

# JUSTHealth

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## 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 Spring 2022 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 we also invite you to consider a role as contributor. 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.

Firstly, we would like to begin by honoring the victims of the multiple recent mass shootings. We believe all Americans should have the ability to attend school, church, and grocery stores without fear of not returning home. We are deflated from hearing repeated news of mass shootings and simply ask we not allow this to continually be the norm.

Secondly, we are saddened to hear about the leaked U.S. Supreme Court draft opinion to overturn *Roe v. Wade*. We believe abortion care is healthcare, and it is a fundamental component to women's health. Access to safe abortions has [significantly decreased](#) maternal mortalities. Instituting restrictive abortion legislation in a Post-*Roe* era will [dispropotenate affect](#) women of color, and women of lower socioeconomic status. Black or Hispanic women are more likely to live in a state that will restrict abortions in a Post-*Roe* era, but these same women have the most need in [seeking out](#) safe abortion care.

*Roe v. Wade* also [increases](#) the likelihood that children are born into houses with greater material resources. Adverse childhood experiences, which are linked to lower socioeconomic statuses, follow an intergenerational pattern leading to [reproduction](#) of mental and physical health issues, thus potentially increasing crime. *Roe v. Wade* assists in ending this cycle by not only legalizing abortions, but also securing access to various forms of [contraception](#). Additionally, the legalization of abortion led to a 17.5% [decrease](#) in overall crime from 1991 to 2014. Abortion ultimately lessens the financial burden parents may face when carrying a pregnancy they know they cannot support. Although putting a child up for adoption may sound like a feasible option, in reality, only 4% of women with an unwanted pregnancy actually put their child up for [adoption](#).

Finally, should the U.S. Supreme Court overturn *Roe v. Wade*, the decision has further implications and places other court rulings in jeopardy. [Roe v. Wade](#) was decided on the legal logic of the right to privacy in the Due Process Clause of the Fourteenth Amendment, and many other cases were decided using this legal logic. Overturning *Roe v. Wade* [jeopardizes](#) other legal decisions, including, but not limited to, [gay marriage](#), [interracial marriage](#), and [access to contraception](#). We are in strong support of upholding *Roe v. Wade* and do not wish to see it overturned because doing so would ultimately exacerbate racial maternal health disparities.

In justice and in health,  
The JUST Health Editorial Board



# The "End" of COVID and the Return of Leaving Disabled People Behind

*By Elizabeth McCarthy*

Two years have passed since the beginning of the pandemic. Many people have moved on or are starting to move on; they tell themselves that the pandemic is over and things can finally go back to normal. This means a return to in-person work and school. This means any awareness of the pandemic is over. Things are back to normal. However, life is not back to normal for people living with disabilities, chronic illnesses, and those newly disabled with long-lasting COVID symptoms following initial infections, also known as 'long COVID' [8]. The push for normalcy has left high-risk individuals feeling, once again, left out of the conversation.

According to the CDC, 1 in 4 adults in the United States has some type of disability [1]. Although most of the country has lifted its mask mandates, the CDC has recommended that high-risk individuals continue to wear a mask if they feel more comfortable or if their doctor recommends it [2-3]. People with disabilities are considered high-risk as well as people who are unable to get vaccinated. Although epidemiologists acknowledge that it is not sustainable to have people wear masks forever, it does beg the question: When will it be safe enough to remove our masks [4]?

Individuals with disabilities are experiencing this gnawing pit of uncertainty as society returns to normal. There has been a push from academic institutions and employers to return to in-person activities, now without a mask and the previously recommended social distancing guidelines. Although the option exists for high-risk individuals to continue wearing a mask, this does not fully protect individuals from the virus even if they are fully vaccinated with the booster. Andrew Pulrang, a noted disability activist, reflects that the responsibility for protection has been placed on the shoulders of individuals with disabilities and high-risk individuals [5].

The pandemic showed us that accommodations are possible. It was difficult for everyone to make the sudden transition to remote life, but this is a reality some individuals with disabilities face daily. Sheltering in place and quarantining indefinitely should not be the new normal; however, instead, the accommodations that existed during the pandemic should still be a viable option. Accommodations help level the playing field, allowing for everyone to have an opportunity to be successful and live a full life. Unfortunately, those accommodations are no longer offered by institutions or workplaces, leaving people with disabilities feeling invalidated again and resigned as they are pushed into a world that has told them they do not matter.

In February, the UCLA Disabled Student Union staged a sit-in to advocate for a permanent hybrid option for students [6]. The Chair of the UCLA Senate said that the Disabled Student Union could not demand instructors to have hybrid courses as there may be sensitive topics discussed that should not be online. What about the nearly two years of online learning students faced where sensitive topics were discussed? Why was it OK for all students to receive online

accommodations at the height of the pandemic but not disabled students when the pandemic is 'over'?

There needs to be a change in policy across the country. It is imperative that we stop leaving individuals with disabilities, chronically ill, and those who are high-risk behind. Haben Girma, a lawyer, disability advocate, and first deaf-blind person to graduate from Harvard Law School, says, "The biggest challenge is ableism, not my disability" [7]. We need to focus on rebuilding our communities to eliminate the systemic oppression of disabled people. Everyone deserves to feel safe and have the accommodations necessary for success.

Do not leave the burden on the disabled community to be their only advocates. Contact your local members of Congress to continue the conversation and advocate for disability rights: <https://www.house.gov/representatives/find-your-representative>.

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# COVID-19 Vaccine Access, Experiences, and Perceptions in the Sick Cell Community: Results from a Global Survey

*By Abibat Oshiobugie-Suleiman, Agyenim-Boateng, Stephen. PharmD, Cassandra Trimmell*

Sickle cell disease is a genetic blood disorder that can affect people from all ethnicities but disproportionately affects people of African and Caribbean descent [1]. Sickle cell disease is an immunocompromising disease that poses a lot of complications, including pain, infections, and many others [2]. COVID-19 continues to present multiple challenges to the world but especially for sickle cell disease patients. A virus-like COVID-19 can cause a plethora of complications to a sickle cell patient's health, which sometimes can carry an added mortality risk. With vaccinations being the primary way the COVID-19 pandemic has been tackled, we sought to conduct a survey to understand COVID-19 vaccine access, experiences, and perceptions in the sickle cell community. The survey contained 36 questions which also evaluated why various sickle cell community members chose to get vaccinated or forgo vaccination against COVID-19. Additionally, the survey evaluated barriers to access to the COVID-19 vaccines and how previous experiences with other vaccinations impact the confidence and trust individuals have towards receiving the COVID-19 vaccine. The results from this survey highlight a critical gap in the access to COVID-19 vaccines, while also revealing gaps in the knowledge of how vaccines are developed and work. A general lack of knowledge about COVID-19 vaccines was also observed. This study aims to bring forth and address a critical unmet need for the sickle cell community, as the CDC has confirmed patients living with sickle cell disease present as one of the groups with the highest risk of severe infection from COVID-19 [3].

## Background

Sickle cell disease (SCD) is a genetic blood disorder that causes a myriad of complications like pain and infections due to impaired blood flow to tissues and organs in the body [1]. Patients living with SCD are more prone to infections, making the SARS-CoV-2 virus more dangerous for SCD patients. The COVID-19 pandemic has posed an additional threat to individuals with SCD, and the CDC lists SCD as one of the underlying medical conditions with the risk of severe illness from COVID-19. The primary purpose of this survey was to evaluate the access to COVID-19 vaccines for individuals with SCD and their experiences and perceptions about the vaccine. Questions were

selected specifically to address these aspects as well as other contributing factors.

## Method

Survey participants included individuals living with SCD and other stakeholders (partners, parents, advocates, healthcare providers, and caregivers) in the sickle cell community. Participants completed a 36-question survey. The survey was conducted electronically from March to April 2021, participants (n=383) were recruited from Sickle Cell 101's social media platforms.

## Results

The survey launched in March 2021 and concluded in April 2021. 78% of surveyed participants live in the United States, and 22% live outside the United States. The top three

states of the participants surveyed from the US were California, New York, and Florida. Of the 22% of international participants, the top three countries were the UK, Nigeria, and Jamaica. 214 participants confirmed they live with SCD, of which 57.9% reported to have been offered and received a COVID-19 vaccine, 20.1% reported to have been offered but declined to receive a COVID-19 vaccine, and 22% reported not being offered a vaccine but are interested in getting vaccinated. The top three reasons why the 57.9% of the participants chose to get vaccinated were to: (1) provide protection for themselves, family, and friends, (2) to reduce the high risk of COVID-19 infection for their sickle cell condition, and (3) help stop the pandemic spread. For those who declined, their top three reasons were: (1) uncertainty about side effects, (2) distrust of the vaccines, and (3) not enough research and published data. In deciding whether to get vaccinated, participants indicated their confidence in the safety and efficacy of the vaccines, advice from their healthcare provider and people they trust, and the sickle cell community getting vaccinated among their top decision factors. The data collected also shows that only about 58% of survey respondents receive an annual flu vaccination. More than 50% of participants indicated they had some or no knowledge of how vaccines are created and tested.

## Discussion

The results from this survey highlight the gaps in access and trust of COVID-19 vaccines for this clinically vulnerable population: people living with sickle cell disease. A critical discovery from this survey also highlights the need to provide more education on why individuals with sickle cell

disease need to get vaccinated yearly for the flu and also adhere to other routine vaccines like pneumococcal as, without them, these infections can be life-threatening due to them being immunocompromised. These findings further warrant the need to provide more focused education on vaccines for the sickle cell community. For example, education should focus on how vaccines are created, tested, and how they elicit an immune response. Such measures allow the sickle cell community to be knowledgeable about vaccines and help make an informed decision to be vaccinated against COVID-19 and other viral infections. Overall, these findings and educational measures will be helpful in planning targeted action toward improving vaccine acceptance, addressing vaccine hesitancy, and enhancing the efficacy of vaccination campaigns in the sickle cell community. As these gaps are being addressed, a longitudinal study surveying people globally could be conducted to observe the improvements and changes being implemented and how effective they are over time.

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# Goals and Gap Years: How Taking Time off can Improve Mental Health

*By Anaelle Ndoye*

This piece explores the idea that a gap year (or years) between undergraduate education and medical school is a good and potentially necessary move for pre-medical students, minority pre-medical students in particular. Though gap years were not seen as typical for decades, a changing world has made it increasingly challenging to produce a well-rounded application within three years (so that one could start medical school right after getting their bachelor's), without compromising the applicant's well-being.

The 'typical' medical school journey can be explained as follows: Start college right after high school. Take your pre-medical course requirements within three years. Simultaneously prepare for the seven-hour-long MCAT. Take the exam before April of your third year. Volunteer, work, get internships, and have hobbies through this time period as well. Clinical experiences are a must, so find your way into the healthcare system (pandemic or not). Write your personal statement and fill out the application by spring of year three. While doing this also save thousands of dollars to pay for this process and take care of your mental and physical well-being. Oh, and make sure to have at least a 3.5 G.P.A. in all of your classes too.

I am a recent college graduate on the pre-med track, and I am here to say that trying to accomplish all of this in the given time frame is nearly impossible in this day and age. With minimum wages that can't pay rent, technology-induced stressors, global unrest, and a pandemic, it seems like there are not enough hours in the day to accomplish everything required for a solid medical school application [1-3]. Pre-med students are over exerting themselves trying to be perfect and getting disappointed if they aren't. That being said, the goal shouldn't be perfection; it

should be well-roundedness and well-being, which sometimes takes time to achieve.

The simple solution: taking a gap year (or more). All too often, gap years have negative connotations attached to them, and admittedly they do have potential drawbacks. Despite that, gap years have huge benefits, and some of the drawbacks can be rectified if pre-meds choose their paths appropriately.

One of the main arguments against gap years is that people will lose their study momentum if they take any time off from school [4]. I would argue that studying at full force for years on end can be harmful to pre-meds as people and learners. Having a break from or slow-down in their studies would allow them time to reflect on their learning journey so far. One of the things minorities often battle when completing higher education is "imposter syndrome" where they doubt their abilities (even though they are very capable and qualified to do the work they do and be where they are). These feelings are sometimes reflected back at students by professors and administrators due to the implicit biases educators have against certain minorities, particularly Black, Latino, and Native American students [5, 6]. This is one of the aspects of their academic career they can reflect on with a distanced perspective during a gap year.

Existing and learning in an environment where self-confidence and self-assuredness are not built up and are sometimes actively broken down can be detrimental to individuals' mental and physical health. These conditions can contribute to imposter syndrome and general feelings of self-doubt, which can cause a ripple effect on a student's entire being. Both imposter syndrome and self-doubt are associated with depression, anxiety, and overall poor mental well-being in addition to being more prevalent in racial minorities [7]. If students do not address these issues, they can end up with potentially severe problems such as increased occurrence and risk of physical health issues, difficulty socializing, and a higher risk of harmful behaviors towards themselves [8]. A gap year would potentially allow students to address any mental health issues they may be having before starting the grueling medical school application process as well as medical school. In doing so, students may be able to separate school/study problems that stem from feelings of self-doubt and those that come from ineffective study habits. By taking a gap year, students will be able to build confidence, find healthy coping mechanisms, and if needed, establish treatment and study plans that will work for them.

There are many ways for people to put these changes into effect such as internships, post-baccalaureate programs, jobs (particularly those where they interact with patients and other providers), and more. If students are concerned about losing their study momentum, many of these activities can also avoid a full stop in studying. It should be noted that seeking mental healthcare or doing things like post-baccalaureate programs or

unpaid internships can cause financial stress and hardships for some. This means that some of these programs could further exacerbate their mental health conditions. Students will have to choose their gap year activities accordingly to avoid adding more stress to their plate, but it is entirely doable. They may even consider taking more than one gap year to spread out what they want to accomplish so it is easier to manage.

Gap years can be filled with a plethora of different activities, opportunities, experiences, and life changes that can help individuals grow and shape who they will be as providers. It also gives people a chance to reflect on their experiences and make changes in their life to improve themselves. Most importantly, gap years give people a chance to find themselves outside of their identity as a pre-medical student.

You can learn more about why people may take gap years and what a gap year can entail here:

<https://www.ama-assn.org/residents-student/s/preparing-medical-school/premeds-capitalize-gap-years-applying-medical-school> [9]

<https://students-residents.aamc.org/applying-medical-school/making-most-your-gap-year> [10]

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# **Mental Health Barriers within the Hispanic and Latinx Communities**

*By Alejandra Moreno*

The mental health crisis in America is an alarming public health issue. Poor mental health can affect all aspects of a person's life: school, work, relationships with family, friends, and how we view ourselves. In 2020, 52.9 million adults in America, 21%, experienced mental health issues. This means 1 in every 5 adults experienced mental health symptoms [1]. As a first-generation Mexican American and child of immigrants, I have experienced and witnessed risk factors that can cause mental health issues that are more likely to affect People of Color (POC). Many of these factors and barriers can be narrowed down to socioeconomic status. I have identified three main barriers that deter Hispanics and Latinx people from seeking mental health treatment: cultural stigma, language barriers, and access to health insurance.

## **Cultural Stigma**

There is an enormous cultural stigma surrounding mental health in the Hispanic and Latinx communities. It is not normally talked about; it is quite a taboo topic. Many people see it as a shame or a sign of weakness, and people who do express their mental health concerns are considered "crazy." There is constant invalidation, criticism, and rejection of negative feelings and emotions. Some phrases I have heard used to invalidate others include "toughen up," "stop complaining," and "it's not real." Much of this stems from machismo and other generational traumas. Machismo is considered masculine pride. It can be observed in other cultures, but machismo embeds itself as toxic masculinity in Hispanic and Latinx communities. Men are put at the forefront, placed in dominance over women, and considered the family's head. Women are seen as inferior to men and are expected to serve men.

## **Language**

It can be disheartening and challenging to find a bilingual provider who speaks the patient's native language. Even though Spanish is the primary language spoken in Latin America,

many patients speak other dialects, such as Mam or Nahuatl, and there is a lack of interpreters and multilingual providers. Out of 39 million people in California, over 10 million people speak Spanish [2]. Surprisingly, according to a study, out of 19,310 primary care physicians in California, only 33% speak Spanish [3]. Without entirely speaking the same language as their providers, it can be difficult for individual patients to confide in their physician, let alone articulate and express their complete thoughts.

## **Health Insurance**

According to the Kaiser Family Foundation, between 2018 and 2019, the number of uninsured Hispanic people, not including the elderly, increased from 10.3 to 10.9 million [4]. As therapy can be costly, with no insurance, people are more than likely unable to afford it. The pandemic and legislation in 2020 led to more Hispanics and Latinx losing health insurance, specifically unemployment, immigrant policy, and an updated Medicaid renewal process. Without insurance, there is less access to adequate healthcare, including mental health professionals.



As someone who has experienced mental health issues and has used therapy in the past, I am grateful my family understood and accepted my concerns and wants for therapy. Through therapy, I explored and understood my emotions, improved my communication and relationships, and learned coping skills. I believe it is important to destigmatize mental health as a taboo topic and emphasize that many people within Hispanic and Latinx communities can benefit from therapy.

### Resources

Even though it might seem like a daunting task, it is vital to have these tough conversations and educate loved ones about mental health. Below are resources in English and Spanish for those that would like to get more informed and/or are seeking mental health treatment.

1. Therapy for Latinx- Program for intersectional communities to find mental health professionals.

<https://www.therapyforlatinx.com/>

2. National Alliance on Mental Illness (NAMI) Compartiendo Esperanza- A three-part video series that goes into finding mental wellness within Hispanic/Latinx communities.

<https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Compartiendo-Esperanza-Mental-Wellness-in-the-Latinx-Community>

3. Mental Health America: Información Y Materiales De Salud Mental En Español-

Mental health resources in Spanish, including national hotlines, guides on how to accept and manage your mental health, and ways to support children dealing with mental health issues.

<https://mhanational.org/latinxhispanic-communities-informacion-y-materiales-de-salud-mental-en-espanol>

4. National Alliance on Mental Illness California: Latino/a/x Resources- Provides Latinx resources such as a database helping Latinx people connect with Latinx therapists, National Resource Center for Hispanic Mental Health, and Sanamente (a Spanish mental health movement in California).

<https://namica.org/resources/latino-a-x-resources/>

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# Society, Deafness, and Motherhood

*By Schantell Williams*

The majority of deaf children are born to hearing parents. Many times these parents have little to no knowledge about deafness and the community. Abruptly, mothers have to make a life-changing decision for their child with limited information. The current medical model uses a normalization approach and pushes mothers into surgeries for their deaf or hard-of-hearing child at a young age. Many mothers are not aware that there is a thriving deaf culture which contradicts the ideologies hearing people have portrayed. I interviewed three mothers of deaf or hard-of-hearing children who shared their experiences with medical professionals and provided their thoughts on areas that can be improved to decrease stress for new mothers with a deaf or hard-of-hearing child.

In the United States, 90% of deaf children are born to hearing parents, hearing loss occurs in 5 out of every 1,000 births, and there are approximately 3 million children reported to have hearing loss [1]. In a matter of minutes after giving birth, a mother is told whether her child is deaf or hearing. Within the first few days of a newborn's life, further hearing tests are taken to confirm that hearing loss is present, and upon learning this information, a mother plunges into unknown territory. Moving forward, a mother is now obligated to decide on what the next course of action should entail. But is the mother properly informed on what options she has? Three mothers were interviewed to research the experiences mothers encounter when informed their child is deaf or hard of hearing.

\*Names of the mothers have been changed for privacy\*

Participant 1, Mary, is a hearing mother that was told her son was hard of hearing after giving birth to him. Mary's son had failed three hearing tests. She was told that this was common and was referred to an audiologist. After visiting the audiologist, Mary

discovered that her son had bilateral mild to moderate hearing loss due to a genetic condition called Pendred Syndrome. The audiologist informed her Pendred Syndrome was a type of progressive hearing loss and there was a chance that her son would lose most, if not all his hearing by the age of three. Mary was connected with a Geneticist, Ear Nose, and Throat (ENT) doctor, an Early Intervention Program, and later, a cochlear implant team. The family saw the audiology team monthly and began the early intervention program by the time her son was four months old. Mary had to decide if she wanted to raise her child completely using sign language or if she wanted to embark upon the journey towards cochlear implants. She stated that she was not pressured by his audiologist, but did feel some pressure from the surgeon. Mary stated the surgeon had some audist perceptions about deaf children and she quickly corrected him because she was outraged at his suggestion that her son couldn't be successful without cochlear implants. It took many years to decide on giving her son the surgery. In the meantime, she continued to educate herself through various programs and she enrolled in a local

college to learn American Sign Language (ASL). She stated ASL will always be a staple in her son's life. Mary shared some doctors were hyper-focused on hearing devices as a solution and only saw her son as a statistic. But, some individuals helped her through every step of the way. Mary feels that medical professionals should be more informed on deaf education, sign language, and resources that can adequately inform hearing parents of their options on both ends of the spectrum. She explains that hearing devices are not the only option, and sometimes not the best option either. Mary says she didn't learn much about options in the deaf community until she took the ASL class and she adds information should be readily available for hearing parents from the very beginning. In her final remarks, Mary expressed though she chose to get implants for her son, she continues to use sign language and it has resulted in her son being self-aware, self-confident, and having a rich exposure to language using ASL, speech, and reading. She understands that being deaf is a part of her son's identity, will be a part of his learning style, and ASL will continue to be his preferred way of communication.

Participant 2, Pricilla, is a hearing mother whose daughter became deaf after having a meningitis fever; Pricilla's daughter was diagnosed deaf in 1995. Her daughter had meningitis fever at 11 months old and was in the Intensive Care Unit (ICU) for 11 days. After her daughter's recovery, doctors informed her there was a possibility her daughter could be deaf. Pricilla's daughter underwent a bone conduction test, which analyzes if the inner ear moves or not. Her daughter failed this test and would have to perform the same test at a different location to confirm that she was deaf. Due to the

numerous appointments and the hospital stay, Pricilla could not miss work to be with her child during the appointment which ultimately confirmed that her daughter was deaf. Pricilla was referred to many programs including Kids with Disabilities in Richmond, California, and Early Intervention of Deafness in Berkeley, California. Pricilla explained how at the time cochlear implants were recently making their way out to patients, and it was a huge bulky device attached to the side of the head. She was discouraged from the device and instead gave her daughter hearing aids. She continued to take her daughter to multiple audiologist appointments for the hearing aids. In 1997, Pricilla had an altercation with the audiologist where he told Pricilla that she should simply give her daughter the implants compared to the number of office visits she was taking up in the appointment schedule. Pricilla had already decided to wait until her daughter was 18 and allow her to choose to pursue the surgery or not. At age 21, while attending college, her daughter decided to get cochlear implants. It took 6 months for her daughter to become accustomed to the implants. The implants allowed her daughter to hear some environmental sounds, but nothing more. Pricilla's daughter suffers from headaches when wearing the implants, so she no longer uses them. Pricilla works with deaf and hard-of-hearing individuals. Pricilla shares her concerns about the numerous children with cochlear implants constantly having headaches. Pricilla also shared her concerns on how the medical community feels like they must "fix" deaf and hard-of-hearing babies, even though deaf individuals don't feel like they are broken. Pricilla sees many deaf and hard of hearing children that do not learn any ASL, which separates them from

being a part of the deaf community. Pricilla attended a panel where she learned most parents gave their child cochlear implants immediately after the diagnosis because they believed their child would have perfect hearing and be like others. However, this was not Pricilla's case. Pricilla shares that parents are not being completely informed of the results of post-cochlear implants. She explained that if a child gets cochlear implants and gains at least sixty percent of their hearing, a child will lose their disability benefits. This means the child cannot receive social security and the child would not qualify for additional resources in school. She finishes by saying there are some pros and cons to the medical field. Medical providers are doing their job, but they are not advocating and letting people know about the positives within the deaf community such as the California School for the Deaf in Fremont where many children excel.

Participant 3, Christina, is a deaf mother that gave birth to three deaf children; When Christina's first child was born, her child did not pass the hearing test. She was not worried at all since she was deaf, as well as her husband and their entire family. Christina states the doctors told her that she needed to go and get her child's hearing tested again. She tried to decline initially, but the doctor explained that it was illegal for them not to proceed with further testing and referred her to a specialist. Christina took her firstborn to the audiologist where they put her child in a box with huge headphones and proceeded to test her child four times. Christina felt uncomfortable and was bothered by the process. After four failed tests they referred her to another audiologist. Again, her child failed four additional tests. The

audiologist explained how there may be water in her child's ear and they must confirm that her child is deaf. Christina begged the audiologist to stop and expressed her frustration. Christina explained how with a hearing baby, the child takes one test, they pass and everything is good, they get to go home. Unfortunately, with a deaf child, there are so many different steps families have to go through and doctors kept stringing these individuals along. She stated the medical field needs to change its perspective and look at it from her point of view. She gave birth to a healthy child and she was a mother with a strong deaf culture that could support her deaf child. Christina stated that she experienced the same process with her second child. After multiple tests, she was referred to an ENT and a geneticist. She states there were more unnecessary steps and confirmed what she already knows: her second child was deaf. With her third child, she pleaded with the doctors to not make her go through the entire process again, which they granted. Christina was upset with a doctor who tried to push her into giving her child a cochlear implant so the child could be considered a part of the hearing world. She expressed to the doctor that this was against her beliefs and would further oppress her community. Christina explained how the medical field needs to inform parents about the California School for the Deaf, that ASL is an option that can be valuable, and there are deaf resources available. She stated the medical field needs to be open-minded to whatever the situation may be. Christina adds medicine needs to look at what the deaf community does have, which is a strong culture and support system within the community. Christina states that hearing parents need to be informed there is a deaf

community that can help, support, and provide schooling. Parents can visit, learn, and take classes themselves to help their children. Christina also expressed how doctors need to work on their piety. Multiple times she got an “I’m so, so sorry to inform you” or an “I apologize”. Doctors need to change their perspective and not make deafness seem like a negative thing.

In today's society, we have learned that altering a human being's life is better than accepting who they are at birth. We suppress a minority because we reconstruct the idea that deafness is shameful. Mothers are experiencing extensive levels of stress at a

time when they are already vulnerable. There is a need for the medical field to be more conscious of the biases they have toward certain communities. Additionally, the medical field must find a better process for mothers that have deaf or hard-of-hearing children. The current process in place affects the mental well-being, socioeconomic statuses, and dynamics of many families.

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# The Effects of Poverty and Low-Income in Youth

*By JcGerard Pascual*

I currently work at First Community Housing development, located in downtown San Jose, California, as a Healthy Food Access intern. Additionally, I work in other programs from the company like digital literacy, sustainability, and diversity, equity, and inclusion. I participated in helping with a grant called "One Hundred Cameras" as a program leader and educator. During my time teaching and assisting in this program, I was able to see firsthand the types of difficult circumstances individuals from low-income backgrounds encounter at a young age. My personal experience and time during the program inspired me to understand different perspectives, which led me to seek out more information. Through analyzing the various programs for low-income or newly unhoused individuals, it was clear that poverty plays a massive role in youth's social determinants of health. This research aims to educate and spread awareness on how low-income individuals are deeply affected by the fear of becoming unhoused. I want to inspire and create a place of discussion where we can start change as the growing number of unhoused individuals is a great crisis in California. First Community Housing emphasizes the need for sustainable living and the importance of taking time to focus on the needs of each program. Healthy food access, digital literacy, and sustainability programs aid in ensuring housing, food, and educational security for those who struggle to access these resources.

## Background

There is a stigma centering on people without housing and who have low-income statuses in which people often think that it is easy for these individuals to climb the ladder. Society may say, "get a job," and assume this is the clear solution. Still, society forgets to realize that certain aspects are expected when applying for a job, such as a stable address, phone access, transportation, proper attire, and hygiene. Many youths experiencing homelessness or low income also have families they need to support and are under very tough circumstances that are often underestimated. The children living under these conditions go through very unfortunate ordeals that significantly impact their overall development in aspects such as hunger, illness, insecurity, and instability. Low-income youth are more likely to experience low

academic achievements, behavioral problems, social and emotional consequences, and detrimental health outcomes such as obesity and other chronic conditions [1]. As a youth instructor, I see how these aspects directly impact their mental health, responsiveness, and behavioral problems, contributing to low academic achievement. These individuals often do not feel safe expressing the need for help, and sometimes asking for help is mistaken for being rude and looked over as "troubled youth." One example is going through the "Map my Story" activity in our curriculum. The objective was to reflect on the past and present and look to the future. One of the conflicts that my student shared with me was that she developed an unhealthy eating disorder at a very young age. She expressed how she felt misunderstood when trying to communicate help to her teachers and adult

peers because of fear that they didn't understand her point of view. Although this was not a direct result of being low-income, this highlights some of the struggles they go through on top of not having stable housing. These unhoused and low-income youth are confronted with stressful and traumatic circumstances at a young age which adds to emotional distress and presents a higher risk of mental health disorders or illnesses relative to housed children. Sixteen percent of older unhoused children, versus nine percent of housed children, have one or more chronic health problems [2]. This highlights the clear need for access to health care services and how much our low-income youth often don't receive benefits because they usually do not have the means to pay for such services.

### **Importance of housing**

The fear these young individuals face when constantly wondering where they will lay their heads for the night emphasizes the need for equal opportunity housing. In addition, because of their emotional and behavioral problems that come from not having stable housing, unhoused children experience twice the incidence of learning disabilities [3]. Although accommodations are provided to unhoused and low-income individuals at the non-profit I work at, the process of choosing these unhoused individuals for housing takes a very long time, sometimes months and years, and they have to go through specific requirements to meet these conditions, such as family income and how many family members are living in the household. In addition, there are not enough housing developments to shelter unhoused individuals. Further, this affects their stable learning and creative environments, which, in

turn, shapes future success in higher education.

### **Access to healthy foods**

The health disparity concerning food deserts and access to healthy foods for low-income and unhoused individuals are linked to food insecurity. Children feel ashamed and embarrassed by their lack of food but cannot communicate this or express their need for food options. Undernutrition among children exhibited 7 to 12 times as many symptoms of conduct disorder, including, but not limited to, fighting, blaming others for problems, troubles with instructions, getting along with their teacher, and stealing versus children who are eating well [7]. First Community Housing has a healthy food access program where individuals are provided with resources and distributed foods to create security and promote healthy lifestyles to avoid these types of situations. I saw this as an excellent opportunity to help our youth learn more about nutrition, its effects on our health, and how it shapes our daily activities. As a leader and educator for these youth, I can clearly see how a simple snack can change their moods and responsiveness to the curriculum being taught. In addition, we see how much this helps alleviate their lack of motivation and behavioral problems.

### **Early Intervention**

In a study by Minnesota's Center for Urban and Regional Affairs (CURA), some unhoused youth can achieve academic excellence from the following conditions: parental closeness and involvement with their children's education, high-quality relationships with teachers and support programs, and relationships with competent

and caring adults [3]. I realized that in seeing the types of experiences the children I work with encounter, it is essential as an educator to be an understanding, helping hand. Specifically, during my time as an instructor, only three young students expressed a desire to attain higher education out of 28 students. When writing journal entries as a class activity, many responded to the prompt “where do you see yourself two weeks from now?” by writing they hoped they would not end up unhoused. Every other day, I would also notice some of them would come into class with puffy red eyes as if they had recently cried or were still crying. Unhoused youth go through negative experiences, but proper support can build resiliency and a sense of normalcy that can make them strive for excellence. Through First Community Housing, I can see how each worker seeks to lessen the barriers these unhoused and low-income individuals have faced.

## Conclusion

As a low-income minority myself, I understand the implications these kids in need experience. When I was growing up, I wanted to see someone be a voice and support me, so I am filling this need for these kids. It is unfortunate that I only saw this type of understanding late in life, but it is incredible how one person can influence and change my direction.

Accessibility to resources such as housing, healthy food, and educational

programs is essential to help support the growing unhoused and low-income population. This apparent need can and will negatively impact the future youth of tomorrow should we not act today. Low-income and unhoused youth deserve the care and attention necessary to eliminate homelessness and poverty to bring forth true health equity for all. It is imperative to understand what unhoused and low income people go through and help them regain their voice.

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## Corrections

N/A

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