Speaker 1 (00:00):

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Nikki Lewis Simon (00:18):

Welcome to GTDRIVES; Dynamic Dialogues. A Greenberg Traurig diversity and inclusion podcast. I'm your host, Nikki Lewis Simon, shareholder and chief diversity officer at the firm. We are excited to share this content with you, our listeners. Welcome to today's courageous conversation, COVID Equity and Inclusion. And this discussion is incredibly timely as we navigate our respective journeys and what I consider to be a dual pandemic, COVID and also social justice. Now I invite our friend and colleague John Voorhees to do more formal introductions.

John Voorhees (00:55):

And let me begin by saying kudos to the Nikki Simon team and her courageous conversation that have been a stable in our law firm for quite some time. We really appreciate what you're doing and again, today is going to be a wonderful example of that. It's my special privilege to introduce the panelists today and our moderator, Troy Eid. And for those of you who need to be educated on what Partners in Health is, it is a nonprofit, social justice organization dedicated to make healthcare a human right. It's working in 11 countries and its mission is to develop a sound and inclusive global health policy in those countries, that includes the United States. Today, we are having Dr. Regan Marsh who's in Boston speak on our panel. She has worked for Partners in Health since 2008, in countries like Malawi, Haiti, Sierra Leon, Rwanda, Liberia.

John Voorhees (02:15):

She's the top COVID public health advocate for Partners in Health and her academic background is undergrad at Princeton, got her medical degree at Pennsylvania, University of Pennsylvania and masters in public health at the Harvard School of Public Health. Joining her, is Dr. Sonya Shin, who has also been with Partners in Health since 2009 and dramatically spending 10 years in Siberia, working for Partners in Health. And she is currently the Community Outreach and Patient Empowerment Program director at the Navajo nation in Gallup, New Mexico. We can hear a lot more about this. Her background too is, got her undergrad degree at Yale and her MD at Harvard Medical School and her master's in public health at the Harvard Public Health. An outstanding panel you guys, and I'm just so pleased to introduce the moderator today, our friend and our colleague here at GT Troy Eid, the incomparable Troy Eid, who is the co-chair of our Native-American Practice Group and President of the Navajo Nation Bar Association and needs no further introduction than that. Welcome everyone, and thanks for tuning in.

Troy Eid (03:39):

Thank you so much, John. And it is such a privilege to be able to speak with Dr. Marsh and Dr. Shin today. And I just want to open this by saying, I know that this is a very tough topic sometimes to talk about. John mentioned the Navajo Nation Bar Association, and just by way of illustration, we have about 500 members and serve a court system that handles about 180,000 cases per year in an area that's bigger than the State of West Virginia. We've lost 16 of our members to COVID, including our founder, former Navajo nation presidents and my adopted big brother Albert Hale to the disease, this has been just a terrible time for many people, but we also see a brightening ahead in so many ways. And one of

the things that gets us through, is the fact that we have people like Regan Marsh and Sonya Shin who have really put themselves out in ways that are absolutely extraordinary.

Troy Eid (04:36):

So let me ask you to, and maybe start with Dr. Marsh. Regan, you had an illustrious academic career, we know that. But why did you join Partners in Health? What was that all about? I mean, what was of interest to you and why did you pick that organization and maybe explain to us where it fits in. We've heard of the French group, Doctors Without Borders and so on and so many other efforts, but this is a more systemic effort. So maybe talk a bit about it.

Regan Marsh (05:02):

Yeah. Thanks Troy. And thanks, John, for the incredible intro. I think I can speak for Sonya and me both when we say we're really grateful for your support and to be here with everyone today. And really my heart goes to you all for your loss of your colleague. I joined Partners in Health honestly, because I read that same book. It's called Mountains Beyond Mountains, Tracy Kidder is a great writer and I had gone to medical school truthfully out of an interest in helping folks who didn't have access to care and I was always interested in science and medicine. And then to find that ability to connect both social medicine and social justice to healthcare delivery, was what led me to Partners in Health. John, I think you did a tremendous job of introing PIH, I will say one slight correction, is I'm pretty sure that Sonya predated me. He was one of my mentors at PIH early on.

Regan Marsh (05:54):

But Partners in Health is an, I think a really transformational organization for the way the world has thought about global health. Traditionally, global health was really in domains around maternal child health or our wonderful colleagues at Doctors Without Borders, MSF who do emergency response, right? And really I think to it amongst the best in the world around earthquakes, around emergencies, around war. But the Partners in Health origins really are around community building and around justice and human rights and the right to healthcare. And so Paul Farmer was a medical student at Harvard. He had studied Haiti as an undergraduate student at Duke and found himself in Haiti early in his medical school career, working very closely with a community based organization and listening to the needs of the people, which I think has been a real theme for us, right? Is taking our cue from the communities with whom we work, and what the community said they needed in rural Haiti was a health center and a way of getting healthcare.

Regan Marsh (06:55):

They were extremely rural, extremely poor and had been displaced because of some industrial projects that had happened. And this was back in 1987 and built up a little clinic that became really the beginning of a movement, and a movement for the rights to healthcare. And our model that we developed there was originally around tuberculosis, which Sonya is an expert in. And then HIV and importantly recognizing that people don't just need medicine to get better, but they need the social supports, right? That a patient with tuberculosis is not going to get better alone with medication or HIV with medication, you need food and safe housing. You need someone with you to accompany you in your journey. And really a lot of our model is built around community health.

Regan Marsh (07:36):

We got a little bit of press truthfully in the '90s, around our outcomes with HIV. We were having better outcomes for our patients with HIV in Central Haiti than we saw in some places in the US. And through that, we were asked to expand our work into places like Peru and Russia, where Sonya work, but then increasingly into Sub-Saharan Africa. And so we went to Rwanda several years after the genocide, Malawi, Lesotho and started tackling these same issues of working on access to care for remote communities around HIV, around TB, around maternal child health, always in rural areas and always with the government in partnership with the public sector, to try to build up the long term health system with the concept that it is governments who endow people with the right to healthcare. And this is one difference from our colleagues at MSF, where they do emergency response and build their own systems to manage the emergency. We are always working with the government.

Sonya Shin (08:29):

Yeah. We were at this meeting where they were talking about... We started working in the prisons and then we were working in the civilian sector as well and the challenge was that most of the people that were really, really hard to treat, had also problems with alcohol use disorders. And sometimes the doctors would say, "Oh, this one, he's a good one. And this one is not the good one." And there was a value placed on which patients were treatable. And I remember Paul saying, "Listen, we can say that, it's the patient's choice or it's the patient's responsibility to come in for care." But in my memory, I remember that being a really pivotal conversation where he flipped it and said, "It's actually, our responsibility, the health system and healthcare providers, we have to shoulder this responsibility. If a patient has a drinking disorder, if they're homeless, if they're just not coming into care, that's actually on us as a healthcare system to take on that responsibility and figure out how do we actually get at the treatment out to those individuals?"

Sonya Shin (09:38):

And so Regan, you were talking about that community based approach. I think that's one of the solutions and I feel like for me, the measure of success has been when we were able to not just figure out, "Okay, which are the right drugs? How do you get them in the country?" And I have stories about that. But more importantly, how do we actually change the system itself so that they're finding those individuals that just fall through the cracks and almost disappear from the books and keeping themselves accountable to making sure that the treatment gets to them daily with home visits, which was what they called the Sputnik model. And then also at the national level, incorporating these guidelines into their national norms. So I think it was a real privilege, to be able to work in Siberia and Tomsk for that period of time. And I think a lot of that helped me bring some thought about that, that long game even as I came out here to Navajo.

Troy Eid (10:46):

So maybe a segue then to Navajo nation and to start getting into the topic of equity and health equity. Maybe Dr. Marsh, you can start off, what are these terms? What is health equity? What are... I think I know what it is, but I found that often I'm projecting whatever I think the word equity means. What does it mean in your line of work, from your approach?

Regan Marsh (11:14):

Thanks. I think equity... And it's interesting talking at a law firm, because I think you all actually often share some of this language with us. My partner works in finance and equity means something really different to him. I think about equity as compared to equality a lot, right? And so equality is giving every,

when we speak from health, is giving everyone the same thing, right? One thing. Equity is making sure that everyone has the ability to reach the same outcome and often means different provision of differential resources based on need, right? Ensuring that we can all live a long and healthy life, recognizing the unjust social structures that often lead, like Sonya was talking about, to these differential outcomes. There's a great, I think, example from a community group in South Carolina that looked at women with breast cancer in their community. And saw that of women of color, only 60% of them were diagnosed when their breast cancer was an early stage and therefore really treatable, but white women in that same community had an 80% rate of being diagnosed with treatable breast cancer.

Regan Marsh (12:26):

And they had been pushing, this was a really active community based organization around women's health and around breast cancer. They had been pushing for mammography, they had been spreading mammography out, but within quality approach, making sure in their mind, that everyone could get access to mammography. And then when they recognized the difference between women of color and white women, they created an equity focused intervention, really targeting women who were having the hardest time getting mammography.

Regan Marsh (12:51):

And often it was stuff that's similar to Sonya, less alcohol use disorder, more issues with getting childcare. So you could take a day off and go for your mammogram, getting a note so you could miss work for the day and go for your mammogram, having the information be in the right language so that you recognized it. And when they did that, they actually not only achieved equal outcomes, 80% of women of all colors, white, black, Latinx women, all getting early diagnosis of breast cancer. They actually raised the whole boat and actually their early diagnosis rate went up to 90% for everyone. And I think that's a great example of where quality focused intervention, spreading mammograms out amongst women really winds up having differential outcomes, because we don't recognize the way that social structures, the upstream social determinants of health affect people differently and affect their ability to get healthcare. And then how that has impacts on really long term outcomes. And frankly, in that case, real survival.

Troy Eid (13:49):

So Sonya maybe expand on that with respect to the Navajo nation and just to set it up for a second. I mean, keep in mind for those who are not as familiar with it, you're talking about a reservation that spans three states, a portion of Utah, New Mexico and Arizona, about two thirds of the reservations of the State of Arizona. As I mentioned, it's about the size of the State of West Virginia, population about 310,000. Unlike the US median population, median age is about 38, I think in the US overall. Navajo it's about 18, it's much lower. And you're between four and five times more likely to have multi-generational [inaudible 00:14:34], that is at least three generations in the same structure. The structures tend to have, I think the average in Navajo is about 18 people or so per structure. And you're talking about typically a mobile home or a modular home or a traditional Navajo home, which is called a hogan, you're talking about very small, in that case, a one room housing unit. That's what you're talking about.

Troy Eid (14:58):

You've got about a third of the population doesn't have electricity, maybe 40%, depending on the measure, don't have running water, number one cause of death overall are problem arising from dirty water in various forms, people having to haul water, there's no clean water where many people live and

work. So look at this, if you would. Dr. Shin, you've led a program and created an effort to really bring quality care to people who desperately need it and who are almost in visible to many Americans who live a very short drive away from them. Maybe talk about how you approach that kind of a problem. And what does it mean in terms of equity? How do you address the inequities?

Sonya Shin (15:44):

Yeah, thanks Troy. And you're describing these statistics and it's really helpful because I'm I just have these visual images of what you're describing, where people have to drive usually like more than an hour to get to town to buy groceries. And a lot of people only buy groceries once a month. So just imagine what it would be like to only buy groceries once a month in the multi-generational homes, which is certainly contributed to COVID. So I appreciate you painting that picture, because sometimes I live in it all the time and I forget how jarring it was when I did my first home visit and visited a home like that, where there was no electricity, no plumbing and we were literally three miles from I 40.

Sonya Shin (16:31):

So it was very different because I think in so some of the international settings where we work, there's definitely disparity and there's juxtaposed wealth versus poverty. But I think sometimes within the United States, it can be pretty invisible. And I guess, I was trying to reflect on how to put this in perspective. And I was thinking of about this meditation instruction that I did once and I have to confess, I'm not a very good meditator. But I remember the instructor saying like, "You have to ask the why behind the why." So if I'm nervous right now, it's because I don't actually... I've never talked to a bunch of doctors before.

Sonya Shin (17:11):

And so then, why are you nervous? So then you go back and say, "Well it's because I had too much coffee this morning." And then you keep on asking the whys to ultimately, kind of just gently and persistently get to what that underlying truth is. And I guess, when I came to Navajo nation, I arrived around a decade ago. I had worked in international settings for a long time, but it's really been a process of just continuing to ask the why. So if we have rates of diabetes where CDC predicts that one out of two Native American children are likely to develop diabetes in their lifetime or if you're in a house, like what you're describing, it's not like this is, it just happened, that's poverty has just been there.

Sonya Shin (18:01):

It's sort of asking like, "Why is that so? Why is there overcrowding in the homes or why are there problems about access to water?" And for me, for instance, with diabetes, which we started to work on, we started to hear from our families, "Well we can't get ahold of food and then if you start to think about, "Well, it's very rural, it's very expansive, but why is household food insecurity 75% of Navajo households compared to 10% in the US?" That's a pretty jarring difference. Then, and I'm grateful to my Navajo colleagues, historians, policy experts who really were very kind and generous to connect for me that relationship with two centuries of historical experience that included pretty systematic destruction of food sources during military conquest, forced relocation and introduction of Western foods, which makes the relationship for Navajo community members with commodity foods or food assistance programs complex. And even to this day, a lot of people like you were alluding to, they won't drink their tap water because they're really worried about the fact that the uranium mine that's like five miles down the road, has never been remediated.

Sonya Shin (19:30):

So I think that was also very important for me to have very kind and generous colleagues here on Navajo nation to help me really continue to ask the why behind the why. And I think it's informed us with all of our programs, how we tried to set about addressing this. So it really... And I think about Partners in Health mission statement about providing a preferential option for the poor. It means going above and beyond for communities that have experienced these marginalizations, because we recognize that there are these underlying systemic structures that actually put them at greater risk. And they're inherently unfair structures.

Sonya Shin (20:16):

So we thought a lot about how can we increase access to healthy food? If we're going to get a diabetes, we do the outreach, we do all the education, we make sure they have insulin. But also, can we actually increase food security in a way that also generates economy into local growers and local business owners? Which has actually been even more important during COVID or more recently, if people won't drink tap water, even if it's safe, they won't drink it because of these concerns. What can we do to help the community feel empowered and be able to overcome these systemic barriers? And so part of it has been for instance, testing water. If they can test their own water and if they can see, "Yeah, it is safe to drink." That might be a way to create more access to something just as basic as clean water.

Sonya Shin (21:11):

So I hope that makes sense. But I think for me, at least, it's really been like 12 years journey and I'm sure I'm only halfway through the whys, I'm sure that there are many things that I still have yet to learn, but I think one of the major outcomes is really respecting the fact that Navajo is this sovereign nation. It knows what it wants to see in its future and as allies, I think I'm sure you feel the same way from the legal standpoint. As allies, we're here to overcome or partially undo some of these underlying structures that are not in their favor.

Troy Eid (21:47):

So Dr. Marsh, let me just ask you to extend what Sonya was talking about. You, as I understand Regan, you led the efforts for Partners in Health in Sierra Leone, and you went in there during Ebola and help help us understand from an equity standpoint, what it means now today as we shift to COVID, there was infrastructure in place that you helped to create and you and your colleagues worked hard to create to deal with an epidemic. And tell us about that, because it had to be a terrifying situation where healthcare workers in the front lines were undoubtedly exposed and were very, I'm sure, very concerned about what was going to happen to them and their families and so on from just treating others. But talk to us about now with respect to COVID, we don't hear as much about Africa, Sub-Saharan Africa in terms of what's happening here in the states, but has it helped in a place like Sierra Leone where you put those structures in place to be able to contend with the next epidemic, COVID or whatever we might face in the future here?

Regan Marsh (22:53):

Yeah, definitely. And like Sonya, I would echo my external gratitude to my colleagues in Sierra Leon, and it was truly my privilege to work with them. They are really... Excuse me, makes me... They're truly the heroes. As measures of equity go in Sierra Leone, which is a country of about 7 million people. At the beginning of the Ebola pandemic, there were about 50 physicians, Sierra Leonian physicians in the whole country, which I often compare to... I'm faculty at the Emergency Department at Brigham. One of

[inaudible 00:23:28]. We have 60 faculty and 60 residents. So 120 physicians who staff in emergency department compared to 50 in a country. There are three times as many nurses at the Brigham as there are in all Sierra Leone. And so the crisis of healthcare workers in West Africa is very real, and to Sonya's why behind the why, in West Africa, it's incredibly complicated history of a difficult civil war all through the '90s, which probably made people's news because of its terrible use of child soldiers.

Regan Marsh (24:01):

But that war was deeply connected to a war over diamond and resources. That was actually interestingly, if you dig into the history, connected a bit to Osama bin Laden and 9/11, there's a really complicated global history related to extraction of resources in West Africa that goes back truthfully, 400 years as Sierra Leone was where the majority of enslaved people were deported from Africa, stolen from Africa. And so the history of extraction in West Africa of people, of mineral rural resources really has devastated the country of Sierra Leone and the neighboring countries really for generations and generations. With regards to Ebola, the civil war had really undermined the healthcare system, leaving it with so few physicians and nurses and really devastating health infrastructure.

Regan Marsh (24:49):

And so when Ebola first emerged, as it's known at what's called the tri-country river region, which is where Sierra Leone and Liberia and Guinea all intersect. It really [inaudible 00:25:02] along as a simmering fire that wasn't noticed because of the weakness of the health system, because of the few healthcare workers. And then frankly, because the world, frankly, wasn't listening well enough to those people who were shouting about it. And our colleagues at Doctors Without Borders were one of those organizations. Our work was, as I said, both healthcare and moral and we went and we did, toward to your point, with others. Build up healthcare systems of Ebola treatment units, community care resources. We hired importantly, Ebola survivors. We worked in one of the highest community burdens of Ebola and we said, everyone at that point on the news was counting deaths and we started counting survivors, because we said, "This is treatable, this is survivable. We know how to do this. This is a question of health equity, we need to put resources in, we need to care for people."

Regan Marsh (25:53):

And so we built up these resources and then importantly concurrently, started building up the long term health infrastructure. So we worked in the Ebola treatment unit, we also worked at the next door district hospital and started putting in resources that reopening the operating room. So women who needed a C-section could have one, reopening the blood bank. So if you needed a blood transfusion, either because you were a child with malaria or a pregnant woman with hemorrhage, you could have a safe blood transfusion. Getting a lab, getting medications. That hospital that I'm talking about, had never had a functional x-ray machine in the history of time. So we put an x-ray machine in, we put running potable water in, we put flush toilets.

Regan Marsh (26:27):

These things had been there in bits and pieces, but had been really destroyed over the proceeding 15 to 20 years and then worsened by Ebola. And I would say it's a great success story and one of our wonderful accomplishments is just on Friday, five days ago, we broke ground on what's called the Maternal Center of Excellence. Sierra Leone has the unfortunate distinction of having the highest maternal mortality in the world. One in 17 Sierra Leonian women in her lifetime die of maternal death,

which I always pause and think about how many women I know in my life and what that would mean of women who I didn't get to continue my life with.

Regan Marsh (27:03):

And so listening to the community again, this was a real need sighted, we need a proper hospital to take care of women, to train midwives and nurses and physicians. And so with a bunch of great collaboration between the government and Partners in Health on Friday, we broke ground on a Maternal Center of Excellence in rural Sierra Leone, which is designed really to tackle these complex issue. But with regards to COVID, I would say all of this work that's at Sierra Leone, Liberia and Guinea did to prepare around Ebola, made the response to those countries COVID cases much better and much more robust.

Regan Marsh (27:39):

I was in Liberia in February of 2020, February of last year. We weren't really paying attention to COVID in the US, but when I landed in Liberia, I had my temperature taken. I had to wash my hands. Every building I went into that was a public building, I had to wash my hands and have my temperature taken, they were screening for symptoms. And when COVID got worse and as we all know, we shut down around March 13th of last year, Sierra Leone and Liberia closed their borders for a while. Because of real fear of what the infection could do in their countries with their weakened health systems. And it's been complex, but I would say Sierra Leone and Liberia have really been a model for how even in a poor country, with good public health systems, with good surveillance, with good messaging, using community health workers and others about wearing masks and washing your hands, really can control the infection.

Troy Eid (28:27):

It's a very good point in terms of reminding us that the experience in a lot of places like Sierra Leone is transferable to us, but we don't necessarily react in real time. I was reminded as you were talking, our son is 24 and he was on a US Department of Defense fellowship after getting his physics degree and Korean language degrees in Chicago. And he was in Seoul and was evacuated the very last week of February. And we were very excited that the US government got him out. We were happy to have him come home, but he went all the way to Morrison, Colorado in the Foothills, were we live and no one took his temperature. When he had his mask on, when he got off the plane in San Francisco, people stared at him like he was from Mars.

Troy Eid (29:16):

And then he literally [heard 00:29:18] TSA officials say, "You need to take that off, so it's a security issue." So I'm just saying that we really need to learn from this experience because there's a whole wealth of knowledge out there. And I would think that having been on the front lines in so many ways, both of you have this experience. Tell us about personal protective equipment while I'm on that. I mean, talk to us about that. I mean, number one, you saw it in place, you obviously saw how it was being implemented in places where you've worked with these, setting up these tremendous responses to such large systemic sorts of health challenges and now you see it in the US. What should we be doing to plan for the next pandemic?

Speaker 1 (30:08):

Thank you for listening to part one of the discussion. Listen to the next episode for part two.