to help their children embrace the facets of their identity and live fulfilling lives. Family members can also

encourage their loved ones struggling with suicidality to engage in help-seeking behavior such as seeing a therapist or speaking with their primary care physician or psychiatrist.

Within my Mexican community, there is an immense stigma surrounding queer identity and mental illness. The LGBTQ+ stigma is due, in large part, to dominant Catholicism and conservative values in Latin American culture. In contrast, mental illness stigma stems from a lack of education and parity between mental and physical health.

Unsurprisingly, the two issues are connected: dismantling health disparities requires breaking the stigma surrounding queer identities and mental health diagnoses.

A Note About Trauma-Informed Care

How can we as parents, friends, medical providers, and community members understand and grapple with the immense suffering of people living with suicidal thoughts and not re-inflict pain onto them? We must incorporate this framework to reduce harm to queer young people who have experienced trauma, and to all people living with mental illness.³

Navigating Institutions

Navigating homophobic environments as a queer person has a significant impact on mental health. So often, work environments and academic institutions prove to be toxic and unsafe, exposing LGBTQ+ individuals to bullying and harassment.

These institutions have a responsibility to improve their cultures and intentionally create spaces where LGBTQ+ students or employees feel supported and understood, but we must report incidents as they arise and demand better for ourselves and our

colleagues. Systemic changes may influence and remedy queer mental health disparities by contributing to an inclusive environment.

More broadly, we must assume responsibility for changing our culture from one of baseline tolerance to one of enthusiastic support for all identities. By embodying inclusivity, we can transform outcomes for LGBTQ+ youth.

Resources To Share In Your Community

While institutional change is a daunting task, we can each take responsibility for creating change at the individual level by ensuring access to youth-focused resources, such as crisis hotlines, text lines, and social support platforms. Sharing crisis resources with loved ones, colleagues, and community members can be a lifesaving measure.

Another option for support is connecting with local organizations. Get in touch with your local NAMI chapter, either in your county or state. If you are a family member of someone with mental illness, consider taking the NAMI Family-to-Family class (offered in Spanish) to learn more about mental health conditions and best practices for supporting loved ones.

Resources for LGBTQ+ Youth

- TrevorLifeline: 1-866-488-7386, a crisis intervention and suicide prevention hotline available 24/7.
- TrevorChat, a confidential online instant messaging tool with a trained Trevor counselor, available 24/7 through a smartphone, tablet, or computer.
- TrevorText, text START to 678-678, a confidential text messaging service with a trained Trevor counselor, available 24/7.

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More than a Language Barrier in Healthcare

By Tran Tieu

Emerging technology such as telehealth services inclusive of Professional Interpreters are part of the care delivery process aimed to provide greater health care access for ALL. These tools intend to bridge the language gap, however, in closer investigation it actually may perpetuate the divide of health equity. Addressing Limited English Proficiency (LEP) Patients' needs go beyond the four walls of the exam room and virtual consultation.

The primary stakeholders and elements that can make an impact with language barriers in health care are: Policy Makers, Clinical Procedures, Community-Based Organization and Digital Equity. Despite mandates of the Title VI Civil Rights Act (1964)¹ and the Section 1557 Affordable Care Act² regarding language barriers, LEP Patients face 50% greater risk for serious medical events than English speaking Patients.³ Federal Laws exist and are mandated, however, they are not tracked or widely enforced.⁴ Professional Interpreters are limited to a select number of clinics and hospitals that can afford the infrastructure and maintenance. Although facilities provide Professional Interpreters, Clinicians resort to other workarounds to gain consent from an LEP patient.

Immediate solutions would be creating best practices on cost-effective implementations that connect as an ICD code for the Revenue Cycle Team to collect Federal Reimbursement. Secondly, provide a minimal workflow with the least disruption to enforce frontline health care providers to use Virtual Professional Translators. Lastly, cross-vertical stakeholders collaboration can shape the future of Language Translation Tools that can be available at every touchpoint along the LEP Patient health management journey. There is a bright global future in breaking down the wall in language barriers.



Artist's Summary of the Piece

Even though today's patient experience includes the use of advanced tools to aid in medical diagnosis & treatment (EHR documentation, genetics testing, STAT labs, same-day appointments, & on-demand virtual professional translators), language barriers still exist. As a result, there is an estimated \$7 Billion over-expenditure and 671,440 preventable Adverse Events (AEs).⁵

Examples: Patient-Doctor Spoken Minute(s) Allocation Doctor Visit

- I. *Marginalization of LEP Patient*
 5 minutes Physician +
 5 minutes Professional Interpreter +
5 minutes LEP Patient

 = 15 Total Minutes Office Visit
- II. *English Speaking Patient*
 7.5 minutes Physician +
7.5 minutes English Speaking Patient

 = 15 Total Minutes Office Visit

Emerging technology such as Virtual Telehealth with Professional Interpreter addresses a silo point-of-view to improve accessible care. The Hmong Patient is unable to ask questions because the word “Cancer” does not exist in the Hmong Language.⁶ The anchor and brick wall symbolizes her refugee/immigrant status that is beyond a citizenship status but also a culture and literacy obstacle in the understanding of health literacy & reading comprehension. Outside the four walls, there are a lot of questions she will have beyond the estimated 5-minute speaking time she has in a one-time office visit.

Health Justice

Communication barriers are a healthcare disparity. Despite the Federal and Local Laws requiring health care institutions to provide professional language services and Federal Funds for Provider Reimbursements “compliance with these laws is not tracked or widely enforced,” Dr. Diamond.⁷ Emerging technology development will perpetuate the social and systematic divide for meaningful health accessible to care & literature. Collaboration between policymakers, community-based organizations, health-care providers, technologists, and LEP patient advocates is essential at this critical juncture in the Patient-Centric facing technology transformation-age that is presently influencing the future of health [that] care[s].

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Access to Healthcare for Physically Disabled Women

By Schantell Williams

The US healthcare system unconsciously continues the pattern of helping the elite, rather than those truly in need. Women with a physical disability are oppressed due to their impairment and many times they are not given the proper care. In fact, a woman with a disability can be legally denied care from a physician due to fear of liability. When looking at healthcare insurance there can be underlying qualifications that don't allow a disabled individual to be granted the insurance that they would like. Many disabled individuals are less likely to have private insurance coverage and more likely to have Medicaid.² Women must first find a doctor that will agree to them being their patient then have to also worry if the doctor will take Medicaid. Medicaid usually only covers what they see as necessary, which makes it difficult for some tests to take place. It is also seen that at times the full cost will not be covered which makes the patient have to come out of pocket. Many times a person that is disabled is of lower-income and cannot afford these expenses, so they would rather choose to not proceed with necessary exams. Women with a physical disability are facing life-threatening disparities and it is necessary to bring light to the challenges that are being faced in order to promote change.

Introduction

Breast cancer is the leading cancer-related death among all women in the United States and it is a major cause of death among women ages 35 to 54.¹ Previous research has shown that when it comes to disabled women there is an association between accessibility and cancer rates.¹ Physical examinations are an important preventative measure that is skipped when it comes to a woman with restricted mobility. Conducting Pap tests for cervical cancer and mammograms for breast cancer are widely acknowledged as effective methods for early detection of cancer.² It is vital to continue to do these routine screenings to help keep women healthy. Unfortunately, these recommended cancer screenings are ignored when it comes to women with disabilities.³ In fact, a woman with a disability can be legally denied care from a physician due to fear of liability.⁴ Health insurance plans often include underlying qualifications that limit women with disabilities from getting coverage. Many

individuals with disabilities are more likely to have Medicaid than private insurance coverage.⁵ Medicaid usually only covers what is necessary, and pays less than other insurance coverages. Women with physical disabilities must first try to find a physician who will care for them, and then additionally worry about whether that physician will take Medicaid. Most of the time a person that is disabled is of lower-income and cannot afford these expenses, so they would rather choose to not proceed with necessary exams.⁵ Even when exams have been approved, a woman with a physical disability must face yet another problem — mobility access!

Health Outcomes

A woman's mobility is challenged during doctor's visits. A provider chooses a route that seems less stressful on their patient's body instead of conducting necessary examinations. This means providers may not take the weight, conduct pap smears or pelvic exams, or even skip mammograms.³ Women

that have a disability are more susceptible to cancer because they are not getting the proper test to have early detection of disease. This is partly because the equipment is inaccessible.³ Physically disabled women have higher rates of breast and cervical cancer due to lack of mobility access.⁶

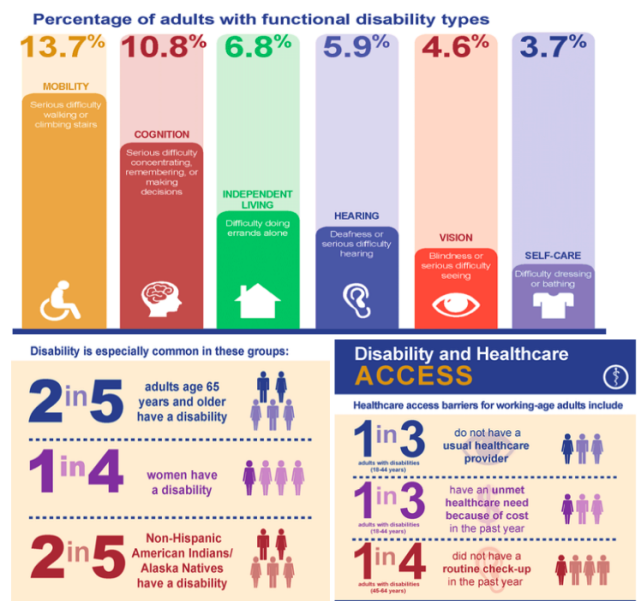
Prevalence ⁷

- Any disability
- Hearing disability
- Vision disability
- Cognitive disability
- Mobility disability
- No disability

<p>Reported Pap test use for cervical cancer screening among women between ages 21 and 65 years with disabilities ranged from 66% to 80%, compared with women without disabilities (81%).⁷</p> <ul style="list-style-type: none"> • 72% • 73% • 77% • 80% • 66% • 81% 	<p>The prevalence of having a mammogram for breast cancer screening among women between ages 50 and 74 years with disabilities also was lower (61% to 68%) compared with women without disabilities (73%).⁷</p> <ul style="list-style-type: none"> • 67% • 67% • 64% • 61% • 68% • 73% 	<p>Screening for colorectal cancer was 57% among adults between ages 50 and 75 years without disabilities and ranged from 49% to 65% among those with disabilities.⁷</p> <ul style="list-style-type: none"> • 62% • 65% • 49% • 56% • 63% • 57%
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Over 1 billion people are estimated to live with some form of disability.⁸ This corresponds to about 15% of the world's population, with up to 190 million (3.8%) people aged 15 years and older having significant difficulties in functioning, often requiring healthcare services.⁸ The number of people living with disabilities is increasing, in part due to aging populations and an increase in chronic health conditions.⁸ About 36 million

women in the U.S. have disabilities — and the number is growing.⁹

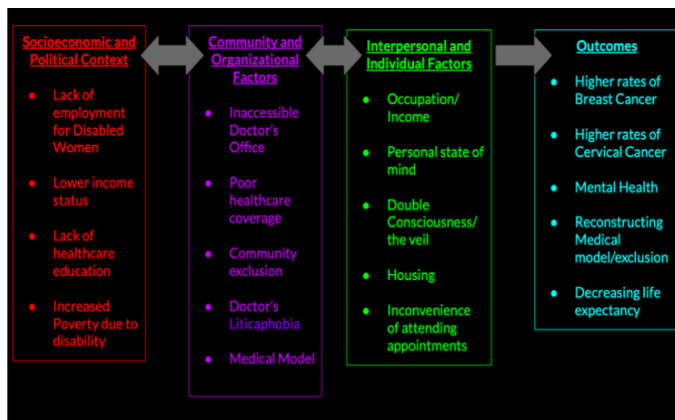


(Disability Impacts All of Us Infographic | CDC, 2021)

It is important to make doctor's offices and healthcare accessible for physically disabled women to better their health. There is a group of individuals suffering due to a preventable lack of access.⁸

The Negative Health Effects Amongst Disabled Women Due To Health Care Barriers

Below is a proposed framework that addresses the multiple barriers that disabled women have to face which all affect their overall health. This framework adopts the WHO conceptual framework to address the social determinants of health amongst disabled women's healthcare. The WHO framework is adopted from the social determinants of health conceptual framework.¹⁰



The first component of the framework displays socioeconomic and political barriers. Under this category, we can see that there is an issue with lower income and a lack of employment opportunities for disabled women. It is a challenge for a disabled woman to obtain work. When employed, women with disabilities have lower salaries than men with or without a disability and have lower salaries than other women without a disability.¹¹ This becomes a problem when trying to cover everyday expenses in addition to medical costs. Disabled individuals usually do not have health insurance or rely on public sector payors.¹¹ There is also an increase in cost when it comes to disabled women due to their more complex healthcare needs compared to women without a disability.¹¹ Unfortunately, being disabled can become costly and disability itself drives some individuals into poverty.¹² Not being able to cover the expenses needed for necessary care drives some disabled individuals away. Ultimately this leads to not receiving preventative care to decrease the chances of illness.

The second component of the framework is the community and organizational factors. Access barriers are a huge factor that prevents women from receiving preventive care.¹¹ Physical accessibility is the most common barrier for a

woman with a disability. Physical entry to the clinic can be the most challenging aspect of obtaining health care.¹¹ Research has shown that 40– 45% of women over age 35 with disabilities reported that they had never had a mammogram, 23% of women with spinal cord injury reported that mammography equipment was not possible to use, and 11% reported that no examination room was accessible for mammograms.¹¹ There is also a low report rate of pelvic exams. We also revisit the idea of having a disadvantage when it comes to having Medicaid for medical coverage. Certain tests and expenses may not be covered with this type of insurance, which leads to medical expenses falling under the patient's responsibilities.¹³ Doctors have what is known as Liticaphobia. Liticaphobia is when a physician is fearful of obtaining a lawsuit.¹⁴ Physicians can avoid accusations about discrimination and legally deny care to disabled women due to their fear of liability.¹⁵ There is also the matter of exclusion and the medical model which both can have a toll on mental health. Community exclusion can drive a disabled woman to feel a lack of belonging. The medical model is organized in a way to portray a disability as being bad and something that needs to be fixed.

Lastly, there are interpersonal and individual factors. W.E.B. Du Bois coined many concepts such as the veil and double consciousness. The existence of 'behind the veil' is explaining how individuals hide behind a mask to be more appealing to the world.¹⁶ The veil represents a covering that is seen as beautiful and non-problematic to outsiders while the individual underneath is hidden/restricted.¹⁶ Double-consciousness is when one is conscious about who they truly are and displays what they know mainstream

society wants to see to fit in.¹⁶ Disabled women can experience mental health problems by always trying to please others and not being themselves. There are also issues of household dilemmas that can cause a woman to not seek care. Women with disabilities are abused at greater rates than their non-disabled counterparts.¹⁷ Compared with non-abused women, women abused by an intimate partner have a greater risk of being disabled or having an illness that affects their activities of daily living.¹⁷ Although disabled women experience similar forms of abuse to those of non-disabled women, some forms of abuse are unique to disabled women due to the limitations that the disability itself presents.¹⁷ There is no telling what is going on within a household and there can be such problems affecting care. If one does know they cannot afford the care they might avoid seeking it. Last but not least, there is the inconvenience of finding transportation, rescheduling work, finding help, etc that can affect not obtaining healthcare.¹⁸ Being that many offices are not accessible and some tests cannot be done, disabled women become frustrated with their experience and decide not to put themselves through it again.¹⁸

Each component affects a disabled woman's health. The outcomes that can come from the categories are higher rates of breast and cervical cancer, increasing mortality amongst disabled women, reconstructing discriminatory ideologies, and increasing mental health problems. The framework points out some key factors that are affecting disabled women's health, and there may be more factors with further research.

Conclusion

Women with disabilities are experiencing higher rates of cancer and poverty due to their condition. Doctors' offices are inaccessible and the costs of making the necessary improvements outweigh the benefits, which leads to continuing the misconception that disabled individuals are the ones who need to fix their problems. Research has shown that disabled women are more likely to not obtain mammography and Pap tests.¹⁹ It is also seen that intersectional minority disabled women experience greater negative health outcomes than their counterparts.²⁰ When looking at healthcare expenses, research shows that many disabled individuals are less likely to have private insurance coverage and more likely to have Medicaid.¹ These factors limit the quality of care and cause disabled women to experience greater poverty rates.

There is a need to change how our healthcare system is operating. We need to provide a physically disabled woman the care she deserves and we must also change the narrative of a disability being seen as the problem. Disabled women should not be treated any less and the healthcare system should not be creating more barriers for them to face. There is a need to provide government incentives to ensure offices are up to standards and proper care is being provided. There is also the need for incentives to pay for the costly equipment. Education about the present disparity and how it affects these women needs to be provided to all those in society. It is vital to provide quality care to all, including women with disabilities.

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HeLa Cells — Injustice in the Path of Scientific Advancement

By Muhammad Khan

Over the past 70 years, biomedical sciences have made giant leaps in understanding the human body and how it reacts to disease. Many of these breakthroughs would not be possible without HeLa cells, an immortal cell line that has aided in countless vaccine, cancer, and physiology research, among other biomedical advances. Unfortunately, these cells, obtained from an African American woman named Henrietta Lacks, were taken without proper informed consent, bringing up the topic of ethics in science. From Lack's, we learn a story of a woman that was taken advantage of for the sake of science, giving us a look at the injustices within a field whose primary focus should be justice.

Before the COVID-19 pandemic, the world was facing another pandemic fueled by Poliomyelitis, the virus that causes Polio. Polio has many symptoms, but the worst include paralysis of lower limbs, severe muscles weakness, and loss of reflexes.¹ Unfortunately, before the early 1950s, there was no vaccine or cure for Polio, leaving tens of thousands in wheelchairs and crutches.² Then, in 1953, Jonas Salk, a virologist at the National Foundation for Infantile Paralysis, started to develop a vaccine to combat the Poliovirus and provide the much-needed relief for adults and their children. The problem, however, was that he did not have the appropriate cells to test the vaccine on. Luckily, during the vaccine research stage, an immortal cancerous human cell line was cultured for the first time, allowing scientists to test the Polio vaccine in large quantities. With the help of this crucial cell line, the Polio vaccine was eventually rolled out, saving millions of lives in the process. Specifically, the vaccine and other eradication efforts have decreased wild poliovirus cases by 99.9% since 1988 and saved 18 million people from life-changing paralysis.³

This seems like a straightforward story, but a dark history of medical injustice lies

behind all the statistics and data. The immortal cell line, formally known as HeLa cells, was obtained from an African American woman named Henrietta Lacks. Lacks suffered from an aggressive cervical cancer and had to undergo chemotherapy for treatment. Although Lacks ultimately lost her fight to her illness, her cells had not. Without proper consent from Lacks or her family, the surgeon treating Lacks had given samples of the cancerous tissue to a researcher in the hospital, who, to his surprise, found that the cells were immortal. The immortality of HeLa cells made them a potent tool in biomedical sciences which continue to be used today to advance medicine and science as we know it.⁴

Despite the advancements the science community has made because of HeLa Cells, the story behind their origin and usage highlights more profound injustices in medicine and research. Henrietta was taken advantage of without her knowledge or input. Her cells were used for purposes she never consented to. Moreover, this happened during a time where minorities were being unjustly used for clinical trials and research, never being told what was going on and what rights they had. A well-known example is the Tuskegee Syphilis study, where African

American sharecroppers were used without consent to observe the progression of syphilis and withheld from treatment despite there being access to some. As were the Tuskegee Syphilis Study participants, the Lacks family were kept in the dark for decades. They, too, were taken advantage of without proper consent by taking blood samples to supply genetic information.⁴ Surprisingly, Henrietta Lacks' family only recently found out about the profit biotech companies made by using and producing her cells. On October 4, the Lacks family sued biotech company Thermo Fisher Scientific and insisted that they "disgorge the full amount of its net profits obtained by commercializing the HeLa cell line to the Estate of Henrietta Lacks".⁵ This reaction from the family is expected, and every company that has benefitted from these cells should be giving their profits to the family.

Cases like these of medical injustice and exploitation have lasting effects that are even seen today in a COVID-ridden world. When the COVID vaccine was first distributed, large numbers of people, many of them minorities, were hesitant to take the vaccine. This hesitancy can be partly attributed to the medical injustices these groups of people have faced in the past and the present. This hesitancy may seem trivial to some, but it shows how meaningful and delicate a patient-provider relationship really

is. It is difficult to mend relationships that have been broken for decades, but that does not make it right to unjustly benefit from other peoples' bodies, especially when they were not adequately informed. We cannot change the past, but we can use the past to change how we approach the future. Going forward, it is necessary for medical professionals and doctors to properly gain consent from individuals to prevent exploitation, unjust profiteering, and prevent cases like that of HeLa cells. For now, it is in the scientific community's interest to pay reparations to the Lacks family in order to show respect and prove medicine is beyond just discovery.

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Corrections

Acknowledgements: *Meleeka's name was originally misspelled in the issue. The JUST Health Editorial Board regrets this error.*

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