Narrator1 (00:00):

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Troy (00:22):

Maybe it comes, maybe it's a COVID variant. Maybe it's something unrelated to COVID. Right? And also look at the issue of how the states have dealt with it. We've had the federal standards, right? But we've had states doing a lot of different things. You know, I'm in Colorado right now, 31 counties have no restrictions of any kind in place. The vaccination rates are between 37% and 22%, I think, depending on where you are in the US, they vary a lot. So talk to us about... You've seen this work in other countries and you've built up programs over years there and relationships. But we're just still in almost year one or year 1.5 or whatever in COVID in the US. What happens now for us in your experience? What should we be doing? Why don't we start with you, Dr. Shin. Put you on the spot.

Dr. Shin (01:13):

Okay. Well, you know, I think in some ways Partners in Health has kind of emerged more, I guess, on the scene in the United States because we have this playbook. And I think from the public standpoint, one thing I can say is that the Navajo nation, as sometimes where they're grappling with so many challenges around how to navigate across three states and federal jurisdictions, but it was an example where the sovereignty that it had was actually an asset. You know, they were very, very upfront, you know, ahead of the curve in terms of like, you know, public orders, lockdown, travel restrictions, curfews, mask mandates.

Dr. Shin (01:57):

And they used data. They used data from the beginning and they continue to. So I think that even if there is a lot of, kind of like, patchwork in terms of how different communities are putting in public orders, the idea of just making sure that all of us have kind of a good understanding of what's going on in our own communities and can make those decisions. Hopefully they've got to, you know, a public sort of sector that's using data-driven decisions. But even so, I think just knowing kind of like what's going on in our communities. I do have hope that we'll get out of this and we will get to a new norm. But I think that sometimes it's really hard when there's just so much kind of different messaging around, you know, what to do.

Dr. Shin (02:51):

So that's like kind of at a personal level. Even these questions about like, you know, should I send my kid to school, like back in person or online, you know, there's data out there. And I'd say from a system standpoint, what we've really tried to do is focus on the public health capacity. And, you know, it's funny Reagan, you're describing what was happening in Sierra Leone, and you could almost just kind of like replace some of the words and you're describing a very similar kind of narrative.

Dr. Shin (03:27):

And like in medicine, you know, sometimes we'll talk about acute on chronic, you know? So like if someone comes into the ER and their kidneys have been sort of chronically weak, it only takes like a little push and their kidneys will shut down because they are just, you know, there's a baseline, their

system is frail. And the same, I would say has been happening to a lot of communities of color, including, you know, Navajo where the vacancy's like, you know, 25% vacancy for doctors, 40% vacancy for nurses, 30% vacancies for community health workers. And then, you know, COVID just like emerges on the scene. It's really hard to stand up a response within that kind of setting.

Dr. Shin (04:10):

But learning from the work that Reagan and others have done in Sierra Leone and elsewhere. I think as we were sort of like building up that response, you know, for instance with contact tracers, which is an area that I've been pretty involved with for Navajo nation, we always kind of have our eye on this long-term goal that these are, as we're training up these people to do very specific calls to just stop the COVID spread today. These are the people that in three years will be filling those vacancies. You know, so how do we actually create that system? How do we find the right people that are like Navajo community members, you know, who speak Dine and get them excited, build their efficacy and sort of create that pipeline of workforce.

Dr. Shin (04:55):

So that's just one example, but I was, you know, thinking about it because you were talking about how, you know, I think in everywhere we've been, we've thought about people who have survived these illnesses and who can really kind of come from that real lived experience. That's the person that you want by your side, if you ever are kind of like, you know, walking that path in the future.

Troy (05:17):

Thank you. Dr. Marsh, you want to add on to that? I'm just curious your perspective as well. And also just for our audience to make sure, I don't like to make assumptions. So when you talk about teaching at Brigham and Women's, this is one of the largest and most respected teaching hospitals in the world, it's affiliated with Harvard medical school and, as I recall, was a combination of several different hospitals that came together into that one unit.

Troy (05:43):

So you've got, you know, two professors, as well as practitioners from the leading clinical and teaching hospital in the country, or one of the very top ones in the country. So Reagan, what do you think when you go back to, say you were in Malawi or you're in Sierra Leone or Haiti. These experiences you've had, but you've learned some best practices in those places. And you've stood up systems at the community level that maybe are not in place here or only partially in place or are different. What can you apply here in the US in light of COVID? Where do we go from there in that sense from your experiences?

Reagan (06:28):

Yeah, it's funny. I think maybe not everyone realizes, at the beginning of COVID in the US in March and April, when all the big cities were standing up emergency response hospitals in Boston, we had Boston Hope. There was the Javits Center, [inaudible 00:06:43], those were all modeled after Ebola treatment unit. Right? Because it's a lot of the same people in similar organizations. And taking some of those best practices around PPE that we learned with our Sierra Leonian colleagues, with our Liberian colleagues. What works well in terms of red zones and green zones, what works well in terms of putting your PPE on and putting your PPE off? What are the things that patients who live in those hospitals while they're sick need to be both physically well, but also mentally well, right? Because you're in this sort of confined space, how can we provide social resources?

Reagan (07:16):

How can we keep people connected to families while they're in either Ebola treatment unit or the Boston Convention Center. So, there was a ton of best practices learned. I think, and Sonia was talking about a lot of this, which is, you know, the US healthcare system is interesting. It's the most expensive healthcare system in the world. We spend close to 18% of GDP on healthcare, which is nearly 50% more than our next closest country counterparts. But since the 1960s, even though US healthcare costs have gone up, what has gone down is our investment in public health systems. We're spending more and more money on hospitals. And in some ways we get good outcomes associated with that, right? If you have cancer care, if you need a complex surgery. But what we've seen is, actually compared to most Western European countries, compared to a lot of Southeast Asian countries, our life expectancy's shorter, our maternal mortality rates are higher, our child mortality rates are higher, and there's real inequity in the US.

Reagan (08:20):

I live in downtown Boston. The neighborhood next to mine is quite affluent. The life expectancy there is 91 years. If I were to take the T five stops and five miles here, the life expectancy in one of the neighboring communities that's part of Boston is 60 years. So in five miles, there's a 30 year life expectancy difference in Boston. And that is not for shortage of healthcare here. Right? We have five academic teaching hospitals that I could walk to from where I'm sitting right now. And what it is because of some of these things, my hypothesis is, around public health and primary and community health that we in PIH have worked with many of our local country partners to build up.

Reagan (09:00):

And so investment in education systems, investment in food, investment in economic opportunities, and really the systems that help connect people to care. And so to your question, Troy, around lessons, when we think about controlling infectious diseases kind of anywhere in the world, if it's TB or COVID or Ebola, we have sort of a test-trace-treat model, right? So testing everybody from COVID, doing contact tracing, which Sonia was talking about, calling and asking, "who have you been in touch with," and then treating and isolating folks. And so those models have been really built over the last 50 years of infectious disease practices. And what we didn't have in the US at the beginning of the pandemic is good public health systems that would let us do that. Our US COVID work, we work really closely in the city of Newark, which is the biggest city in New Jersey, 280,000 people.

Reagan (09:56):

The city of Newark lost its Department of Health. Staffing was cut by 50% in the 2008 financial crisis. And still is at that same funding level. So it went from having a staff of 700 to a staff of 300, and no epidemiologist on staff at the beginning of COVID. And so the ability to scale up testing, tracing and treating when you have a tiny team that in many ways is smaller than the teams we would see in Rwanda or some of the places we work was really hard. And so I think what we've done as PIH, and as a lot of public health organizations have done over this last year, is build up those systems, build up contact tracing systems, build up relationships with community-based organizations. And I think to your question of like, what's next, what do we need to do, is what we need to do is keep in these investments in public health, we need to not like say, "Whew, the pandemic is over. Like we can go back to business as usual."

Reagan (10:52):

What we need to do is keep the contact tracers on as community health workers or higher community health workers, we need to build our relationships with communities, particularly communities that have been historically oppressed and marginalized so that they have the sort of upstream resources that are needed. We need to make connections to healthcare. We certainly will have another pandemic. Like that is quite clear, whether it's a variant of COVID or another respiratory infection, we have to sort of take this as an opportunity to build up the systems and keep them in place and use them to create healthy communities, both for emergencies, but also for things like Sonya was talking about. Like diabetes and cancer care screening programs, and mental health and addiction issues. Right? And that's how we'll get at some of these 30-year life-expectancy differences we see, you know, from here to there in all across the country.

Troy (11:40):

So let me ask you, just pick up on the 30 year life expectancy difference within, you know, five stops on a subway or a train. Project that out onto vaccines. What do you see in terms of vaccine utilization? And are we equitably, right now, providing vaccines in the United States? A big question. Or just pick Boston. You know, whatever you wanted to speak to, or not. Help us understand that issue. The term vaccine equity is thrown around a lot now, I see it in social media a lot, but I don't really know what it means. And I'm thinking maybe your example can help us understand.

Reagan (12:21):

Yeah, definitely. And Sonia, I think can talk some about the Navajo, because the Navajo's done great with this, really. So back to equality and equity, right. Equality would be just saying, everyone can get a vaccine. Equity would be thinking about where is COVID the worst, which communities have been most affected by COVID, and then really targeting vaccine interventions to those communities.

Reagan (12:44):

So in Newark, another example from Newark, Newark is a city in Essex county. Essex county is basically half Newark and then half upper Essex county, which is quite wealthy and affluent, New Jersey horse-farming kind of area. The county stood up five mass vaccine sites. And in the first month or so only 7% of the people vaccinated were Newarkers. Despite the fact that the vast majority of people in Essex county who had COVID were from Newark. And so what the city of Newark did, and the Department of Health of Newark did, with our support was set up mobile vaccination sites to some of the long term... Not long term, the elderly communities in Newark, where the residents really had difficulty with mobility.

Reagan (13:29):

So set up a mass mobile vaccine site right there. And do messaging with trusted folks from Newark, from the mayor, who's well loved in Newark, to community leaders. Setting up vaccine sites outside of school, outside of the bus stop or the train stop, places where people go. Both on supply side. So putting the vaccine where the people are. And then on demand side, right? Talking to people, answering questions, understanding people's concerns and answering them really honestly. And then also pairing some of these vaccine initiatives with some of the long term stuff that we need to do.

Reagan (14:03):

So taking the opportunity to screen for food and housing insecurity, connect people to insurance programs, connect people to food banks. So that it makes it worth your while, not just in terms of shot in the arm, but in terms of getting connected to the social program. And so to answer your question, I

don't think we've reached vaccine equity yet. I think we are moving in a good direction, but it's going to take real targeted interventions to understand some of these upstream. The "why behind the why" that we see these differences and really target the interventions around.

Troy (14:39):

Thank you. Dr. Shin, maybe you can talk about how that's working at Navajo, where the rate of vaccination has been so high. You work in a place and you've created programs where there's a phenomenal rate of vaccination, which I think is a wonderful thing. How do we apply that to other parts of the country too? And what has it meant at Navajo and the lessons you've learned?

Dr. Shin (15:04):

Thanks Troy. I mean, first of all, it kind of feels good to be able to talk about sort of the successes in Navajo around vaccination...

Troy (15:13):

[crosstalk 00:15:13] It sure does.

Dr. Shin (15:13):

Because you know, the media... Like, Navajo has hit the top of the charts, you know, first not a good way and now in a good way. So it just feels really, you know, sort of like moving, and just good to be able to talk about it. And just recently, I think there's some speculation, and we'll see what happens, but I think some folks are speculating that maybe Navajo will be the first community to reach herd immunity, you know, in the US. Which would be pretty cool. One thing is, Troy to your comment earlier, everybody's lost someone. There's going to be a lot of healing that's going to happen, you know, even beyond like the vaccine rollout.

Dr. Shin (15:55):

And we're talking about that too, but I think, you know, first the community has just been really excited to get the vaccine. And I think there's been just a lot of motivation because of personal loss, and then because the message is the same. You know, all of the leaders, the party line, whether it's the federal Indian health services or the Navajo president, the messaging is very, very consistent and continuous around vaccine safety. So I think part of it has been that, they've done a good job of overcoming some of the mistrust that could happen and, you know, still does exist.

Dr. Shin (16:37):

And, you know, Regan, I think a lot of the things that you were talking about with just rollout, that's been something that we've seen here on Navajo nation, that we're not like really giving the vaccines in the clinics. I mean, it happens once in a while, but the vaccines are out there, you know, in these like sort of drive-through sites that are out in the communities with the least amount of coverage, people are going, you know, the community health workers are going into the homes to vaccinate elders. One thing that was really kind of impressive to me was that instead of saying, "we're only going to vaccinate the elder," well, who looks after the elders, you know? In these multi-generation homes, it's going to be the daughter and then the granddaughter and the sister.

Dr. Shin (17:19):

And so they were really very open about offering vaccination to everyone. And not just like in that home, but we knew that a lot of... You know, every time the rates would come down, when they started to creep up again at Navajo, we would hear about those first cases happening when somebody traveled to Phoenix or somebody traveled to, you know, I won't put Denver on the spot, like to Albuquerque or elsewhere, because they have relatives, you know, that live close by and people are traveling all the time to check in on each other.

Dr. Shin (17:48):

And so Navajo, I thought this was kind of interesting. They really thought about like, what's important? Like who is the community here? How do we do this in a way that makes sense for Navajo culture? And they opened up the vaccination even to non-residents that were members of the Navajo nation that didn't have access down in Phoenix and we're welcomed with open arms, you know, here on Navajo. So I think those are just some examples that I think have been, you know, standouts for me. And I really hope that they'll be able to just get through that final mile and that hopefully, you know, some of these lessons will be applicable to other tribal nations.

Troy (18:28):

What can we do in the US to advocate for an equitable approach to COVID here in the US and globally. And maybe we can talk about globally, because we've not talked yet about, you know, there are now statements about, we have vaccines that are left over in the US. I heard that phrase this morning used on television. And of course there've been many calls from the World Health Organization and others, the declaration to try to get vaccines out to other places. Can you speak to that issue? Dr. Marsh maybe can start us off?

Reagan (19:01):

Yeah. I think this is a critical issue. I would say in terms of vaccines, the first and foremost thing, it's the right thing to do, right? We are all one planet and one people and it is the absolutely the right thing to do. The other thing is a bit more selfish, which is we're not safe until we're all safe, right, with COVID. This is a global pandemic and there will be continued emergence of variants, which will become more contagious over time if we don't control COVID at the global level. And so, you know, my heart says we should just care about other people, right? That's like our very fundamental, the sort of premise within Partners in Health. But even besides that, there really is a global need to support vaccination everywhere.

Reagan (19:52):

There are a couple global organizations really trying to support vaccination in low and middle income countries. But right now those organizations are targeting things like 20% vaccination rates in low income country. Which we know is well below the threshold for herd immunity or population immunity, which is at the 70, 80, 90%. And so advocacy for war global vaccination is key. Locally I think like all politics are local is what I'm increasingly learning. And I know we're approaching time Troy will say.

Reagan (20:22):

One thing that happened in Boston was the first vaccination sites that came out in the Metro Boston area were in the wealthy and predominantly white suburbs. And there was like a very appropriate social media outcry about it. And very quickly the mayor and the governor stood up vaccination sites in the communities that had been differential affected, really profoundly affected by COVID, to put vaccination

sites there. So there really is a lot of power in that. And then there's a lot of organizations, ours and others, who are doing work to support COVID in most affected communities. Getting involved with those organizations. It's always worthwhile both locally and globally. I'm careful on time here.

Troy (21:03):

So I know our time is almost up, but let me just ask just before I turn this back over to John, and thank you so much for this incredible conversation to learn from you too. What, is it about you two that you could do anything that you wanted in the medical field, and I'm sure any other field, frankly. I mean, given what you've achieved academically, professionally, but why have you, and question to each one of you, why did you choose partners and health and are you glad you did? And what do you want to do in the future? Just something real quick, kind of a sound bite. So Reagan, you go first.

Reagan (21:39):

I was hoping Sonya would take me off the spot. I mean, I can't think of a single thing I love more doing, right. What an incredible opportunity to be able to take care of people, both individually as a practicing physician, but also through communities with our Partners in Health. To work really with some of the most incredible people I've ever met, they inspire me every day. And so I genuinely believe that it is my like true honor to be able to do this work.

Troy (22:05):

Well, you're inspiring. And Dr. Shin, Sonya, how about you?

Dr. Shin (22:11):

Yeah. I mean, ditto to Reagan, your comments, and also, first of all, I just want to thank you for even calling these sessions courageous conversations, because in some ways like this is kind of how I sleep at night. You know, right now, like we're talking about systemic racism and we're talking about really, really big issues, you know, and health equity can be sort of thrown around at least kind of like catch words. But like this is kind of how I sleep at night is to find a way to feel like some level of efficacy to be trying to fix things and make things better. You know, I think we can all do it at different levels. It doesn't have to be like a career thing. But I just feel so grateful that I'm able to be part of the solution.

Troy (22:54):

Well, Reagan, Sonya, thank you. And I'm going to turn this back over to my friend, John Bore, he's going to close us up here.

John (23:01):

Your presentations, I've been asked to just wrap up with three takeaways and here they are. Number one, we're at an inflection point on this. COVID has brought the country's attention to these issues. Just like what Dr. Shin, you just mentioned, with regard to civil rights. This is a moment that we're all experiencing. We are all focused right now on these issues. Number two, inspiration. Just listening to your knowledge and your experience and your commitment leads me to believe that another takeaway is we cannot fail with doctors like you engaged in this extraordinary national event and crisis. And finally Partners in Health. I love that phrase because "partners in health" means it's not just about you and it's not just about me. It's about us. As partners in health. I love that. And you guys are an inspiration. Thank you Troy, for moderating the session. And to our friends. Thank you for listening in.

narrator2 (24:23):

Thank you for listening. Tune in to future podcast episodes of GT Drives Dynamic Dialogues as we continue our courageous conversation series.