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Health Crises and Health Inequities in the United States, 1900-Present

California History-Social Science Framework Connections: Grade 11 US History -- Contemporary American Society (pages 426-431)
California History-Social Science Content Standards: Standard 11.11. Students analyze the major social problems and domestic policy issues in contemporary American society.
California State Standards for English Language Arts & Literacy in History/Social Science Connections: See Appendix 3

Purpose:

- Understand what affects health in your community and your own health, in both the past and present.
- Learn how social factors determine our health and shape health inequities, especially for communities of color and low-income Americans.
- Examine health crises after 1900 for evidence of health inequities.
- Develop strategies and proposals for redressing health inequities going forward.

Plan of Instruction:

Activity I (Day 1) Challenges in Healthcare and the Pandemic in 2020: Students consider health challenges facing the United States in the 21st century.

Activity II (Days 2-3) Health Inequities in Pandemics in the U.S., 1918-Present: Students research four major pandemics (Spanish influenza; polio; HIV/AIDS; COVID-19) with a focus on health inequities then research healthcare legislation and agencies in the United States from 1900-present.

Activity III (Days 4-5) Taking Informed Action: Students analyze the health inequities as evidenced in pandemics and propose ways to remedy those inequities generally and for future pandemics.

Extension Activity: Comparing Public Awareness Posters for Pandemics: Appendix 4

Compelling Question:

How can we redress significant inequities in American healthcare and health outcomes, especially in communities of color and for low-income people, as exposed in pandemics since 1900?

Materials: (computer & internet access needed)

Activity I:
- Student Reference Guide: Viruses and Pandemics
- Document 1: "We Can Do Better"
- Handout A: Health Challenges for Americans
- Teacher Guide 1: "We Can Do Better"

Activity II:
- Student Resource: Timeline of Health Care Challenges
- Documents 2-21: Readings on pandemics
- Documents 22-30: Readings on government agencies & acts
- Handout B: Pandemics
- Handout C: Healthcare Legislation and Agencies
- Teacher Guide 2: Pandemics
- Teacher Guide 3: Healthcare Legislation and Agencies

Activity III:
- Documents 31-33
- Handout D: Taking Informed Action

Appendices:
1. Primary Documents 1-36
2. Additional Resources
3. California CCSS Standards and C3 Framework
4. Extension Activity

Culminating Task:

Students will use their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st centuries to propose plans of action to remedy health inequities going forward and in future pandemics.

California ELA Standards:

IA1: Exchanging information and ideas with others.
1A3: Offering and justifying opinions.
1B6, 8: Reading closely literary and informational texts; analyzing how writers and speakers use vocabulary and other language resources.
1C9: Expressing information and ideas in formal oral presentations.

Key Terms & Concepts:

- **Activity I:** pandemics; epidemics; COVID-19; virus; health inequity; quarantine; social distancing; contact tracing
- **Activity II:** Spanish influenza; polio; HIV (Human Immunodeficiency Virus); AIDS (Acquired Immunodeficiency Syndrome); COVID-19 (Coronavirus 2019)
- **Activity III:** appropriate healthcare

Module Contents (for purposes of navigation)

Health Crises and Health Inequities in the United States (1900-Present)

Purpose

In 2020, the COVID-19 pandemic has required every American to consider their health and the ways that American society and government contribute to our good health or bad health. This module will explore Americans' experiences in health crises since 1900 and differences in outcomes, including death rates, among diverse groups in American society, especially underserved poor people and communities of color. It considers the nature, causes, and effects of inequities in healthcare. The goal is to understand what affects your own health and health in your community, both now and in the future.

Like all Americans, your health and the healthcare available to you are the products of our history: whether your family had enough income to buy adequate food, whether your neighborhood had nearby stores with good food, whether the air and water were clean and not polluted, whether medical care and hospitals were convenient and affordable, whether the available jobs entailed greater risks to health and safety.

All of these elements in your life are the result of decisions made by people in the past ("history"), whether governments, health providers, private organizations or businesses, and these circumstances directly affect the healthcare available to you, the likelihood of major health challenges in your life, and your life expectancy.

This module focuses on four major health crises in this country since 1900: the 1918 influenza pandemic; polio in the 1950s; HIV-AIDS since 1980; and the 2020 COVID-19 pandemic. Students will examine: (1) the extent to which some groups of Americans, particularly communities of color and low-income people, have been affected more severely than others; (2) medical, economic, social, and historical factors that affect health and healthcare, including access to good nutrition, good education, good neighborhoods, and a healthy environment; and (3) the possible effects of inequities and discrimination long embedded in United States' society, such as legacies for African Americans from enslavement and Jim Crow segregation; conditions of Native Americans on reservations; experience of LatinX immigrants and migrant farmworkers; and conditions of low-income whites across the country, especially in Appalachia and rural areas.

The culminating task asks students to apply their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st century to propose a plan of action to remedy existing inequities, advance appropriate healthcare, and establish equitable healthcare for all Americans in the future.

Plan of Instruction

- **Activity I, Day One — Issue Activity (one 50-minute class period): Challenges in Healthcare and the Pandemic in 2020**
    - Reflection on the COVID-19 pandemic
- **Activity II, Days Two and Three — Historical Activity (two 50-minute class periods): Health Inequities in Pandemics in the United States, 1918 - Present**
    - Analyze major pandemics and their impact on U.S. populations.
    - Understand U.S. legislation and government agencies that address health issues.
- **Activity III, Days Four and Five — Taking Informed Action To Redress Health Inequities (two 50-minute class periods)**
    - Identify inequities experienced by diverse populations during health crises.
    - Develop and share a plan of action to advance access to appropriate healthcare and address inequities in the future.
- **Extension Activity (optional) — Comparing Public Awareness Posters for Pandemics**

Compelling Question

- How can we redress significant inequities in American healthcare and health outcomes, especially in communities of color and for low-income people, as exposed in pandemics since 1900?

Central Questions

Day One

1. What are major current healthcare issues and inequities that the United States is facing today?
2. What have we learned from COVID-19?
3. What contributes to health inequities and unequal access to appropriate healthcare?
4. How can we address those inequities in the future?

Days Two and Three

1. What health crises has the United States faced since 1900?
2. During each crisis, what actions did individuals take to protect themselves? What actions did health and medical organizations take? What actions did the local, state or federal governments take?
3. What remedies and practices have been developed in response to those challenges, by individuals, health providers, and governments?
4. To what extent did these responses deal with legacies of inequality and injustice from earlier in our history, such as enslavement, treatment of Native Americans, economic economic inequality, or segregation?
5. Have their responses both generally and during health crises advanced or impeded health equity for Americans?

6. How did these crises affect different populations and communities within the United States in years afterward?

Days Four and Five

1. What contributes to health inequities and unequal access to appropriate healthcare?
2. How should equality be achieved, especially for those poor and minority groups who have had less access to appropriate healthcare in past decades and who have been subject to discrimination, racism, or deprivation going far back in U.S. histiory?
3. Why is this a 21st century concern/issue?

Culminating Task

- Students will use their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st centuries to develop a plan of action to remedy existing inequities, advance appropriate healthcare, and establish equitable healthcare for all Americans in the future.

Outcomes

1. Students will read multiple sources and gather evidence of inequalities experienced by diverse populations both generally and during health crises.
2. Students will have an understanding of sources and causes of health inequities.
3. Students will use their research and analysis in formulating a plan of action to redress health inequities going forward.

Appendices

- Appendix I: Primary Documents 1-36
- Appendix II: Additional Resources
- Appendix III: California CCSS Standards and C3 Framework
- Appendix IV: Extension Activity

Readings and Resources

Books and Articles

- “The Fullest Look Yet at the Racial Inequity of Coronavirus,” by Richard A. Oppel, et al., *New York Times*. July 5, 2020. https://nyti.ms/3f286n9

- “Left Out: Barriers to Health Equity for Rural and Underserved Communities,” Report of the Committee on Ways and Means Majority, U.S. House of Representatives, July 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report_07.2020_FINAL.pdf

- “We Can Do Better — Improving the Health of the American People,” by Steven A. Schroeder, M.D. *New England Journal of Medicine*, 2007; 357: pp. 1221-8. https://www.nejm.org/doi/full/10.1056/nejmsa073350

- “Testimony of Ibram X. Kendi, PhD: The Disproportionate Impact of COVID-19 on Communities of Color,” House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Kendi_Testimony.pdf

Online Resources

- House Ways and Means Committee Subcommittee on Health, https://waysandmeans.house.gov/subcommittees/health-116th-congress

I. ISSUE ACTIVITY: Challenges in Healthcare and the Pandemic in 2020

Day One

***Background*:**
In March 2020, the life of every American was dramatically affected by the coronavirus, as the country largely locked down to minimize the spread of the virus and its severe consequences. Prior to COVID-19, significant public health concerns included the opiate crisis,the cost of healthcare, and health insurance coverage. COVID-19 has made health a paramount concern for everyone.

At the outset students are engaged by having them briefly consider ways that COIVD-19 has already changed their lives. The module is fundamentally about them and their lives, both in the near term as the pandemic runs its course and in the longer term as effects on the pandemic unfold in society.

After this personal opener, the module provides a reference guide covering major terms and concepts, including: the difference between pandemic and epidemics, viruses and bacteria, treatments, and prevention through vaccines.

With this foundation, the class turns to consider the fact that the United States spends far more on health per person than any other country in the world, but has significantly worse health outcomes overall than other developed Western countries. These worse outcomes are the result of a wide array of social factors. Good health involves far more than quality medical treatment. These determinant factors fall into five domains: genetics, social circumstances, environmental exposures, behavioral patterns, as well as health care. These factors help frame the opening question: can we do better?

COVID-19 has plainly exposed the fact that health inequities occur throughout the U.S. healthcare system. Days Two and Three seek to put the coronavirus pandemic into historical context by looking at other 20th century health crises. Then it looks forward, asking students in Days Four and Five to develop proposals for advancing appropriate healthcare and redressing inequities.

Finally, it is worth noting that throughout history, pandemics have resulted in fundamental change. They have caused massive deaths and devastated societies. They also have ushered in transformative changes and new opportunities. We may not know all the long term effects of the coronavirus pandemic for decades.

Suggested Time Frame: One 50-minute class period

Key Terms: pandemic; epidemic; contagious; COVID-19; virus; health inequity; quarantine; social distance; contact tracing

Supporting Questions:

1. What are major current healthcare issues and inequities that the United States is facing today?
2. What have we learned from COVID-19?
3. What contributes to health inequities and unequal access to appropriate healthcare?
4. How can we address those inequities in the future?
5. Can we do better as a country?

Looking Ahead: Culminating Task (Day 5):

- Students will use their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st centuries to develop a plan of action to remedy existing inequities, advance appropriate healthcare, and establish equitable healthcare for all Americans in the future.

Before the Lesson:

1. Have students review the **Student Reference Guide** prior to the lesson.

Procedures:

1. Have students do a quick write or pair-share to identify three memories or experiences of the effect of COVID-19 on their lives in 2020.
   Key question: How do you think the COVID-19 pandemic will continue to affect your life into the future? What specific effects can you imagine?
2. After the quick write or pair-share, have students share their answers as a way to make this module relevant for the students.
3. Review key vocabulary from **Student Reference Guide.**
4. Introduce compelling question:
   What contributes to unequal access to appropriate healthcare? How have pandemics since 1900 exposed significant inequities in American healthcare and outcomes, especially in communities of color and for low-income people? How can these inequities be redressed going forward?
5. Introduce culminating activity:
   Using their research and analysis from prior days, students will use their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st centuries to develop a plan of

action to remedy existing inequities, advance appropriate healthcare, and establish equitable healthcare for all Americans in the future.

Encourage students to have this culminating activity in mind as they read Document 1 and complete Handout A. What aspects of American healthcare mentioned in this document, "We Can Do Better," might be of interest for the culminating project? If a teacher would like to shape the culminating activity for a particular class, that approach can be introduced at this point on Day One.

6. Have students read **Document 1: "We Can Do Better"**
    a. Working in pairs, assign each student one half of the article to read.
    b. After reading, student pairs will discuss their observations and findings from the article.
    c. Guiding question: What health challenges do Americans face today?

7. As a class, hold a class discussion highlighting the key information from the article. See **Teacher Resource 1** for key findings from **Document 1.**
8. Set the stage for the following days by explaining that students will be considering the compelling question in light of four pandemics that heavily impacted the United States during the 20th and 21st centuries: Spanish Influenza; polio; HIV/AIDS; and COVID-19).

Materials:

- Student Reference Guide: Viruses and Pandemics
- Document 1: "We Can Do Better" by Stephen Schroeder, M.D. (Appendix I)
- Handout A: "We Can Do Better"
- Teacher Guide 1: "We Can Do Better"

Additional Resources:

- See Additional Resources Appendix

Student Reference Guide: Viruses and Pandemics	
Pandemic	A pandemic (from Greek πᾶν, pan, "all" and δῆμος, demos, "people") is an epidemic of an infectious disease that has spread across a large portion of the earth, for instance multiple continents or worldwide, affecting substantial number of people.
Epidemic	An epidemic is the rapid spread of disease to a large number of people in a given population within a short period of time. For example, in meningitis (meningococcal) infections, an attack rate in excess of 15 cases per 100,000 people for two consecutive weeks is considered an epidemic.
Virus	A virus is a submicroscopic infectious agent that replicates only inside the living cells of an organism. Viruses can infect all types of life forms, including people, animals, plants, and microorganisms.
Coronavirus	Coronavirus is a type of viral disease, of which COVID-19 is just one of many. Coronaviruses are named for the crown-like spikes on their surface. Coronaviruses usually cause a range of respiratory issues for those infected, from mild cold-like symptoms to more severe infections, like pneumonia. Scientists and doctors are continually learning more about the nature and effects of this virus.
Diseases caused by a virus	Diseases caused by viruses include, but are not limited to: flu, infectious mononucleosis, mumps, measles, shingles, hepatitis, chickenpox, pneumonia, polio, HIV/AIDS, coronavirus.
Treatment for a virus	Vaccines have been developed since the beginning of the 20th century. They drastically reduce the number of new cases of viral diseases such as polio, measles, and chickenpox. In addition, vaccines can prevent such infections such as the flu, hepatitis A, hepatitis B, human papillomavirus (HPV), and others. However, the treatment of viral infections has proved more challenging. Successful vaccines have been developed only for some viruses. For some viral diseases, such as herpes simplex virus infections, HIV/AIDS, and influenza, antiviral medications have become available that treat and control the disease, but drug-resistant microbes have been created as a result, and patients are not “cured.”

Difference between a virus and bacterial infection	Throughout history, millions of people have died of diseases such as bubonic plague or the Black Death, which is caused by *Yersinia pestis* bacteria, and smallpox, which is caused by the variola virus. In recent times, viral infections have been responsible for two major pandemics: the 1918-1919 “Spanish flu” pandemic that may have killed 50 million people worldwide, and the ongoing HIV/AIDS epidemic that killed an estimated 1.5 million people worldwide in 2013 alone. Bacterial and viral infections are dissimilar in many important respects, most of them due to the organisms' structural differences and the way they respond to medications. Most viruses are prevented by a vaccine. Bacterial infections can be treated with antibiotics.
How to avoid getting a virus	Viruses are often highly contagious. Always keep your hands clean. Follow tips for coughing and sneezing without contaminating. Avoid touching your nose, eyes and mouth with unwashed hands, because the nose, eyes and mouth are entry sites for viruses and bacteria. Avoid contact with people who are sick, who may be contagious. Do not get close to them and do not touch objects they have used, like their utensils for instance. Clean your surroundings regularly, as well as the appliances you use. For example, clean your counters and other surfaces that you touch often with your hands. Cleaning is very effective in killing viruses, which can survive on hard surfaces. Wearing a mask and practices of social distancing are effective, especially for airborne transmission. Isolation and quarantine of infected persons is often necessary to prevent them from infecting others.

Handout A: Health Challenges for Americans: “We Can Do Better” by Steven Schroeder, M.D.	
Partner A (Pages 1-2)	**Partner B (Pages 3-5)**
Spending and health:	Social policies affecting healthcare and health:
Evidence of health status:	Environmental factors:
Five factors influencing population health:	Poor and disadvantaged:

Behavioral changes:	Role of government
Non-behavioral determinants of health, including class:	Ways to make improvements:
	Social benefits of better health:

Teacher Guide 1: Health Challenges for Americans: "We Can Do Better" by Steven Schroeder, M.D.	
Partner A (Pages 1-2)	**Partner B (Pages 3-4)**
Spending and health ● U.S. spends heavily on healthcare ● Ranks poorly in healthcare world wide ● Many Americans do not receive good healthcare or have access to adequate healthcare	Social policies affecting healthcare and health: ● quality and access to healthcare ● universal health insurance
Evidence of health status: ● Organization of Economic Cooperation and development ranks US at bottom of measures of healthcare ● Large disparities in healthcare by geography, race, ethnicity, class	Environmental factors: ● pollution ● neighborhood dangers ● physical activity
Five factors influencing population health: ● genetics, social circumstances, environmental exposures, behavioral patterns, healthcare ● Healthcare has little effect on early death	Poor and disadvantaged: ● Recognition that social policies have health consequences ● Public policies often widen the gap between classes ● Weak health status comes from problems in political economy ● Less advantaged are poorly represented in politics

Behavioral changes: ● Personal behavior is most important in reducing early deaths ● Personal behavior accounts for 40% of all deaths ● Obesity, smoking, and physical inactivity are contributors	Role of government: ● Lack of health insurance. number of underinsured ● Policy to focus on new technologies and support for biomedical research
Non-Behavioral changes: ● Social class and connections to income, education, employment, residential neighborhoods ● People in lower classes are less healthy and die earlier than other groups	Ways to make improvements: ● Personal behavior factors ● Political action to measure and improve healthcare
	Social benefits of better health ● Improved health will lead to a better workforce and improved economy ● Doctors must take an active role.

II. HISTORICAL ACTIVITY: Health Inequities in Pandemics in the US, 1918 – Present

Background:
The Days two and three activity explores four major health crises since 1900, using an array of primary sources. These crises are the 1918 influenza that devastated the world in a little more than a year; the polio epidemic that paralyzed Franklin D. Roosevelt as a young man and then tens of thousands of children after World War II; the ongoing HIV/AIDS epidemic that became significant in the 1980s; and finally COVID-19 in 2020. A student resource timeline is provided.

Using handout B, small groups will research important elements of each and record facts about each, as well as personal, medical, and governmental responses. One member in each group will be the group "expert" on one pandemic. A range of primary sources for each are provided in an edited form, to help use class time efficiently. This inquiry includes consideration of health inequities exposed by each crisis.

Each small group will spend a portion of Day 3 researching basic facts about significant federal health legislation since 1900 and the resulting federal health agencies.

Suggested Time Frame: Two 50-minute class periods

Key Terms: Spanish influenza; polio; HIV (Human Immunodeficiency Virus); AIDS (Acquired Immunodeficiency Syndrome); COVID-19 (Coronavirus 2019)

Supporting Questions:

1. What health crises has the United States faced since 1900?
1. During each crisis, what actions did individuals take to protect themselves? What actions did health and medical organizations take? What actions did the local, state or federal governments take?
2. What remedies and practices have been developed in response to those challenges, by individuals, health providers, and governments?
3. To what extent did these responses deal with legacies of inequality and injustice from earlier in our history, such as enslavement, treatment of Native Americans, economic inequality, or segregation?
4. Have their responses both generally and during health crises advanced or impeded health equity for Americans?

5. How did these crises affect different populations and communities within the United States in years afterward?

Looking Ahead: Culminating Task (Day 5):

- Students will use their understanding of health inequities experienced by diverse populations during pandemics of the 20th and 21st centuries to develop a plan of action to remedy existing inequities, advance appropriate healthcare, and establish equitable healthcare for all Americans in the future.

Day Two

Procedures:

1. Conduct a quick review of **Activity I: Introduction.**
2. Distribute **Student Resource: Timeline of Healthcare Challenges, 1918-Present.**
    a. Ask students to review the timeline with another student. What do they notice? What questions do they have?
3. Conduct a brief overview of the four pandemics that had a significant impact on the United States during the past one hundred years [See **Documents 2, 7, 12, 17** for overview]:
    a. Spanish Influenza, 1918-1920
    b. Polio, 1950s
    c. HIV/AIDS, 1981 – present
    d. COVID-19, 2019 – present
4. Explain to students that they will form small groups and research each pandemic, beginning first by examining the pandemic and then focusing on actions taken by the U.S. government, other governments, or non-governmental organizations to combat the health crisis.
5. Jigsaw Activity:
    a. Have students form Home Groups of four. One student within their group will research one of the four identified pandemics (Spanish Influenza, Polio, HIV/AIDS, or COVID-19). Each will choose which one.
    b. Have students form Expert Groups for each pandemic. For larger classes, consider multiple groups for each pandemic. Using **Handout B: Pandemics in the United States, 1918 - Present** and **Documents 2-21**, have students research their assigned pandemic. Each expert will lead completion of their respective columns in the **Handout B.**

Day Three

***Procedures**:*

1. Have students return to their Home Group and share their research on the pandemics.
2. When finished, distribute **Handout C: Healthcare Legislation and Agencies in the United States, 1900 - Present**. Explain that students will be gathering information about actions taken by the government to safeguard health.
3. Have students complete **Handout C** with their Home Group by referencing to **Documents 22-30.** Consider dividing responsibility for completing **Handout C** among group members and have them share the information with their group.
4. At the end of class, ask students to discuss with their groups:
    a. What questions do you have about your research?
    b. What similarities did you find between the pandemics?
    c. What differences did you find?
    d. What specific evidence of health inequities did you find in your research?
5. Explain that students will share their findings tomorrow, and focus on these inequities during the remainder of this module.

Materials:

- Student Resource: Timeline of Healthcare Challenges,1918-Present
- Documents 2-21: Readings on pandemics (Appendix I)
- Documents 22-30: Readings on government agencies and acts (Appendix I)
- Handout B: Pandemics in the United States, 1918 - Present
- Handout C: Healthcare Legislation and Agencies in the United States, 1900 - Present
- Teacher Guide 2: Pandemics in the United States, 1918 - Present
- Teacher Guide 3: Healthcare Legislation and Agencies in the United States, 1900 - Present

Additional Resources:

- See Additional Resources Appendix

HANDOUT B DOCUMENTS

Spanish Flu (1918-1920) Resources

- DOCUMENT 2 - “1918 PANDEMIC (H1N1 VIRUS),” by Centers for Disease Control and Prevention
- DOCUMENT 3 - “There Wasn’t A Lot of Comfort in Those Days,” by Vanessa Northington Gamble
- DOCUMENT 4 - “In 1918, and 1920, Race Colors America’s Response to Epidemics,” by Soraya Nadia Mcdonald
- DOCUMENT 5 - *The Great Influenza* (excerpt), by John M. Berry
- DOCUMENT 6 - “California Lessons From The 1918 Pandemic: San Francisco Dithered; Los Angeles Acted And Saved Lives,” by James Rainey and Rong-Gong Lin II

Polio (1950s) Resources

- DOCUMENT 7 - “What is Polio,” by Centers for Disease Control and Prevention
- DOCUMENT 8 - “Race and the Politics of Polio,” by Naomi Rogers
- DOCUMENT 9 - “How the Poor Get Blamed for Diseases,” by Elena Conis
- DOCUMENT 10 - “Breaking the Back of Polio,” by David. M. Oshinsky
- DOCUMENT 11 - “Wiping Out Polio: How The U.S. Snuffed Out a Killer,” by Jason Beaubien

HIV/ AIDS (1981-Present) Resources

- DOCUMENT 12 - “About HIV/AIDS,” by Division of HIV/AIDS Prevention
- DOCUMENT 13 - “Rumors and Realities,” by Jacob Heller
- DOCUMENT 14 - “The Confusing and At-Times Counterproductive 1980s Response to the AIDS Epidemic,” by Natasha Geiling

- DOCUMENT 15 - “HIV and Hispanics/Latinos,” by Division of HIV/AIDS Prevention
- DOCUMENT 16 - “The LGBTQ Health Clinic That Faced a Dark Truth About the AIDS Crisis,” by Abdallah Fayyad

COVID-19 (2019-Present) Resources

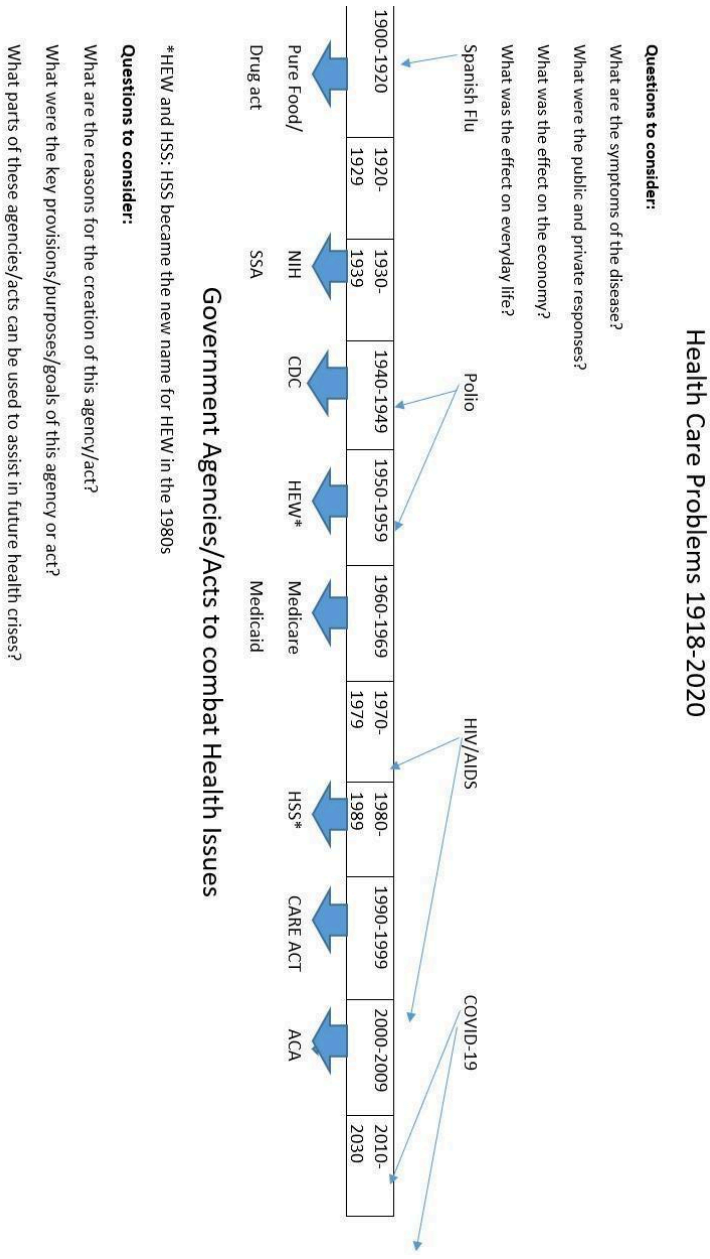
- DOCUMENT 17 - “COVID-19 Overview,” by National Center for Immunization and Respiratory Diseases (NCIRD)
- DOCUMENT 18 - “Covid-19 is Hitting Black and Poor Communities the Hardest,” by Grace A. Noppert
- DOCUMENT 19 - S32.“For Latinos and Covid-19, Doctors are Seeing an Alarming Disparity” by Miriam Jordan and Richard A. Oppel Jr.
- DOCUMENT 20 - “How COVID-19 is impacting Indigenous people in the U.S.,” by Randall Akee
- DOCUMENT 21 - “It’s Not Obesity, It’s Slavery,” by Sabrina Strings

HANDOUT C DOCUMENTS

- DOCUMENT 22 - “Pure Food and Drugs,” by U.S. National Library of Medicine
- DOCUMENT 23 - “About the NIH,” by National Institutes on Health
- DOCUMENT 24 - “Social Security Act (1935),” by U.S. National Archives and Records Administration
- DOCUMENT 25 - “History,” and “Mission, Role, and Pledge,” by Centers for Disease Control and Prevention
- DOCUMENT 26 - U.S. Department of Health and Human Services Overview
- DOCUMENT 27 - “Medicaid Overview,” by Medicare Rights Center
- DOCUMENT 28 - “Medicare, A Simple Explanation,” by Darlynda Bogle

- DOCUMENT 29 - “The Ryan White HIV/AIDS Program,” by Kaiser Family Foundation
- DOCUMENT 30 - “Obamacare Explained,” by Kimberly Amadeo

Student Resource: Timeline of Healthcare Challenges, 1918-Present



Handout B: Pandemics in the United States, 1918 - Present					
20th & 21st Century Diseases	**Spanish Flu**	**Polio**	**HIV/AIDS**	**COVID-19**	**Your Questions**
Number of cases (Actual or estimated)	500 million infected worldwide	Approximately 15,000 cases/year; 58,000 in 1952; 21,000 with side effects	Approximately 1 million new cases/year worldwide*	3.4 million (as of July 2020)** in US	
Number of deaths	50 million worldwide; 670,000 in US	3,200 deaths in 1952	692,790 in US (1982-2018)*	135,000 (as of July 2020)**	
Groups most affected in severity, mortality (age; gender; race)					Why are these different groups most affected by the disease?

**For updated HIV/AIDS data, visit the CDC's HIV/AIDS Dashboard: https://www.cdc.gov/hiv/basics/statistics.html*
***For updated COVID-19 data, visit the Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/*

Handout B: Pandemics in the United States, 1918 – Present (*continued)*					
20th & 21st Century Diseases	**Spanish Flu**	**Polio**	**HIV/AIDS**	**COVID-19**	**Your Questions**
Personal responses by citizens (everyday behavior)					
Public responses by government (national, state, local responses; legislation)					
Medical responses	None; large doses of aspirin	Salk vaccine	Three types of medications; no vaccine	None yet; vaccine trials	

Teacher Guide 2: Pandemics in the United States, 1918 - Present					
20th & 21st Century Diseases	**Spanish Flu**	**Polio**	**HIV/AIDS**	**COVID-19**	**Your Questions**
Number of cases (Actual or estimated)	500 million infected worldwide	Approximately 15,000 cases/year; 58,000 in 1952; 21,000 with side effects	Approximately 1 million new cases/year worldwide*	3.4 million (as of July 2020)** in US	
Number of deaths	50 million worldwide; 670,000 in US	3,200 deaths in 1952	692,790 in US (1982-2018)*	135,000 (as of July 2020)**	
Groups most affected in severity, mortality (age; gender; race)	Less than 5 years old; 20-40 year old; 65+ in age; lower rates among African Americans	Thought as only affecting middle class whites; minority groups also affected	Gay men; LGBTQ; people of color	Originally those over 60; Underlying health issues; Native Americans; Blacks; Latinx	Why are these different groups most affected by the disease?

**For updated HIV/AIDS data, visit the CDC's HIV/AIDS Dashboard: https://www.cdc.gov/hiv/basics/statistics.html*
***For updated COVID-19 data, visit the Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/*

Teacher Guide 2: Pandemics in the United States, 1918 – Present (*continued)*					
20th & 21st Century Diseases	**Spanish Flu**	**Polio**	**HIV/AIDS**	**COVID-19**	**Your Questions**
Personal responses by citizens (everyday behavior)	Isolation; quarantine; personal hygiene; limited gatherings	Theatres, pools, parks closed; Stay at home orders	Safe sex; AIDS quilt; activism; African American distrust of medical field	Masks; physical distancing; personal hygiene;	
Public responses by government (national, state, local responses; legislation)	Building new Black hospitals; established Chicago Department of health; masks; closed movies, theaters, pool rooms	March of Dimes, a charitable organization, fundraising; vaccine development	American with Disabilities Act; Clinton funding; Ryan White Care Act	Stay at home orders; Testing; tracing; closed businesses; shut down of economy	
Medical responses	None; large doses of aspirin	Salk and Sabin vaccines	Three types of medications; no vaccine	None yet; vaccine trials	

Handout C: Healthcare Legislation and Agencies in the Unites States, 1900-Present				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Pure Food and Drug Act				
National Institute of Health				
Social Security Act				

Handout C: Healthcare Legislation and Agencies in the Unites States, 1900-Present *(continued)*				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Centers for Disease Control (formerly Communicable Disease Center, CDC				
Health and Human Services (formerly Health, Education, and Welfare), HSS				
Medicare				

Handout C: Healthcare Legislation and Agencies in the Unites States, 1900-Present *(continued)*				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Medicaid				
Ryan White Care Act				
Affordable Care Act				

Teacher Guide 3: Healthcare Legislation and Agencies in the Unites States, 1900-Present				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Pure Food and Drug Act	1906	Interstate commerce; mishandling of food, drinks, drugs	Sanitation of workplace; labeling of ingredients; protection of consumer	Labeling of ingredients
National Institute of Health	1887	To improve health and lengthen life	Research on causes, diagnosis of diseases; effects of contamination; publication of information	Medical research
Social Security Act	1935	Support for the elderly, children, blind, unemployed	Employee and employer contribution in form of taxes on income and wages	

Teacher Guide 3: Healthcare Legislation and Agencies in the Unites States, 1900-Present *(cont.)*				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Centers for Disease Control (formerly Communicable Disease Center, CDC	1946	Health promotion, prevention, and preparedness; protect U.S. from health, safety, and security threats from U.S. and abroad	Detecting new health threats; use of science and technology to guide responses	Coordinate government and public responses
Health and Human Services (formerly Health, Education, and Welfare, HEW), HSS	1953 (HEW) 1979 (HSS)	Fostering advances in medicine, public health, society	Oversees more than two dozen other health agencies, including NIH, CDC, FDA	Funding, leaderships, and public information
Medicare	1965	Health care for 65+ and people with disabilities	Coverage for physician services, pharmacy needs, skilled nursing, home health care; patient pays portion of bills	

Teacher Guide 3: Healthcare Legislation and Agencies in the Unites States, 1900-Present *(cont.)*				
Government agencies/acts	**Date created**	**Purpose or target of agency/act**	**Key features**	**Actions to deal with new diseases**
Medicaid	1965	Health insurance for low income, pregnant women, children, elderly, people with disabilities, and those in long-term care	Each state has own program; states with lower income receive more federal aid; funded by state and federal government; pays for some similar things as Medicare	
Ryan White Care Act	1990	Aid to people living with HIV	Fills gaps in insurance coverage for families and individuals affected by HIV	
Affordable Care Act	2010	Expands available insurance options and offers affordable coverage for U.S. citizens and legal residents	Can purchase coverage; also provides exemptions for poor, Native American, and those with hardships; increases funding for Medicaid	

III. TAKING INFORMED ACTION TO REDRESS HEALTH INEQUITIES

***Background*:**
Class reading and research on Days One to Three have addressed health inequities exposed by the four pandemics studied. Following up on the overall assessment of American healthcare in Document 1, "We Can Do Better," subsequent readings have highlighted the wide range of factors—personal, historical, social, economic, environmental, etc.—that have affected such inequities. Documents have considered the complexity and interactions among these socials determinants of health, as well as the huge scale of our healthcare system.

Based on the work in Days One to Three, small groups in Day Four will identify a problem related to inequities and make a proposal for taking informed action to advance appropriate healthcare and address that health inequity. Each group will prepare and make a presentation about their problem and proposed solution.

Day Five concludes with a debrief of the class, considering what they have learned and how that may better prepare them for the future.

NOTE: Teachers are encouraged to shape **Activity III: Taking Informed Action** to best suit their class.

Suggested Time Frame: Two 50-minute class periods

Key Term: appropriate healthcare [medical care that is based on sound medical diagnostics and provides corresponding treatment, without treatment elements driven by non-medical factors, such as insurance, concern for malpractice suits, etc.]

Supporting Questions:

1. What contributes to health inequities and unequal access to appropriate healthcare?
2. How can the American healthcare system "do better?" How should equality be achieved, especially for those poor and minority groups who have had less access to appropriate healthcare in past decades and who have been subject to discrimination, racism, or deprivation going far back in U.S. history?
3. Why is this a 21st century concern/issue?

Day Four

Procedures:

1. Ask students to review **Handout B** and share their findings in **Handout B** with the class:
    a. What questions do you have about your research?
    b. What similarities did you find between the pandemics?
    c. What differences did you find?
    d. What specific evidence & examples of health inequities were found in your research?
    e. What factors contributed significantly to those inequities?
    f. How were these inequities affected by the actions of individuals/families, private organizations and companies, medical professionals, and governments?
2. As a class, discuss:
    a. What examples of inequities did they find among diverse groups in each pandemic, and what factors contributed to inequities for each group?
    b. How can we ensure that responses to health crises are equitable and advance appropriate healthcare?
    c. What are the key learnings from each of these pandemics to make changes going forward? What factors may be easier to change, and which harder to change?
    d. What strategies and actions can be used to make such changes?
    e. Should it be important for all Americans if some Americans have less access to appropriate healthcare and have higher rates of disease? In what ways might health inequities affect all Americans, particularly those who are not directly affected?
3. Each student should review their **Handout A** notes on **Document 1, "We Can Do Better."** They should consider Dr. Schroeder's assessment of American healthcare, the range of personal and systemic factors it considers, and the kinds of improvements identified.
4. Have students return to their group and devise a plan of action to remedy one or more health inequities they have identified. Using **Handout D: Taking Informed Action to Redress Health Inequities** as a guide, ask students to:
    a. Identify with evidence the factors contributing to inequities in healthcare your group will address.
    b. Outline strategies to address these inequities and advance appropriate healthcare, generally as well as for a future pandemic.
    c. Develop an action plan for effectively implementing their strategies.
    d. NOTE: **Handout D** presents categories that students should consider when addressing the complexity presented by the issue. Help students understand that they do not need to fill out **Handout D** completely, but should determine which categories or agencies would most effectively address the issue.

5. Consider using the **Additional Resources** below to help students understand the complexities of healthcare issues facing the country as a whole, as well as diverse communities.
6. Following are some sample problems that a group may choose to address:
    a. Developing a system of community health clinics.
    b. Developing a nondiscriminatory national vaccination program reaching all Americans.
    c. Providing impoverished and/or rural communities better access to affordable, fresh, and healthy foods.
    d. Providing public schools with adequate personal protective equipment (PPE) like masks, gloves, and sanitation products.

Materials:

- Handout D: Taking Informed Action to Redress Health Inequities

Additional Resources (Appendix I):

- DOCUMENT 31 - "Testimony of Ibram X. Kendi, Ph.D.," House Ways and Means Committee
- DOCUMENT 32 - Majority Staff Report: "Left Out: Barriers to Health Equity for Rural and Underserved Communities," House Ways and Means Committee
- DOCUMENT 33 - "The Fullest Look Yet at the Racial Inequity of Coronavirus," by Richard A. Oppel, et al.

Day Five

Procedures:

1. Review the compelling question with students:
    a. Compelling Question: How can we redress significant inequities in American healthcare and health outcomes, especially in communities of color and for low-income people, as exposed in pandemics since 1900?
2. Using the information from **Handout D**, have groups create charts or digital representations of their plans of action they developed on Day Four.
3. Have students share their plans with other students. This could be in the form of a gallery walk, digital presentation, or other methods.

Debrief:

a. Did this module help you better understand health issues and health inequities that you, your family and community may face, and the roles that individuals, medical professionals, and the various levels of governments play?
b. Do you feel better prepared to deal with healthcare issues?
c. Who should have what responsibilities for the health of Americans and appropriate healthcare in the 21st century?
d. How important is it to you to redress inequities and help bring about greater equality and better access to appropriate health, especially for Americans who have experienced inequities for a very long time?
e. How hard do you think it will be to make significant improvements? What do you think the biggest obstacles are likely to be?

Materials:

- Handout D: Taking Informed Action To Redress Health Inequities

Handout D: Taking Informed Action to Redress Health Inequities	
Inequity	
Research results	
Public institutions that can effect change	
Individual roles: persons, private groups	
Medical professionals	
Historical legacies of inequality and discrimination	
Cost factors	

Handout D: Taking Informed Action to Redress Health Inequities *(continued)*	
Inequity	
Role of insurance	
Important medical issues	
Government funding?	
Proposed solution or goals	
Responsible persons and/or agencies	
Action steps	

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Health Crises and Health Inequities in the United States, 1900-Present

Appendix I
Primary Documents 1-36

Description:

Below are the key documents required for students to complete the module. Many of the documents below have been edited for length and content. The full version of each document can be accessed by clicking on the link provided.

Activity I: Introductions to Healthcare and Health Crises

Handout A Document

DOCUMENT 1

"We Can Do Better — Improving the Health of the American People," by Steven A. Schroeder, M.D. New England Journal of Medicine, 2007; 357: pp. 1221-8.
https://www.nejm.org/doi/full/10.1056/nejmsa073350

The United States spends more on health care than any other nation in the world, yet it ranks poorly on nearly every measure of health status. How can this be? What explains this apparent paradox?

The two-part answer is deceptively simple — first, the pathways to better health do not generally depend on better health care, and second, even in those instances in which healthcare is important, too many Americans do not receive it, receive it too late, or receive poor-quality care.

Among the 30 developed nations that make up the Organization for Economic Cooperation and Development (OECD), the United States ranks near the bottom on most standard measures of health status. . . . It is true that within the United States there are large disparities in health status — by geographic area, race and ethnic group, and class. But even when comparisons are limited to white Americans, our performance is dismal. And even if the health status of white Americans matched that in the leading nations, it would still be incumbent on us to improve the health of the entire nation.

Health is influenced by factors in five domains — genetics, social circumstances, environmental exposures, behavioral patterns, and health care. When it comes to reducing early deaths, medical care has a relatively minor role. Even if the entire U.S. population had access to excellent medical care — which it does not — only a small fraction of these deaths could be prevented. The single greatest opportunity to improve health and reduce premature deaths lies in personal behavior. In fact, behavioral causes account for nearly 40% of all deaths in the United States. Although there has been disagreement over the actual number of deaths that can be attributed to obesity and physical inactivity combined, it is clear that this pair of factors and smoking are the top two behavioral causes of premature death.

. . . If the public's health is to improve, however, that improvement is more likely to come from behavioral change than from technological innovation. Experience demonstrates that it is in fact possible to change behavior, as illustrated by increased seat-belt use and decreased consumption of products high in saturated fat. The case of tobacco best demonstrates how rapidly positive behavioral change can occur….

Improving population health will also require addressing the non behavioral determinants of health that we can influence: social, health care, and environmental factors. (To date, we lack tools to change our genes, although behavioral and environmental factors can modify the expression of genetic risks such as obesity.) With respect to social factors, people with lower socioeconomic status die earlier and have more disability than those with higher socioeconomic status, and this pattern holds true in a stepwise fashion from the lowest to the highest classes. In this context, class is a composite construct of income, total wealth, education, employment, and residential neighborhood. . . . [E]ven when behavior is held constant, people in lower classes are less healthy and die earlier than others.

. . . There are ways to address the effects of class on health. . . . More fundamental, however, is the recognition that social policies involving basic aspects of life and wellbeing (e.g., education, taxation, transportation, and housing) have important health consequences. Just as the construction of new buildings now requires environmental-impact analyses, taxation policies could be subjected to health-impact analyses. When public policies widen the gap between rich and poor, they may also have a negative effect on population health. One reason the United States does poorly in international health comparisons may be that we value entrepreneurialism over egalitarianism. Our willingness to tolerate large gaps in income, total wealth, educational quality, and housing has unintended health consequences. Until we are willing to confront this reality, our performance on measures of health will suffer….

There are two basic ways in which health care can affect health status: quality and access. . . . In the area of access, however, we trail nearly all the countries: 45 million U.S. citizens (plus millions of immigrants) lack health insurance, and millions more are seriously underinsured. Lack of health insurance leads to poor health.[43] Not surprisingly, the uninsured are disproportionately represented among the lower socioeconomic classes.

Environmental factors, such as lead paint, polluted air and water, dangerous neighborhoods, and the lack of outlets for physical activity, also contribute to premature death. People with lower socioeconomic status have greater exposure to these health-compromising conditions. As with social determinants of health and health insurance coverage, remedies for environmental risk factors lie predominantly in the political arena.

Since all the actionable determinants of health — personal behavior, social factors, health care, and the environment — disproportionately affect the poor, strategies to improve national health rankings must focus on this population. To the extent that the United States has a health strategy, its focus is on the development of new medical technologies and support for basic biomedical research. . . .

The comparatively weak health status of the United States stems from two fundamental aspects of its political economy. The first is that the disadvantaged are less well represented in the political sphere here than in most other developed countries, which often have an active labor movement and robust labor parties. Without a strong voice from Americans of low socioeconomic status, citizen health advocacy in the United States coalesces around particular illnesses, such as breast cancer, human immunodeficiency virus infection and the acquired immunodeficiency syndrome

(HIV–AIDS), and autism. These efforts are led by middle-class advocates whose lives have been touched by the disease. . . .

The relatively limited role of government in the U.S. healthcare system is the second explanation. Many are familiar with our outlier status as the only developed nation without universal health care coverage. Less obvious is the dispersed and relatively weak status of the various agencies responsible for population health and the fact that they are so disconnected from the delivery of health services. In addition, the American emphasis on the value of individual responsibility creates a reluctance to intervene in what are seen as personal behavioral choices.

The largest potential for further improvement in population health lies in behavioral risk factors, especially smoking and obesity. We already have tools at hand to make progress in tobacco control, and some of these tools are applicable to obesity. Improvement in most of the other factors requires political action, starting with relentless measurement of and focus on actual health status and the actions that could improve it. Inaction means acceptance of America's poor health status.

Improving population health would be more than a statistical accomplishment. It could enhance the productivity of the workforce and boost the national economy, reduce health care expenditures, and most important, improve people's lives. But in the absence of a strong political voice from the less fortunate themselves, it is incumbent on health care professionals, especially physicians, to become champions for population health.

Activity II: Pandemics in the US, 1918 – Present

Handout B Documents

Spanish Flu (1918-1920) Resources

DOCUMENT 2

"1918 PANDEMIC (H1N1 VIRUS)," Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD), March 20, 2019. https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

The 1918 influenza pandemic was the most severe pandemic in recent history. It was caused by an H1N1 virus with genes of avian origin. Although there is not universal consensus regarding where the virus originated, it spread worldwide during 1918-1919. In the United States, it was first identified in military personnel in spring 1918. It is estimated that about 500 million people or one-third of the world's population became infected with this virus. The number of deaths was estimated to be at least 50 million worldwide with about 675,000 occurring in the United States.

Mortality was high in people younger than 5 years old, 20-40 years old, and 65 years and older. The high mortality in healthy people, including those in the 20-40 year age group, was a unique feature of this pandemic. While the 1918 H1N1 virus has been synthesized and evaluated, the properties that made it so devastating are not well understood. With no vaccine to protect against influenza infection and no antibiotics to treat secondary bacterial infections that can be associated with influenza infections, control efforts worldwide were limited to non-pharmaceutical interventions such as isolation, quarantine, good personal hygiene, use of disinfectants, and limitations of public gatherings, which were applied unevenly.

DOCUMENT 3

"There Wasn't A Lot of Comfort in Those Days: African Americans, Public Health and the 1918 Influenza Epidemic," by Vanessa Northington Gamble, Public Health Rep. 2010; 125 (3): pp. 114–122.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862340/

When the 1918 influenza epidemic began, African American communities were already beset by many public health, medical, and social problems, including racist theories of black biological inferiority, racial barriers in medicine and public health, and poor health status. To address these problems, African Americans mounted efforts such as establishing separate hospitals and professional organizations and repudiating racist scientific theories. Contradicting prevailing theories about African Americans' increased susceptibility to disease, it appears that during the 1918 epidemic the incidence of influenza was lower in African Americans. Although the epidemic had a less devastating impact on African American communities, it still overwhelmed their medical and public health resources. Observations about the lower rates of influenza in African Americans did not derail racist theories about the biological inferiority of black people or overturn conceptualizations of black people as disease threats to white people. When the epidemic ended, the major problems that African Americans faced still remained.…

The medical and public health problems that African Americans faced during the 1918 influenza epidemic must be understood within a broader context. At the turn of the 20th century, black people found themselves in the midst of the "nadir in American race relations," an historical period marked by disfranchisement, anti-black violence, legalized segregation, black peonage, and white supremacist ideology. Racism and legalized segregation restricted access by black patients and health professionals to health-care facilities. Racist scientific theories advanced notions of African American's biological, physiological, and moral inferiority. In addition, African Americans lacked political and economic power and lived in the least desirable and most disease-ridden neighborhoods. But despite their plight, African Americans created separate hospitals, facilities, and organizations to take care of themselves. During the 1918 influenza epidemic, these institutions proved essential because of rigid racial barriers in medicine and public health….

The lack of accurate data collection during the public health crisis and the possibility that African American influenza cases may have been underreported because of inadequate access to medical care make it difficult to conclude definitively whether the incidence of influenza was lower in African Americans during the epidemic. However, in 1918 the belief that influenza took a lesser toll on African Americans was widespread and strongly held. The black lay public, black physicians, and white public health officials all shared this conviction. Thus, it appears likely that the incidence of influenza was lower in African Americans. Several factors might explain this racial differential. Alfred W. Crosby argues that African Americans were more susceptible to Spanish influenza and that many contracted it during the milder spring epidemic and thus were immune during the more severe fall epidemic. But it can also be argued that black people were less susceptible to influenza during both waves of the epidemic. Segregation cannot be discounted as a factor. It may have functioned as a de facto

quarantine that limited the exposure of African Americans to influenza. The reasons for the apparent racial disparity are not clear….

In October 1918, black Philadelphia physician, John P. Turner, hailed the “noble work” and “unselfish devotion to duty” of black physicians “in treating and relieving victims of every race” during the influenza epidemic. He optimistically predicted that the epidemic had brought a “new brand of professional democracy.” “No one stopped to inquire into the racial identity of the doctor,” he wrote. Turner's optimism proved premature. The influenza epidemic led to no major changes in opportunities for black health professionals—they remained segregated in the black medical world. The epidemic also did not prompt white people to develop any major public health or medical initiatives to improve the continued poor health status of African Americans. It also did not overturn racist scientific theories about the inferiority of African Americans or conceptualizations of black people and their neighborhoods as disease threats to white people.

In 1918, even after the “War to Make the World Safe for Democracy,” African Americans continued to live under the specter of poor health, legalized discrimination, socioeconomic inequities, disenfranchisement, and growing white supremacy….

DOCUMENT 4

"In 1918, and 1920, Race Colors America's Response to Epidemics: A Looks at How Jim Crow Affected African Americans Fighting the Spanish Flu, " by Soraya Nadia Mcdonald, The Undefeated, April 1, 2020.
.https://theundefeated.com/features/in-1918-and-2020-race-colors-americas-response-to-epidemics/

In American epidemics, race is a preexisting condition. Whether it's the influenza pandemic of 1918 or COVID-19 over a century later, race and ethnicity have been, and continue to be, enormous factors in determining whether people will receive medical attention when they become ill, and the sort of attention they will receive….

According to the Centers for Disease Control and Prevention estimates, the 1918 flu infected 500 million people worldwide and resulted in 50 million deaths around the globe, 675,000 of which were American. But while viruses don't discriminate, people do. In cities across the nation, black people struck by the flu were often left to fend for themselves. They received substandard care in segregated hospitals, where they could be relegated to close quarters in basements, or they were only allowed admittance to black-only hospitals. Even in death, black bodies were neglected by white public infrastructure. In Baltimore that year, white sanitation department employees refused to dig graves for black flu victims after the city's only black cemetery, Mount Auburn, could not accommodate any more graves.

"Fear driven by propaganda, censorship and lies were so much a powerful part of the spread of the Spanish flu. People were misled, often deliberately, by officials," {Historian Kenneth C.] Davis said. "Newspapers were censored. The reason it is the Spanish flu is because of censorship. [During the war] Spain was a neutral country. It didn't censor its news reports as rigorously as some of the warring countries did, so the first report of a massive epidemic comes out of Madrid in the spring of 1918 and that's the reason it was reported by Reuters in London that Madrid was under a mass epidemic. That's the reason it was called the Spanish flu. It certainly didn't originate there."...

When the flu epidemic of 1918 came to Chicago, black people were blamed...The reason for such ills wasn't any innate inferiority that could be attributed to blackness. In an academic paper about Jim Crow and public health, Betsy Schroeder Schlabach, a professor of history and African American studies at Earlham College in Richmond, Indiana, explained how discriminatory housing policies created ghettos. Black people were relegated to limited parts of the city. Housing was overcrowded, and white landowners became slumlords, charging rents that were 15% to 25% higher for black tenants, and then refused to make needed repairs when asked….

Schlabach found that Robertson's public health edicts functioned as another layer of Jim Crow laws, limiting the movement of black Americans, and effectively quarantining them to ghettos on the city's South Side. Public health officials became a de facto police force. Beginning in 1917, Robertson's health department passed 75 regulations, regulating where people could drink water to where children could play. It also implemented mandatory reporting of flu cases.…

The Public Health Department sent visiting nurses on expeditions to find people who were sick. They would visit homes, and that resulted in about 40,000 visits [across the city] during the pandemic where nurses and public health officials could come into your house without your permission and ask if you were infected.

“What that does, especially for black households during the pandemic, is it takes away the sanctity of the home, giving the Public Health Department, who also had the power of the police, entering into your home. For the black family in early 20th-century Chicago, that’s a direct threat to their safety. These ordinances about mandated reporting of disease were the ones that functioned similarly to Jim Crow laws that regulated all facets of black life.”

Black people who were wealthy enough could visit a doctor in his office. Dr. Roscoe Giles, for example, placed ads in The Chicago Defender announcing his services. But for those who were less fortunate, Provident Hospital, the nation’s first black-owned and -operated hospital, was one of the few places where black people could be seen and treated....Even as they were relegated to inadequate medical facilities, with black doctors and nurses facing shabby treatment and disrespect, black people still found ways to make the best of horrible situations.

“Black Chicagoans responded with innovation and tremendous grit and determination,” Schroeder Schlabach said. “At one point, the Public Health Department mandated that people needed to wear a mask. And what a group of black Chicago ladies do is that they start innovating with the masks and making them out of delicate lace and exquisite jewels. So even in the face of the pandemic, they were looking fabulous in these diamond-studded flu veils. Doctors and nurses just refused to accept any form of segregation. They’re more like icons. I see that as remarkable determination.”….

DOCUMENT 5

The Great Influenza (excerpt), by John M. Barry. New York: Penguin Books, 2004, pp. 359-360, 363.
https://books.google.com/books?id=BYsW6qTP0pMC&printsec=frontcover#v=onepage&q&f=false

It was as if the virus were a hunter. It was hunting mankind. It found man in the cities easily, but it was not satisfied. It followed him into towns, then villages, then individual homes. It searched for him in the most distant corners of the earth. It hunted him in the forests, tracked him into jungles, pursued him onto the ice. And in those most distant corners of the earth, in those places so inhospitable that they barely allowed man to live, in those places, where man was almost wholly innocent of civilization, man was not safer from the virus. He was more vulnerable.

In Alaska, whites in Fairbanks protected themselves. Sentries guarded all trails, and every person entering the city was quarantined for five days. Eskimos had no such luck. A senior Red Cross official warned that without "immediate medical assistance the race" could become "extinct."

Neither Red Cross nor territorial government funds were available. The governor of Alaska came to Washington to beg Congress for $200,000—compared to the $1 million given to the Public Health Service for the entire country. A senator asked why the territory couldn't spend any of the $600,000 in its treasury. The governor replied, "The people of Alaska consider that the money raised by taxes from the white people of Alaska should be spent for the improvements of the Territory. They need the money in roads a great deal. . . . They want to have the Indians in Alaska placed more on a parity with the Indians of other parts of the United States, where they are taken care of by the United States government."

He got $100,000. The navy provided the collier USS Brutus to carry a relief expedition. At Juneau the party divided and went in smaller boats to visit villages.

They found terrible things. Terrible things. In Nome, 176 of 300 Eskimos had died. But it would get worse. One doctor visited ten tiny villages and found "three wiped out entirely; others average 85% deaths. . . . Survivors generally children. . . . probably 25% this number frozen to death before help arrived."....

And populations whose immune systems were naive, whose immune systems had seen few if any influenza viruses of any kind, were not just decimated but sometimes annihilated. This was true not only of Eskimos but of all Native Americans, of Pacific Islanders, of Africans.

In Gambia, 8 percent of the Europeans would die, but from the interior one British visitor reported, "I found whole villages of 300 to 400 families completely wiped out, the houses having fallen in on the unburied dead, and the jungle having crept in within two months, obliterating whole settlements."

DOCUMENT 6

"California lessons from the 1918 pandemic: San Francisco dithered; Los Angeles acted and saved lives," by James Rainey and Rong-Gong Lin II, Los Angeles Times, April 19, 2020.
https://www.latimes.com/california/story/2020-04-19/coronavirus-lessons-from-great-1918-spanish-flu-pandemic

...In Los Angeles, the first signs of trouble arrived in mid-September 1918, when sailors aboard a Navy ship in San Pedro fell mysteriously ill. By the end of the month, 55 students at Polytechnic High School in downtown L.A. had the bug, which eventually killed 675,000 in the United States and an estimated 50 million worldwide....

By Oct. 11, the mayor had declared a state of emergency. Commissioner Powers ordered most public gathering places — including movie houses, theaters and pool rooms — closed as of 6 p.m. that night. Adding a peculiarly L.A. flavor, Powers told the city's ascendant movie moguls they would have to stop filming mob scenes, according to the Michigan archive.

Even though its first influenza cases appeared about the same time as those in L.A., San Francisco's board of health did not vote to shut down "all places of public amusement" until a week later, Oct. 18. The city did not include churches in the shutdown, leaving that to their leaders' discretion...

Los Angeles shut down its Liberty Day parade, while many other cities went ahead with the mass gatherings, exposing tens of thousands of people to others who were contagious. "In Los Angeles, however, residents had at least one less opportunity for getting sick," the University of Michigan researchers concluded....

San Francisco's leaders eventually also closed a significant number of public facilities, but they obsessed on a singular response to the disease: face masks. That response came courtesy of the city's health officer, Dr. William C. Hassler. He had first gained acclaim after the Great Earthquake of 1906, for helping fight off a rat infestation and fears of bubonic plague that menaced the city....

By Oct. 25, the Board of Supervisors required every resident and visitor to the city to wear a mask. The Red Cross pronounced that "the man or woman or child who will not wear a mask now is a dangerous slacker." California Gov. William Stephens concurred, calling it a "patriotic duty for every American citizen."...

Los Angeles went in a different direction. Despite repeated attempts by Mayor Woodman and others, the City Council refused to order Angelenos to wear masks, with the exception of health workers and those known to be in contact with influenza patients...

Polio (1950s) Resources

DOCUMENT 7

"What is Polio," and "Polio Elimination in the United States," by Centers for Disease Control and Prevention, Global Immunization. October 24, 2019. https://www.cdc.gov/polio/index.htm

Polio, or poliomyelitis, is a disabling and life-threatening disease caused by the poliovirus. The virus spreads from person to person and can infect a person's spinal cord, causing paralysis (can't move parts of the body)....

Polio was once one of the most feared diseases in the U.S. In the early 1950s, before polio vaccines were available, polio outbreaks caused more than 15,000 cases of paralysis each year. Following introduction of vaccines—specifically, trivalent inactivated poliovirus vaccine (IPV) in 1955 and trivalent oral poliovirus vaccine (OPV) in 1963—the number of polio cases fell rapidly to less than 100 in the 1960s and fewer than 10 in the 1970s.

Since 1979, no cases of polio have originated in the U.S.

However, the virus has been brought into the country by travelers with polio. The last time this happened was in 1993.

DOCUMENT 8

"Race and the Politics of Polio: Warm Springs, Tuskegee and the March of Dimes," by Naomi Rogers. Am J Public Health. May 2007; 97(5): 784–795.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1854857/

The Tuskegee Institute opened a polio center in 1941, funded by the March of Dimes. The center's founding was the result of a new visibility of Black polio survivors and the growing political embarrassment around the policy of the Georgia Warm Springs polio rehabilitation center, which Franklin Roosevelt had founded in the 1920s before he became president and which had maintained a Whites-only policy of admission. This policy, reflecting the ubiquitous norm of race-segregated health facilities of the era, was also sustained by a persuasive scientific argument about polio itself: that Blacks were not susceptible to the disease.

After a decade of civil rights activism, this notion of polio as a White disease was challenged, and Black health professionals, emboldened by a new integrationist epidemiology, demanded that in polio, as in American medicine at large, health care should be provided regardless of race, color, or creed.…

During the 1910s and 1920s defenders of medical segregation had argued that Blacks were simply not susceptible to the disease, but epidemiological statistics nonetheless revealed numbers of Black polio cases whose very existence, activists pointed out, had been kept invisible by medical racism and neglect. By the 1930s, polio became a civil rights issue that Roosevelt's Democratic advisers and the directors of the Warm Springs center could not ignore. The building of a special center for rehabilitative care and professional training at Tuskegee, funded by the March of Dimes, ran in tandem with the US Public Health Service's Tuskegee syphilis experiment *[see addendum below]. But polio lacked the virulent racist connotations associated with a sexually transmitted disease. More than this, the sentimentalized appeal of disabled children, rather than adults facing the so-called penalties of promiscuity, helped to make polio a more palatable issue for civil rights activism.

The fight to desegregate Warm Springs made visible the narratives of Black patients and emboldened claims for compassion and equity. Although medical practices remained infused with racism, the turmoil allowed the appalling inequities in access and quality of care among disabled minorities and the idea of polio as a White disease to come under critical scrutiny. Under the leaky umbrella of Roosevelt's pluralist New Deal, although conspicuously without its proactive support, Blacks were able to alter the official record and assert the right to an equal standard of health care. As the fight against Jim Crow medicine grew more forceful in the 1950s, Blacks—now recognized as susceptible to the polio virus and as deserving recipients of the advances of medical science—waited eagerly for their children to receive the Salk vaccine. But all too often it was offered to children waiting on the lawn outside the local White school door.

***[ADDENDUM] "Tuskegee Syphilis Study," Britannica.**
https://www.britannica.com/event/Tuskegee-syphilis-study

Tuskegee syphilis study, official name Tuskegee Study of Untreated Syphilis in the Negro Male, American medical research project that earned notoriety for its unethical experimentation on African American patients in the rural South.

The project, which was conducted by the U.S. Public Health Service (PHS) from 1932 to 1972, examined the natural course of untreated syphilis in African American men. . . the PHS enlisted the support of the prestigious Tuskegee Institute (now Tuskegee University), located in Macon county, Alabama. A group of 399 infected patients and 201 uninfected control patients were recruited for the program. The subjects were all impoverished sharecroppers from Macon county.

The subjects were not told that they had syphilis or that the disease could be transmitted through sexual intercourse. Instead, they were told that they suffered from “bad blood,” a local term used to refer to a range of ills. . . . it was decided to follow the subjects until their deaths, and all treatment was halted. Penicillin was denied to the infected men after that drug became available in the mid-1940s, and it was still being withheld from them 25 years later, in direct violation of government legislation that mandated the treatment of venereal disease. It is estimated that more than 100 of the subjects died of tertiary syphilis.

The Tuskegee syphilis study finally came to an end in 1972 when the program and its unethical methods were exposed in the Washington Star.

DOCUMENT 9

"How the Poor Get Blamed for Disease," Elena Conis. The Atlantic, November 9, 2014.
https://www.theatlantic.com/health/archive/2014/11/how-the-poor-get-blamed-for-disease/382338/

In September 1962, about a month before President John F. Kennedy signed the Vaccination Assistance Act into law, a white 11-year-old girl was admitted to a hospital in Sioux City, Iowa. Her face was swollen, her cervix was inflamed, and her enlarged tonsils were coated in a "grayish membrane" that covered the upper part of her throat. The swelling obstructed her breathing, so doctors cut an incision in her trachea to bring oxygen to her lungs. But the girl only worsened: The wound turned purple and red and then bled, her kidneys failed, and she seized repeatedly. She fell into a coma, and on her fifth day in the hospital she died. Cultures of bacteria from her throat confirmed the cause of death: diphtheria….

The start of the 1960s was characterized by an optimism about the conquest of infectious disease. New vaccines and new federal resources had led a growing number of experts to predict that vaccine-preventable infections would soon be wiped out for good. But in Sioux City and elsewhere, outbreaks of preventable disease persisted. Health experts who attempted to explain the trend often revived age-old assumptions about the ignorance and disease-breeding proclivities of the poor; these were the very ideas insinuated by the Sioux City investigators' comments about "skid row" and "transients." This tendency to hold the poor accountable for outbreaks also reflected a new pattern of disease that emerged over the course of the 60s. With record numbers of middle- and upper-class parents vaccinating their children, preventable infections began to concentrate in new populations. This was particularly true for polio and measles, both targets of federally sponsored vaccination programs that overshadowed diphtheria prevention. In the wake of national immunization efforts, polio, once a middle-class disease, became a disease of the "slums" and, in some areas, of minorities. Measles, which once struck all children, became a disease of the disadvantaged.

The 1960s campaigns against polio and measles took place in the context of a national war on poverty, widespread anxiety about the decline of American cities, and the civil-rights movement; worries about poverty, urban transformation, and race were thus subtly inscribed upon the nation's efforts to immunize against these infections. The decade was also marked by growing scientific enthusiasm for disease eradication, which inspired a push not just to vaccinate against diseases, but eliminate them entirely.

The decade's most high-profile vaccination campaigns both shifted their target diseases' epidemiology—the pattern of who got sick where and when—and provoked changes in the diseases' popular reputations. Measles-eradication proponents, for instance, urged Americans to see measles not as a familiar part of childhood, but as a fate worse than polio, drawing upon middle-class anxieties about poverty and urban decay as they did so. As one health educator put it, measles-immunization programs needed to highlight the disease's "dramatic aspects" in order to make Americans fear the disease, for only then would the country stand a chance at wiping out a disease still

harbored in its “ghettoes” and “slums.” This approached reinscribed vaccination as a middle-class concern, even as the decade’s social-welfare programs aimed to ensure vaccination’s equitable distribution across class lines.

In 1959, Surgeon General Leroy Burney penned a letter to health departments across the country, encouraging them to redouble their efforts against polio. “We in the Public Health Service share with you a deep concern that there was more paralytic poliomyelitis in 1958 than in the previous year,” he wrote. When Salk’s polio vaccine was first introduced in 1955, demand for it was so overwhelming, and vaccination rates climbed so quickly, that cases of the disease quickly plummeted. But demand then quickly slackened, noted Burney. And while rates of polio were still far lower than they had been a decade before, the sudden decline in cases showed troubling signs of reversal. There were roughly 5,500 cases in 1957 and close to 6,000 cases in 1958. If health departments didn’t act quickly to halt the trend, things would only get worse because more than half the population under 40 was either unvaccinated or incompletely vaccinated, and close to a third of children under five weren’t protected at all against the disease.

DOCUMENT 10

"Breaking the Back of Polio," by David M. Oshinsky. Yale Medicine Magazine, Autumn 2005.
https://medicine.yale.edu/news/yale-medicine-magazine/breaking-the-back-of-polio/

...What follows is the story of Dorothy Millicent Horstmann, M.D., FW '43, whose patience and intuition produced a stunning breakthrough that made polio vaccines possible….

Though poliovirus has long been present in the environment, the disease, unlike smallpox or influenza, had triggered no major outbreaks around the world. Why it took root in Western nations, especially the United States, during the 20th century is still a matter of debate. Some researchers pointed to more careful reporting and better diagnostic techniques. Others noted the circulation of more virulent strains of poliovirus, capable of multiplying at a ferocious rate. Still others saw a correlation between the spread of polio and the ever-increasing standards of personal hygiene in the United States—people were less likely to come into contact with poliovirus early in life when the infection is milder and maternal antibodies offer temporary protection. Put simply, America's antiseptic revolution brought risks as well as rewards....

The drive to combat polio was led by the National Foundation for Infantile Paralysis, now known as the March of Dimes...Millions of foundation dollars would be spent to set up virology programs and polio units across the country, with the first grant going to the Yale School of Medicine in 1936. Although research funding went in many directions, one point became increasingly clear: the best way to prevent polio would come through a vaccine....

In New Haven, Horstmann joined the Yale polio unit....Using an approach pioneered by Paul and known as "clinical epidemiology," the polio unit, including Horstmann, tracked polio epidemics in Connecticut, Illinois, New Jersey, western New York state and Hickory, N.C., site of one of the worst outbreaks of the 20th century. The unit tested water and sewage, trapped flies and other insects and took blood samples from those who had the disease and those without symptoms, hoping to discover both the route of poliovirus through the body and the manner of transmission from one person to another...

Like others in the polio group, Horstmann combined her clinical studies with laboratory research. During a polio epidemic in New Haven in 1943, she collected blood specimens from every patient admitted to the hospital with symptoms of the disease—111 in all. Only one tested positive for poliovirus, a little girl with minor neck pain. Was it possible, Horstmann wondered, that poliovirus was only present in the bloodstream during the brief period before a victim took sick and the physical symptoms became apparent?

To test this theory, she began a series of experiments on monkeys, feeding them poliovirus by mouth to determine if, and when, it turned up in their blood. The results were dramatic. Poliovirus was detected within days of the feedings...Horstmann's discovery...would pave the way for both the Salk killed-virus polio vaccine and the Sabin live-virus polio vaccine....

DOCUMENT 11

"Wiping Out Polio: How The U.S. Snuffed Out a Killer," by Jason Beaubien, NPR, October 15, 2012.
https://www.npr.org/sections/health-shots/2012/10/16/162670836/wiping-out-polio-how-the-u-s-snuffed-out-a-killer%C6%92jason

Sixty years ago, polio was one of the most feared diseases in the U.S.

As the weather warmed up each year, panic over polio intensified. Late summer was dubbed "polio season." Public swimming pools were shut down. Movie theaters urged patrons not to sit too close together to avoid spreading the disease. Insurance companies started selling polio insurance for newborns.

The fear was well grounded. By the 1950s, polio had become one of the most serious communicable diseases among children in the United States.

In 1952 alone, nearly 60,000 children were infected with the virus; thousands were paralyzed, and more than 3,000 died. Hospitals set up special units with iron lung machines to keep polio victims alive. Rich kids as well as poor were left paralyzed.

Then in 1955, the U.S. began widespread vaccinations. By 1979, the virus had been completely eliminated across the country. . . .

The first major polio epidemic in the United States hit Vermont in 1894 with 132 cases. A larger outbreak struck New York City in 1916, with more than 27,000 cases and 6,000 deaths. As the number of polio cases grew, the paralytic disease changed the way Americans looked at public health and disability.

Franklin D. Roosevelt contracted polio 12 years before he became president. Roosevelt concealed the extent to which he suffered from polio, but he acknowledged having it. His presidency put polio front and center on the national stage. . . . "Polio was a fear of parents throughout this country," says Dr. John L. Sever . . .Early attempts to develop a vaccine ran into numerous hurdles. A vaccine tested on 10,000 children by two researchers at New York University provided no immunity and left nine children dead. Other vaccine trials used "volunteers" at mental institutions.

At the University of Pittsburgh, Jonas Salk launched what was then the largest human trial in history, injecting nearly 2 million American kids with a potential vaccine. When it was announced that his vaccine worked, Salk was hailed as a humanitarian hero.

Famed CBS newsman Edward R. Murrow asked Salk who owned the patent to his vaccine. The scientist replied: "There is no patent. Could you patent the sun?"

HIV/AIDS (1981-Present) Resources

DOCUMENT 12

"About HIV/AIDS," by Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, December 2, 2019. https://www.cdc.gov/hiv/basics/whatishiv.html

HIV stands for human immunodeficiency virus. It is the virus that can lead to acquired immunodeficiency syndrome or AIDS if not treated. Unlike some other viruses, the human body can't get rid of HIV completely, even with treatment. So once you get HIV, you have it for life.

HIV attacks the body's immune system, specifically the CD4 cells (T cells), which help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body, making the person more likely to get other infections or infection-related cancers. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. These opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS, the last stage of HIV infection.

No effective cure currently exists, but with proper medical care, HIV can be controlled. The medicine used to treat HIV is called antiretroviral therapy or ART. If people with HIV take ART as prescribed, their viral load (amount of HIV in their blood) can become undetectable. If it stays undetectable, they can live long, healthy lives and have effectively no risk of transmitting HIV to an HIV-negative partner through sex. Before the introduction of ART in the mid-1990s, people with HIV could progress to AIDS in just a few years. Today, someone diagnosed with HIV and treated before the disease is far advanced can live nearly as long as someone who does not have HIV.

DOCUMENT 13

"Rumors and Realities: Making Sense of HIV/ AIDS Conspiracy Narratives and Contemporary Legends," by Jacob Heller, Am J Public Health. 2015 January; 105(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265931/

The social context of the early HIV/AIDS epidemic in the United States provided fertile ground for rumors about transmission. Today, however, rumors about HIV/AIDS persist only within the African American public. Focus group and public discourse data reveal the content and distribution of HIV/AIDS origin and conspiracy rumors. Rumor and contemporary legend theory allows reinterpretation of rumors as a measure of trust between the African American public and health professionals, not as evidence of ignorance or of historical racial oppression. To improve public health results in the African American community, HIV/AIDS efforts must acknowledge the sources and meanings of rumors, include rumors as a measure of trust, and address the underlying distrust that the rumors signify....

In different and sometimes overlapping ways, the rumors described here can be understood as (1) the result of historical experiences that have engendered distrust, (2) a result of continuing distrust, and (3) an indication of social anxieties associated with the HIV/AIDS epidemic, drug use (as a source of HIV and as an arm of the genocide attempt), and African Americans' place in American society. Establishing a genuinely trusting relationship between the public health professions and the African American community may be the only way to put rumors on the same road to extinction as rumors about mosquitos transmitting HIV.

Establishing trust poses real challenges, however; whether it is a consequence of collective memory or lived experience, African Americans are less likely than nearly any other ethnic or racial group in the United States to trust mainstream institutions. Specific distrust for health professions adds another multiplier. Fine and Turner cite the example of HIV-positive men who refused azidothymidine (AZT) treatments because they feared "sometimes it accelerates the rate at which full-blown AIDS develops in Black men."...

Treatment disparities may play a role in the persistence of distrust, and this was reflected in the focus group data on cures and treatments. Effective antiretroviral therapies are nominally available to everyone in the United States through a variety of federal and state programs, yet access to these drugs varies widely across geographic, political, and demographic boundaries in the United States.Disproportionately lower spending on HIV/AIDS prevention in African American communities also contributes to the trust gap. Even statements identifying at-risk groups can trigger anger, because of the implicit implication that there is fault associated with infection, as this excerpt from a focus group interview suggests: "[L]ook at everybody else who has AIDS. . . . So many people have it, but they're trying to say, 'Oh, it's mostly Black women spreading it,' it's really offensive to me" (African American woman, 2014)

Understanding such distrust as part of a reasonable response to underfunded and poorly designed programs is neither a complete nor a satisfying explanation, however: when funding is low, it makes sense to ask for more funding, not to reject efforts that are already funded. As with the legacy of historical abuses, underfunding may contribute to African Americans distrust of medical institutions, but until we understand the full range

of causes and mechanisms for the distrust, health professionals will continue to confront difficulties irrespective of objective measures of validity. People who distrust can't be reassured by evidence they deem untrustworthy.…

Of course, there are no easy solutions. Distrust that is woven into the fabric of a society stratified by race cannot easily be undone. As stories, however, rumors are mutable and can fade—they are more symptom than cause...A measure as simple as ascertaining the prevalence of rumors in a particular community where an HIV/AIDS initiative will be undertaken—through focus groups with a cross-section of community members—can alert public health workers to the level of distrust (detecting rumors as a measure of distrust). Even providing a forum where rumors can be openly spoken about may also help displace them. In this research, off-the-record comments by participants expressed relief and pleasure at having had a chance to participate in discussions where they could speak freely and without judgment about the stories they recounted.

DOCUMENT 14

"The Confusing and At-Times Counterproductive 1980s Response to the AIDS Epidemic," by Natasha Geiling. Smithsonian Magazine, December 4, 2013.
https://www.smithsonianmag.com/history/the-confusing-and-at-times-counterproductive-1980s-response-to-the-aids-epidemic-180948611/

In 1981, an unknown epidemic was spreading across America. In June of that year, the Centers for Disease Control and Prevention's newsletter mentioned five cases of a strange pneumonia in Los Angeles. By July, 40 cases of a rare skin cancer were reported by doctors working in the gay communities of New York and San Francisco. By August, the Associated Press reported that two rare diseases, the skin cancer Kaposi's sarcoma and pneumocystis, a form of pneumonia caused by a parasitic organism, had infected over 100 gay men in America, killing over half of them. At the end of 1981, 121 men had died from the strange disease; in 1982, the disease was given a name; by 1984, two different scientists had isolated the virus causing it; in 1986, that virus was named HIV. By the end of the decade, in 1989, 27,408 people died from AIDS.

In the years following the AIDS epidemic, medical research has given us a better understanding of HIV and AIDS, as well as made some remarkable breakthroughs unimagined in the 1980s: today, people living with HIV aren't condemned to a death sentence, but rather have treatment options available. Still, to think of the AIDS epidemic in medical terms misses half of the story--the social aspect, which affected America's perception of HIV and AIDS just as much, if not more than medical research.

The two sides of the story are told through a collection of articles, pictures, posters and pamphlets in Surviving and Thriving: AIDS, Politics and Culture, a traveling exhibit and online adaptation curated by the National Library of Medicine that explores the rise of AIDS in the early 1980s, as well as the medical and social responses to the disease since. The human reaction to the AIDS epidemic often takes a back seat to the medical narrative, but the curators of Surviving and Thriving were careful to make sure that this did not happen--through a series of digital panels, as well as a digital gallery, readers can explore how the government and other community groups talked about the disease.

At the beginning of the epidemic, response was largely limited to the communities which were most affected, especially the gay male community. "People with AIDS are really a driving force in responding to the epidemic and seeing how change is made," says Jennifer Brier, a historian of politics and sexuality who curated the exhibit.

In 1982, Michael Callen and Richard Berkowitz, two gay men living with AIDS in New York City, published How to Have Sex in an Epidemic, which helped spread the idea that safe sex could be used as protection against spreading the epidemic--an idea that hadn't yet become prevalent in the medical community. The pamphlet was one of the first places that proposed that men should use condoms when having sex with other men as a protection against AIDS.

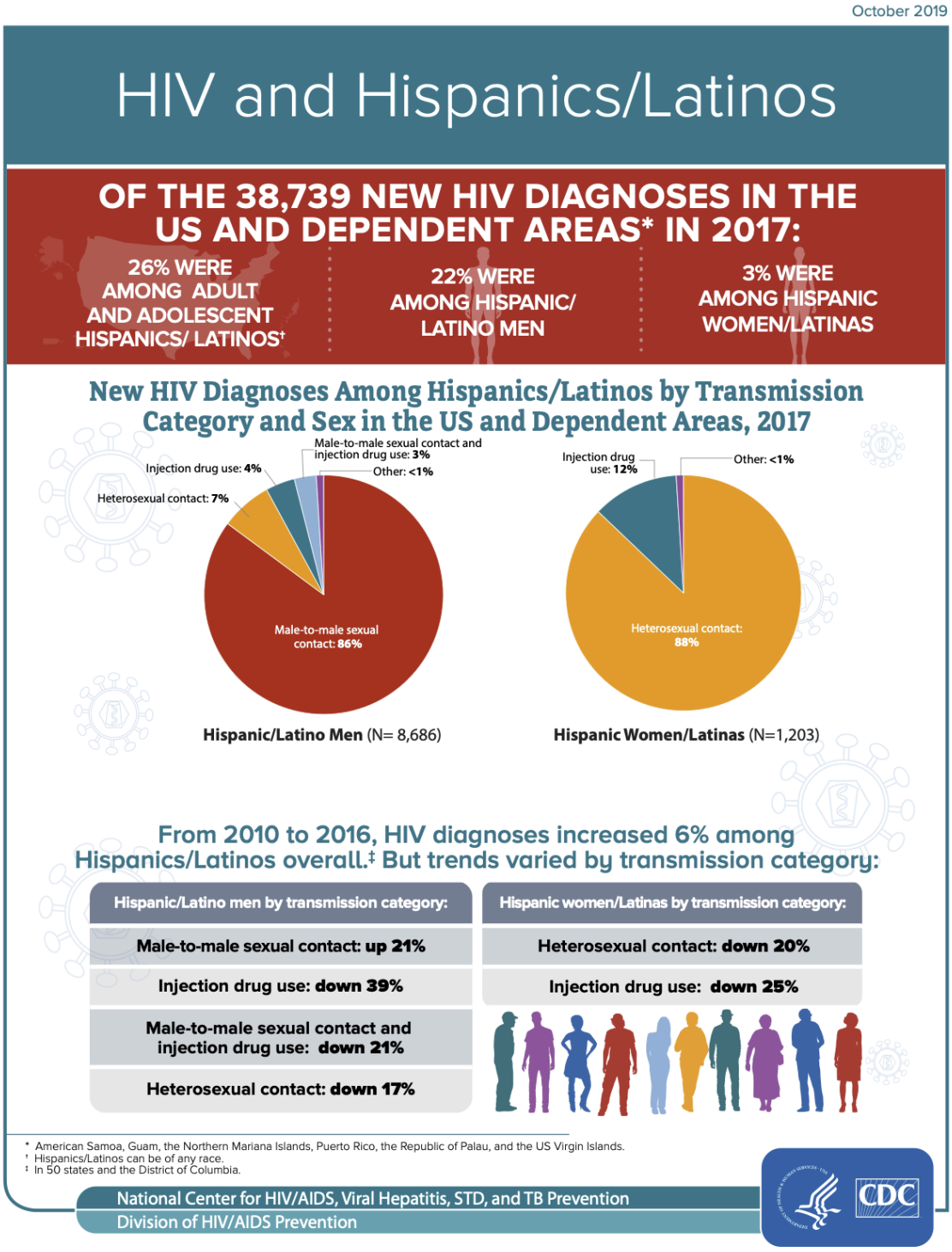
Condoms as protection against AIDS became a major theme for poster campaigns. The above poster, paid for by the Baltimore-based non-profit Health Education Resource Organization, shows how visuals attempted to appeal, at least at first, to the gay community. Due to widespread misinformation, however, many people believed that AIDS was a disease that affected only white gay communities. As a response to this,

black gay and lesbian communities created posters like the one below, to show that AIDS didn't discriminate based on race.

Many posters and education campaigns harnessed sexual imagery to convey the importance of safe sex in an attempt to make safety sexy (like the Safe Sex is Hot Sex campaign), but it wasn't a campaign tactic supported by governmental bodies--in fact, in 1987, Congress explicitly banned the use of federal funds for AIDS prevention and education campaigns that "[promoted] or [encouraged], directly or indirectly, homosexual activities" (the legislation was spearheaded by conservative senator Jesse Helms and signed into law by President Reagan)....

DOCUMENT 15

"HIV and Hispanics/Latinos," - Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, Feb 6, 2020.
https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html



Around 1.1 million people are living with HIV in the US.‡ People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.

AT THE END OF 2016, AN ESTIMATED **254,600** HISPANICS/LATINOS HAD HIV.‡

5 in 6 KNEW THEY HAD THE VIRUS.

For every 100 Hispanics/Latinos with HIV in 2016:‡

- **60** received some HIV care
- **49** were retained in care
- **51** were virally suppressed

A person with HIV who takes HIV medicine as prescribed and gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

What places some Hispanics/Latinos at higher risk?

Knowledge of HIV Status

Many Hispanics/Latinos do not know their HIV status. People who do not know they have HIV can't get the care they need and may pass HIV to others without knowing it.

Stigma and Discrimination

Stigma, fear, discrimination, and homophobia may impact the lives of some Hispanics/Latinos. These issues may put some Hispanics/Latinos at higher risk for HIV.

Sexually Transmitted Diseases (STDs)

Hispanics/Latinos have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.

Access to HIV Prevention and Care

Immigration status, poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanics/Latinos to get HIV testing and care.

How is CDC making a difference?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Reduce Your Risk

HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit **gettested.cdc.gov** to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

All content is based on the most recent data available in October 2019.

DOCUMENT 16

"The LGBTQ Health Clinic That Faced a Dark Truth About the AIDS Crisis," by Abdallah Fayyad, Atlantic Monthly, July 22, 2019.
https://www.theatlantic.com/health/archive/2019/07/us-aids-policy-lingering-epidemic/594445/

...But as local organizations confronted the virus, the federal government often stood in their way. When Bill Clinton was sworn in to the presidency in 1993—after roughly 200,000 people diagnosed with AIDS in the U.S. had died—he launched a far more rigorous federal response to the epidemic than his predecessors had, dramatically increasing funding for research, treatment, and care. But the ramped-up efforts to stifle the epidemic left some communities behind when political fights got in the way. In 1998, Clinton upheld a Reagan-era ban on the use of federal funds for needle exchanges amid unsubstantiated concerns that those programs would promote drug use. That same year—when the epidemic's death toll had reached more than 400,000—Congress, which oversees Washington, D.C.'s budget, banned the city from using its own municipal funds for syringe exchanges....

Whitman-Walker, the LGBTQ-focused clinic that partnered with the ClubHouse, was on the front lines of the AIDS crisis in D.C. It was one of many clinics that had cropped up across the country in the 1970s as part of a growing LGBTQ health movement, which was galvanized by the Stonewall riots and the broader LGBTQ liberation movement. At the time, "most doctors and most hospitals and clinics would see homosexuality as an illness," says Lawrence Deyton, a senior associate dean for clinical public health at George Washington University and a founding volunteer at Whitman-Walker. "It was hard to find care that wasn't really laced with stigma."...

As Whitman-Walker grew, it became a part of a network of organizations that covered services the U.S. government didn't. While the government worked with and financed many of these clinics, it set limits on what it would support, and pulled funding from certain programs that became too politically sensitive. Many of those programs disproportionately helped the marginalized groups that the government was trying to reach through these clinics in the first place—LGBTQ people, people of color, and LGBTQ people of color in particular. When it came to needle exchanges, for example, black and brown people across the country were, and continue to be, likelier to contract HIV through injection-drug use than their white counterparts.

During the Clinton administration, many major public-health officials—ranging from the surgeon general to the heads of the Food and Drug Administration, the National Institutes of Health, and the CDC—spent years trying to persuade the president to lift the Reagan-era ban on federal funds for needle-exchange programs. "There was no question that the science was clear," says Donna Shalala, who served as Clinton's Secretary of Health and Human Services. But, she says, the perception that needle exchanges promoted drug use worried some Democrats in Congress that their party would appear to be soft on drugs if it funded the programs. Ultimately, Clinton refused to remove the ban….

Clinton's predecessor, George H. W. Bush, signed the Americans With Disabilities Act into law, which prohibited discrimination against people living with HIV/AIDS in the

health-care system, and also famously passed the Ryan White CARE Act, which provided treatment and services for HIV-positive people. But like Ronald Reagan, Bush ignored much of the World Health Organization's advice on other methods to reduce the spread of the virus, and often categorized prevention strictly in terms of personal responsibility. "I'm in favor of behavioral change," he once said. "[AIDS] is a disease where you can control its spread by your own personal behavior." This focus on behavior rather than funding for preventative measures such as safe-sex programs would end up harming those most affected by HIV and AIDS at the time: gay and bisexual men.

Clinton's successor, George W. Bush, is often praised for his administration's efforts to fight HIV and AIDS in the global South, particularly in Africa. But in the United States, the rates of HIV worsened during his tenure. He continued the bans on both federal and D.C.-specific funds for needle exchanges, which contributed to a worsening epidemic in Washington, particularly among African Americans. He also supported funding for "abstinence-only" education programs that downplayed the role of condoms in prevention….

Toward the end of Obama's presidency, more lawmakers, including the traditional conservative opponents to needle exchanges, began embracing the program as the opioid epidemic ravaged urban and rural communities alike. After a new HIV outbreak in Scott County, Indiana, a Republican-led bill, signed into law by President Obama in 2016, finally lifted the ban on federal funds for needle exchanges....

COVID-19 (2019-Present) Resources

DOCUMENT 17

"COVID-19 Overview and Infection Prevention and Control Priorities in Non-US Healthcare Settings," by National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases. July 8, 2020.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/overview/

Coronaviruses are a large family of viruses that can cause illness in animals or humans. In humans there are several known coronaviruses that cause respiratory infections. These coronaviruses range from the common cold to more severe diseases such as SARS, MERS, and COVID-19….

Coronavirus disease 2019 (COVID-19) was identified in Wuhan, China in December 2019. COVID-19 is caused by the virus SARS-CoV-2 which is a new virus in humans causing respiratory illness which can be spread from person-to-person.

The primary transmission of COVID-19 is from person-to-person through respiratory droplets. These droplets are released when someone with COVID-19 sneezes or coughs. COVID-19 can also be spread when you are in close contact with someone who is sick (e.g., shaking hands or talking). A physical distance of at least 1 meter (3 ft) between persons is suggested by the World Health Organization (WHO) to avoid infection, although some WHO member states have recommended maintaining greater distances whenever possible. Respiratory droplets can land on objects or surfaces around the person when they cough or talk, and people can then become infected with COVID-19 from touching these objects or surfaces and then touching their eyes, nose or mouth. Recent data suggests that there can be transmission of COVID-19 through droplets of those with mild symptoms or those who do not feel ill….

In some cases, people who get COVID-19 can become seriously ill and develop difficulty breathing. These severe complications can lead to death. The older population (> 50 years of age) as well as those with underlying medical conditions such as those who are immunocompromised, have serious heart problems, or chronic lung disease are more likely to develop serious illness.

Currently, care for patients with COVID-19 is primarily supportive. Care is given to patients to help relieve symptoms and manage respiratory, and other organ, failure. There are currently no specific antiviral treatments licensed for COVID-19, however many treatments are under investigation.

DOCUMENT 18

"Covid-19 is Hitting Black and Poor Communities the Hardest," by Grace A. Noppert, JSTOR Daily, April 14, 2020.
https://daily.jstor.org/covid-10-hitting-black-poor-communities-hardest/

As the COVID-19 epidemic continues to ravage the American public, an unsurprising story emerges: Poor communities are hot spots for COVID transmission. The death rate from COVID-19 appears to be staggeringly high among African Americans compared to whites. The Washington Post reports, for example, that while 14% of the Michigan population is black, 40% of COVID-19 deaths are among blacks.

This is a familiar pattern to a social and infectious disease epidemiologist like myself. It is evidence of centuries of segregation and discrimination that have disproportionately placed people of color in communities without access to health care, with degraded and crowded living conditions and a lack of basic opportunities for health and wellness.

In the context of the current pandemic, blacks are more likely to have low-paying jobs that do not allow remote work options or offer health insurance or paid medical leave. The result of centuries of sidelining by American society plays out most obviously in worse health.…

The poor and marginalized already unfairly bear the burden of other diseases such as asthma, certain kinds of cancer, stroke and cardiovascular disease. This ongoing pandemic looks to be no different. And poverty in the U.S. is very much tied to race and ethnicity. In 2018, 11% of whites had a household income below the federal poverty level compared to 23% of blacks and 19% of Hispanics. People of color are also more likely to live in low-income communities with a lack of access to basic resources for health and wellness.

The link between poverty and infectious disease is well-documented. Influenza-related hospitalizations in low-income neighborhoods are nearly twice that of high-income neighborhoods. Pediatric hospitalizations from bacterial pneumonia are significantly higher in low-income neighborhoods compared to high-income neighborhoods.

The same is largely true of tuberculosis in the U.S. where active transmission of TB is ongoing in poor neighborhoods – patterns that are not simply due to more people living in these areas.

TB, in particular, has long been tied to socioeconomic status. Even in the face of a widespread TB epidemic in the U.S. in the early 1900s, there was a noticeable pattern in which people of color, immigrants and those living in poor environments were more likely to be infected with TB and less likely to receive care.

Those of us who study the burden of disease on the poor have seen the same basic pattern play out in the U.S. today. People with TB often experience extreme socioeconomic disadvantage. Poor neighborhoods and people of color continue to disproportionately bear the burden of TB among U.S.-born individuals...

DOCUMENT 19

"For Latinos and Covid-19, Doctors are Seeing an 'Alarming' Disparity," by Miriam Jordan and Richard A. Oppel Jr., June 26, 2020.
https://www.nytimes.com/2020/05/07/us/coronavirus-latinos-disparity.html

Dr. Eva Galvez works as a family physician for a network of clinics in northwestern Oregon, where low-income patients have been streaming in for nasal swabs over the past several weeks to test for the coronavirus.

Dr. Galvez was dumbfounded by the results. Latinos, about half of those screened, were 20 times as likely as other patients to have the virus.

"The disparity really alarmed me," said Dr. Galvez, who began trying to understand what could account for the difference.

It is a question that epidemiologists around the country are examining as more and more evidence emerges that the coronavirus is impacting Latinos, and some other groups, including African-Americans, with particular force….

Because most of the clients at the Virginia Garcia Memorial Health Center clinics in Oregon are relatively poor whatever their ethnic background, Dr. Galvez decided that income could not explain the disparity.

Public health experts say Latinos may be more vulnerable to the virus as a result of the same factors that have put minorities at risk across the country. Many have low-paying service jobs that require them to work through the pandemic, interacting with the public. A large number also lack access to health care, which contributes to higher rates of diabetes and other conditions that can worsen infections.

Oregon last month expanded testing criteria to prioritize Latinos and other minorities, citing the higher risk posed from the virus because of "longstanding social and health inequities."...

Carlos, an undocumented Guatemalan who was one of the clinic's patients, never stopped reporting to his job cleaning large supermarkets, even after he began coughing and feeling ill, said his wife, Blanca, who did not want the family's last name to be published because of their immigration status.

Her husband medicated himself on cough syrup, but his condition quickly deteriorated, and he was gasping for air when she finally rushed him to the hospital. He died on April 1 from Covid-19. Now Blanca, her brother and the couple's 13-year-old son have all tested positive for the virus….

"Not all Latinos are created equal," said Daniel López-Cevallos, professor of Latino and health equity studies at Oregon State University. More Latinos in states with established communities, he said, are likely to have middle-class jobs or the sort of wealth that could help tide them over through the pandemic without having to work outside the home.

By contrast, those in places like Oregon and Washington "tend to be lower income, with lower educational levels, lower levels of health insurance and more employment in essential services," Mr. López-Cevallos said. "They have fewer support systems in place."

According to a Pew Research Center survey in April, about half of the Latinos questioned said they or someone in their household had either lost a job or taken a pay

cut, or both, because of the outbreak — compared with a third of all adults in the United States.

The data from a number of states takes an unexpected turn: It indicates that even though Latinos may have higher rates of infection, they have been dying from the virus at lower reported rates over all than other groups.

But experts say those raw numbers understate the risks for those who become sick, because they do not take into account that the Latino population — the country's second-largest ethnic group — is significantly younger than other groups. And there have been much fewer deaths among the young from a virus whose lethality grows sharply with its victims' age.

But among adult Latinos, fatality rates can be much higher. That was what officials in California found when they took a closer look.

There, Latinos, who are 39 percent of the population, account for almost half of all reported virus cases but only 35 percent of deaths — placing their overall death rate slightly below that of whites who are not Hispanic.

But when California public health officials drilled down further, they found that in every age group over 17, Latinos were dying at significantly higher rates than whites — as were African-Americans….

DOCUMENT 20

"How COVID-19 is impacting Indigenous people in the U.S.," by Randall Akee. PBS Newshour, May 13, 2020.
https://www.pbs.org/newshour/nation/how-covid-19-is-impacting-indigenous-peoples-in-the-u-s

There is emerging evidence that many disadvantaged communities in the United States are being disproportionately impacted by COVID-19. Native American communities share some of the characteristics of other disadvantaged communities that might make them susceptible to greater impacts, but they also face unique challenges. Difficulties inherent in studying small population groups as well as differences in access to testing for COVID-19 present challenges to understanding the full impact of the epidemic on these communities. However, there are indications that some Native American populations are facing a disproportionate brunt of the COVID-19 epidemic with higher infection and mortality rates than the overall U.S. population. Understanding how the disease is affecting these communities is important to mitigating the damage. Specific measures that address water infrastructure in some reservations and language or communication barriers may be warranted.

Many disadvantaged communities in the U.S. are at higher risk for COVID-19 infection than the general population, though national race-disaggregated data is lacking….

Historical inequities in public funding, in areas like healthcare and infrastructure, have also contributed to health disparities that put Indigenous peoples and other minorities at higher-risk in the COVID-19 crisis….

There is a wide range of COVID-19 rates among different American Indian reservations, but a handful of reservations have many-fold greater infection rates compared to the general U.S. population.[T]he rate of verified COVID-19 infection per 100,000 individuals is around 400. Current verified COVID-19 cases on U.S. American Indian reservations range from 0 to 3,300 per 100,000 individuals; the average rate is about 32 per 100,000. However, the Mississippi Band of Choctaw Indians, the Ho-Chunk Nation, the Navajo Nation, the Pueblo of San Felipe, and the Pueblo of Zia have astonishingly high reservation-based COVID-19 rates per 100,000 at 500, 800, 1100, 1400 and 3300, respectively...This variation may be attributable to differences in rates of testing, but also likely reflects the differential access to resources of different reservations.

Examining the characteristics of different reservations — such as access to running water and English proficiency — may help explain some of the disparities in COVID-19 rates...COVID-19 cases were more likely to occur in tribal communities with a higher proportion of homes lacking indoor plumbing, even when taking into account other characteristics like household size, age, and income. Lacking complete plumbing is defined as missing any or all of the following: flush toilet, hot and cold water, and a tub or shower in the American Community survey. While American Indian households on tribal reservations are 3.7 times more likely to lack complete indoor plumbing relative to all other households in the United States, this average obscures differences among reservations with some experiencing much higher rates of incomplete plumbing

facilities, such as the Navajo reservation (18%). We also find that COVID-19 cases were less likely to occur in tribal communities where households spoke English-only. This was true even after taking into account differences in socioeconomic characteristics. This association suggests that access to relevant public health information in Indigenous languages may play a key role in the spread of COVID-19...

There are some signs that Native Hawaiian and Pacific Islanders are also disproportionately affected. In California, Native Hawaiian and Pacific Islanders (NHPI) make up approximately 1% of all cases in the state as of May 7, 2020 according to California state data. However, NHPI make up only 0.3% of California's population; this means that their cases are more than three times their population proportion...In Alaska, American Indians and Alaska Natives are approximately 15% of the state's population, however, they accounted for 6% of all cases and approximately 20% of all deaths related to COVID-19 in the state, as of May 8, 2020…

Small population race and ethnic groups must be identified and counted during public health epidemics. There are continuing issues and concerns that American Indian and Alaska Native (AIAN) individuals are being mis-categorized as Latinx or Hispanic based on surnames or appearance in certain state counts. In many state health departments, AIAN individuals are simply classified as "other." If this is the case, then there will be an undercount of the severity of the COVID-19 pandemic in certain communities….

DOCUMENT 21

"It's Not Obesity, It's Slavery: We Know Why COVID-19 is Killing So Many Black People," by Sabrina Strings, New York Times, May 25, 2020.
https://www.nytimes.com/2020/05/25/opinion/coronavirus-race-obesity.html

…Some of the experts had devoted their entire careers to addressing questions surrounding racial health inequities. Years of research, and in some instances failed interventions, had left them baffled. Why are black people so sick?

My answer was swift and unequivocal. "Slavery."

My colleagues looked befuddled as they tried to come to terms with my reply. I meant what I said: The era of slavery was when white Americans determined that black Americans needed only the bare necessities, not enough to keep them optimally safe and healthy. It set in motion black people's diminished access to healthy foods, safe working conditions, medical treatment and a host of other social inequities that negatively impact health.

This message is particularly important in a moment when African-Americans have experienced the highest rates of severe complications and death from the coronavirus and "obesity" has surfaced as an explanation. The cultural narrative that black people's weight is a harbinger of disease and death has long served as a dangerous distraction from the real sources of inequality, and it's happening again.

Reliable data are hard to come by, but available analyses show that on average, the rate of black fatalities is 2.4 times that of whites with Covid-19. In states including Michigan, Kansas and Wisconsin and in Washington, D.C., that ratio jumps to five to seven black people dying of Covid-19 complications for every one white death….

Despite the lack of clarity surrounding these findings, one interpretation of these disparities that has gained traction is the idea that black people are unduly obese (currently defined as a body mass index greater than 30) which is seen as a driver of other chronic illnesses and is believed to put black people at high risk for serious complications from Covid-19.

These claims have received intense media attention, despite the fact that scientists haven't been able to sufficiently explain the link between obesity and Covid-19. According to the Centers for Disease Control and Prevention, 42.2 percent of white Americans and 49.6 percent of African-Americans are obese. Researchers have yet to clarify how a 7 percentage-point disparity in obesity prevalence translates to a 240 percent-700 percent disparity in fatalities.

Experts have raised questions about the rush to implicate obesity, and especially "severe obesity" (B.M.I. greater than 40), as a factor in coronavirus complications.

An article in the medical journal The Lancet evaluated Britain's inclusion of obesity as a risk factor for coronavirus complications and retorted, "To date, no available data show adverse Covid-19 outcomes specifically in people with a BMI of 40 kg/m2." The authors concluded, "The scarcity of information regarding the increased risk of illness for people with a BMI higher than 40 kg/m2 has led to ambiguity and might increase anxiety, given that these individuals have now been categorised as vulnerable to severe illness if they contract Covid-19."

Promoting strained associations between race, body size, and complications from this little-understood disease has served to reinforce an image of black people as wholly swept up in sensuous pleasures like eating and drinking, which supposedly makes our unruly bodies repositories of preventable weight-related illnesses. The attitudes I see today have echoes of what I described in “Fearing the Black Body: The Racial Origins of Fat Phobia.” My research showed that anti-fat attitudes originated not with medical findings, but with Enlightenment-era belief that overfeeding and fatness were evidence of “savagery” and racial inferiority.

Today, the stakes of these discussions could not be higher. When I learned about guidelines suggesting that doctors may use existing health conditions, including obesity, to deny or limit eligibility to lifesaving coronavirus treatments, I couldn’t help thinking of the slavery-era debates I’ve studied about whether or not so-called “constitutionally weak” African-Americans should receive medical care.

Fortunately, since that event I attended five years ago, experts focused on the health of African-Americans have continued to work to direct the nation’s attention away from individual-level factors.

The New York Times’ 1619 Project featured essays detailing how the legacy of slavery impacted health and health care for African-Americans and explaining how, since the era of slavery, black people’s bodies have been labeled congenitally diseased and undeserving of access to lifesaving treatments.

In a recent essay addressing Covid-19 specifically, Rashawn Ray underscored the legacy of redlining that pushed black people into poor, densely populated communities often with limited access to health care. And he pointed out that black people are overrepresented in service positions and as essential workers who have greater exposure than those with the luxury of sheltering in place….

Evaluating the inadequate and questionable data about race, weight and Covid-19 complications with these insights in mind makes it clear that obesity — and its affiliated, if incorrect implication of poor lifestyle choices — should not be front and center when it comes to understanding how this pandemic has affected African-Americans. Even before Covid-19, black Americans had higher rates of multiple chronic illnesses and a lower life expectancy than white Americans, regardless of weight. This is an indication that our social structures are failing us. These failings — and the accompanying embrace of the belief that black bodies are uniquely flawed — are rooted in a shameful era of American history that took place hundreds of years before this pandemic.

Handout C Documents

Government Agencies/Act Resources

DOCUMENT 22

"Pure Food and Drugs: Images from the History of the Public Health Service," by U.S. National Library of Medicine, January 5, 2012.
https://www.nlm.nih.gov/exhibition/phs_history/foodanddrugs.html

Concern about the purity of food, drink, and medicines goes back at least to the beginning of recorded history. Regulation of food in the United States dates from early colonial times. Federal controls over the drug supply, namely banning the importation of adulterated drugs, started in 1848.

In the last quarter of the 19th century many attempts were made to enact a national food and drug law. Gradually a coalition developed, including farmers, food processors, state officials, physicians, women's club members, and muckraking journalists. Pressure from this powerful lobby together with public alarm over unhygienic conditions in Chicago's meat-packing plants revealed in Upton Sinclair's novel, The Jungle, and confirmed by government investigators, finally pushed Congress to enact, in l906, both a meat inspection law and the Food and Drugs Act. The law forbade adulteration and misbranding of foods, drinks, and drugs in interstate commerce but contained few specific requirements to insure compliance….

In 1902 Dr. Harvey W. Wiley, chief chemist at the U.S. Department of Agriculture and the "human catalyst" who helped coordinate the national campaign for pure food and drugs, started research with human volunteers, officially designated the "Hygienic Table," to determine the effects of food preservatives on digestion and health. Overnight the press made the "Poison Squad" a national sensation. Wiley's research showed that such additives as borax, salicylic acid, and formaldehyde were harmful….

Before the Food and Drugs Act of 1906 prohibited interstate commerce in misbranded and adulterated foods, drinks, and drugs, thousands of questionable remedies, some containing only harmless and inert preparations but many having narcotic drugs and alcohol, were sold everywhere and to anyone, without restriction. They claimed to cure every disease and symptom. Most labels did not declare ingredients, and warnings against misuse were unheard of. What information the public got about these products came from the physician or pharmacist, from hearsay, or sometimes from bitter experience….

Unprocessed foods such as milk, eggs, poultry, and oysters were of particular concern because of unsanitary conditions in many establishments and the primitive nature of refrigeration. Here, inspector John Earnshaw examines eggs. In order to ensure uniform enforcement of the law, an Inspector's Manual was issued in 1908. This manual contained a checklist of conditions to be reported, such as sanitation, the health

of employees, and the use of chemical preservatives and colors, matters which still concern the Food and Drug Administration.

DOCUMENT 23

"About the NIH," by National Institutes on Health, July 8, 2015.
https://www.nih.gov/about-nih/what-we-do/mission-goals

Begun as a one-room Laboratory of Hygiene in 1887, the National Institutes of Health (NIH) today is one of the world's foremost medical research centers. An agency of the Department of Health and Human Services, the NIH is the Federal focal point for health research.

NIH is the steward of medical and behavioral research for the Nation. Its mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.

The goals of the agency are:

- to foster fundamental creative discoveries, innovative research strategies, and their applications as a basis for ultimately protecting and improving health;
- to develop, maintain, and renew scientific human and physical resources that will ensure the Nation's capability to prevent disease;
- to expand the knowledge base in medical and associated sciences in order to enhance the Nation's economic well-being and ensure a continued high return on the public investment in research;
- and to exemplify and promote the highest level of scientific integrity, public accountability, and social responsibility in the conduct of science.

In realizing these goals, the NIH provides leadership and direction to programs designed to improve the health of the Nation by conducting and supporting research:

- in the causes, diagnosis, prevention, and cure of human diseases;
- in the processes of human growth and development;
- in the biological effects of environmental contaminants;
- in the understanding of mental, addictive and physical disorders; and
- in directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

DOCUMENT 24

“Social Security Act (1935),” by U.S. National Archives and Records Administration.
https://www.ourdocuments.gov/print_friendly.php?flash=false&page=&doc=68&title=Social+Security+Act+%281935%29

Before the 1930s, support for the elderly was a matter of local, state and family rather than a Federal concern (except for veterans’ pensions). However, the widespread suffering caused by the Great Depression brought support for numerous proposals for a national old-age insurance system. On January 17, 1935, President Franklin D. Roosevelt sent a message to Congress asking for "social security" legislation. The same day, Senator Robert Wagner of New York and Representative David Lewis of Maryland introduced bills reflecting the administration’s views. The resulting Senate and House bills encountered opposition from those who considered it a governmental invasion of the private sphere and from those who sought exemption from payroll taxes for employers who adopted government-approved pension plans. Eventually the bill passed both houses, and on August 15, 1935, President Roosevelt signed the Social Security Act into law.

The act created a uniquely American solution to the problem of old-age pensions. Unlike many European nations, U.S. social security "insurance" was supported from "contributions" in the form of taxes on individuals’ wages and employers’ payrolls rather than directly from Government funds. The act also provided funds to assist children, the blind, and the unemployed; to institute vocational training programs; and provide family health programs. As a result, enactment of Social Security brought into existence complex administrative challenges. The Social Security Act authorized the Social Security Board to register citizens for benefits, to administer the contributions received by the Federal Government, and to send payments to recipients. Prior to Social Security, the elderly routinely faced the prospect of poverty upon retirement. For the most part, that fear has now dissipated.

DOCUMENT 25

"History," by Centers for Disease Control and Prevention, December 4, 2018. https://www.cdc.gov/about/history/index.html; "Mission, Role, and Pledge," by Centers for Disease Control and Prevention, May 13, 2019. https://www.cdc.gov/about/organization/mission.htm

On July 1, 1946 the Communicable Disease Center (CDC) opened its doors and occupied one floor of a small building in Atlanta. Its primary mission was simple yet highly challenging: prevent malaria from spreading across the nation….

Today, CDC is one of the major operating components of the Department of Health and Human Services and is recognized as the nation's premiere health promotion, prevention, and preparedness agency….

CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise….

CDC's Role:

- Detecting and responding to new and emerging health threats
- Tackling the biggest health problems causing death and disability for Americans
- Putting science and advanced technology into action to prevent disease
- Promoting healthy and safe behaviors, communities and environment
- Developing leaders and training the public health workforce, including disease detectives
- Taking the health pulse of our nation

DOCUMENT 26

U.S. Department of Health and Human Services Overview. Document information sourced from: U.S. Department of Health and Human Services, https://www.hhs.gov/

The U.S. Department of Health and Human Services (HHS) is a federal organization that provides “for effective health and human services and fostering advances in medicine, public health, and social services.” It was formed on April 11, 1953 as the Department of Health, Education, and Welfare. In 1979 the U.S. Department of Education began overseeing all educational functions, at which point the organization was renamed as the Department of Health and Human Services.

HHS is responsible for the oversight of over two dozen other health-based agencies and initiatives, including Medicare, Medicaid, the National Institutes of Health (NIH), the Centers for Disease Control (CDC), and the Food and Drug Administration (FDA).

DOCUMENT 27

"Medicaid Overview," Medicare Rights Center, 2020.
https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-and-medicaid/medicaid-overview

[Signed into law in 1965], Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. Each state runs different Medicaid-funded programs for different groups of people, including:

- Older adults
- People with disabilities
- Children
- Pregnant people
- Parents and/or caretakers of children

All states also have Medicaid programs for people with limited incomes and assets who need nursing home care, long-term care services, and home health care services. Some states also have programs for individual adults who don't fit any of these categories.

Each state uses financial eligibility guidelines to determine whether you are eligible for Medicaid coverage. Generally, your income and assets must be below a certain amount to qualify, but this amount varies from state to state and from program to program. You are eligible for Medicaid if you fall into an eligible group and meet that group's financial eligibility requirements.

If you are eligible for Medicare and Medicaid (dually eligible), you can enroll in both. Medicaid can cover services that Medicare does not, like long-term care. It can also pick up Medicare's out-of-pocket costs (deductibles, coinsurances, copayments).

Some states offer a Medicaid spend-down program or medically needy program for individuals with incomes over their state's eligibility requirements. A spend-down program allows you to deduct your medical expenses from your income so that you can qualify for Medicaid. Contact your local Medicaid office to learn if a spend-down is available in your state.

DOCUMENT 28

"Medicare, a Simple Explanation," by Darlynda Bogle, Social Security Administration, October 24, 2019.
https://blog.ssa.gov/medicare-a-simple-explanation/

Social Security and Medicare are both programs that are household names, but do you know the true difference? Both programs help safeguard millions of Americans as well as improve the quality of life for their family and friends. While Social Security offers retirement, disability, and survivors benefits, Medicare provides health insurance.

[Signed into law in 1965], Medicare is our country's health insurance program for people age 65 or older and younger people receiving Social Security disability benefits. The program helps with the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you want drug coverage, you can join a separate Part D plan. To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage. Examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or from a former employer or union.

Medicare Advantage (also known as Part C)

Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D. Part C plans may have lower out-of-pocket costs than Original Medicare. They also may offer extra benefits that Original Medicare doesn't cover — like vision, hearing, dental, and more.

If you can't afford to pay your Medicare premiums and other medical costs, you may be able to get help from your state. States offer programs for people eligible for or entitled to Medicare who have low income. Some programs may pay for Medicare premiums and some pay Medicare deductibles and coinsurance. To qualify, you must have limited income and resources.

DOCUMENT 29

"The Ryan White HIV/AIDS Program: The Basics," by Kaiser Family Foundation, February 4, 2019.
https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/

The Ryan White HIV/AIDS Program (Ryan White), the largest federal program designed specifically for people with HIV in the United States, serves over half of those in the country diagnosed with the disease. First enacted in 1990, the Ryan White Program has played an increasingly critical role as the number of people living with HIV has grown over time and people with HIV are living longer. It provides outpatient care and support services to individuals and families affected by the disease, functioning as the "payer of last resort" by filling the gaps for those who have no other source of coverage or face coverage limits…

The Ryan White HIV/AIDS Program, first enacted as an emergency measure, has grown to become a central component of HIV care in the U.S., playing a critical role in the lives of low and moderate-income people with HIV who have little or no access through other sources. Looking ahead, there are several key issues facing the program:

- As a federal grant program, its funding depends on annual appropriations by Congress, and funding levels do not necessarily correspond to actual need including the number of people who need services or the costs of services. As a result, historically, not all states and communities have been able to meet the needs of their jurisdictions. For these reasons, monitoring appropriations allocations and any cuts enacted by Congress will be important going forward.
- It will be critical to assess how future reauthorization impact structure and financing of the program….

DOCUMENT 30

"Obamacare Explained, " by Kimberly Amadeo, The Balance, July 24, 2020.
https://www.thebalance.com/obamacare-explained-3306058

In 2010, President Barack Obama and Congress created Obamacare. Why? They wanted to make sure all Americans were able to get health insurance. More important, they wanted to lower the cost of health care. That would reduce the growing cost of Medicare and Medicaid. Those two programs threaten to take over the entire federal budget….

Anyone can compare plans on the exchanges, which are websites run by the state or the federal government. These exchanges also let people know when they qualify for tax credits. Obamacare is paying for most of the cost of operating these exchanges….

People With Health Insurance - Here's six ways Obamacare improved your family's health insurance.

1. Parents can add their adult children (up to age 26) to their plans.
2. If anyone gets sick, the insurance company can't drop them from the plan or limit how much insurance your family uses.
3. If anyone is chronically ill, a new insurance company can't deny coverage.
4. Wellness and pregnancy exams are now free. That includes copayments.
5. Insurance companies can't raise premium payments without approval from state governments....

People Without Health Insurance - Open enrollment on the health care exchanges is usually from November 1 to December 15 each year. If you miss the enrollment period, you may still be able to get short-term insurance…..

Obamacare allows more people to get Medicaid. The eligible income is 138% of the federal poverty level. The exact income level varies by state….

Most families that make too much to get Medicaid will still get help. They can get subsidies every month or even reduced copayments and deductibles. This eligible income is 400% of the poverty level, and it increases with inflation each year….

People on Medicare - Obamacare allows seniors with Medicare to receive wellness and preventive care visits for free. Medicare provides a list of all preventive services that it covers.

ACTIVITY III: Taking Informed Action To Redress Health Inequities

DOCUMENT 31

"Testimony of Ibram X. Kendi, PhD: The Disproportionate Impact of COVID-19 on Communities of Color," House Ways and Means Committee, May 27, 2020.
https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Kendi_Testimony.pdf

As a historian, I must take you back in time. To 1896. To a major racial text issued that year. . . . Frederick Hoffman's Race Traits and Tendencies of the American Negro. . .

Hoffman showed higher Black death rates and that Black Americans were more infected with syphilis, tuberculosis, and other infectious diseases—death and infection disparities reflecting today with COVID-19. . . .

As of Monday, Black Americans are dying at nearly two times their national population share.5 In five out of the six counties with the highest death rates, Black Americans are the largest racial group. In Alaska, the Asian American case rate is double their population. In Hawaii, Native Hawaiians and Pacific Islanders make up 10% of the population, but 17% of the cases. In Arizona, Native American case and death rates are five times their population.6 In D.C. and 41 states, Latino Americans are disproportionately testing positive for the coronavirus, according to the COVID Racial Data Tracker.

This is the racial pandemic within the viral pandemic—older than 1896—as new as COVID-19. . . .

In April, many Americans were choosing the racist explanation; saying people of color were not taking the virus as seriously as White people—until challenged by survey data and majority White demonstrations to reopen states. Then the racist explanation zeroed in on Black underlying illnesses due to unhealthy behavior as if all races do not engage in unhealthy behavior. But according to the Foundation for AIDS Research, employment, access to health insurance and medical care, as well as neighborhood pollution are more predictive of Black infections and deaths than underlying illnesses like heart disease and diabetes.

We should be asking: why are Black and Latino people less likely to be working from home; less likely to be insured; less likely to live in unpolluted neighborhoods? The answer is racist policy.

Will policymakers turn away as people of color suffer . . . —all the while blaming them for their own suffering—all the while adding to the racist history of their suffering? Or will policymakers be antiracist? Meaning no longer blaming people of color for disparities. And focused on pushing policy that leads to equity and justice for all.

DOCUMENT 32

"Left Out: Barriers to Health Equity for Rural and Underserved Communities," Report of the Committee on Ways and Means Majority, U.S. House of Representatives, July 2020

https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report_07.2020_FINAL.pdf

The United States (U.S.) spends almost twice as much on health care as other developed countries, yet our population continues to have worse outcomes. Underserved communities, whether rural or urban, face a complex set of challenges related to public health and health care delivery. From aging infrastructure, economic disinvestment, workforce shortages, and environmental challenges to higher burdens of chronic conditions, residents of underserved communities endure many circumstances that make it difficult to live healthy lives.

Achieving health equity in the U.S. requires all Americans to have the opportunity to attain their highest level of health and not be disadvantaged because of avoidable, unfair, or remediable differences among the communities they call home. . . .Residents of these communities also cope with a higher burden of disease and lower life expectancy, being more likely to die prematurely from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than individuals living in areas with greater access to health resources. For non-White residents in these communities, health status and outcomes are often exponentially worse than their White counterparts. . . .

The health and economic crisis stemming from the novel coronavirus (COVID-19) crisis has magnified the systemic barriers to health and how they are particularly worse for marginalized groups. Though past and current efforts have focused on addressing health outcomes – racial and geographic health disparities – today's social climate demands that stakeholders acknowledge how systemic racism and economic inequality are drivers of health inequities, which, in turn, perpetuate disparities. . . .

The United States spends the most money per capita on health care compared to all other Organization for Economic Cooperation and Development (OECD) countries – nearly double the OECD average in 2017 – yet the return on this investment is markedly poor, as Americans today are less healthy than previous generations and their OECD counterparts….

Many Americans struggle to access preventive and primary care and often only link to care upon being diagnosed with a chronic condition, such as obesity and diabetes. Chronic conditions are the primary driver of healthcare costs, plaguing millions of Americans – 60 percent of adults live with one chronic disease, and 40 percent of adults have two or more conditions…..

Communication and language barriers are yet another key challenge in delivering health care in both rural and urban underserved communities. These barriers are associated with patients having poorer care and clinical outcomes….

Life expectancy metrics can vary drastically by geography, but are useful in examining how environmental, political, socioeconomic, and structural conditions impact health….

The Social and Structural Determinants of Health

The most upstream non-medical drivers of health outcomes are structural in nature. These structural drivers represent the difference in the accessibility of goods, services, and opportunities by race (structural racism), gender (structural sexism), class (structural classism)....

The non-medical social conditions in which people are born, live, work, worship, and age – often called "social determinants of health" (SDH) – are also fundamental to good health. SDH include access to reliable income, stable housing, food security, high-quality education from an early age, stable employment, absence of physical violence, and others.

Behaviors

Health behaviors, such as substance use, diet and exercise, and sexual health practices, continue to influence health outcomes and are modifiable at a structural policy level. Perhaps the most powerful example of policy influencing health behaviors is federal regulation of the tobacco industry and its resultant impact in decreasing rates of smoking, cancer, and lung disease. Since a 1964 Surgeon General report linking smoking to disease, smoking rates among Americans are 2.3 times lower today; one study estimated that this decline has prevented eight million deaths.

Access to Food

Food deserts – areas with limited access to healthy food – are another example of how policy influences behaviors, such as the ability to follow a healthy diet. Supermarket availability is a proxy for food stability, yet a recent study found that low-income census tracts had half as many supermarkets as wealthier tracts. Less access to food due to distance or affordability, is a key contributing factor to the higher burden of chronic disease in affected areas….

Clean Air and Water

Perhaps one of the most underappreciated conditions that has the potential to heavily influence positive health outcomes is one's physical environment. Without a healthy environment, including safe air and safe water, communities are at enhanced risk of communicable diseases, chronic lung conditions, and chronic disease related to poor air quality…

Transportation

From road maintenance and safety to ambulance accessibility, road and transportation infrastructure is also a critical determinant of health….

Broadband

Expansion of access to health care, social and other related services through technology depends on the availability of affordable broadband internet….

Health Insurance Coverage

Health insurance coverage drives health care access for most Americans, including residents of rural and underserved communities. According to the Census Bureau's September 2019 report, there were approximately 27.5 million uninsured Americans

(8.5 percent of the population) as of 2018, which increased from 25.6 million uninsured people in 2017….

Workforce

. . . One of the largest barriers to health care delivery in underserved rural and urban communities is the widespread shortage of providers. The necessary components of an effective health workforce include: availability, accessibility, acceptability, service utilization, and quality….

Similar to primary care, a majority of the country faces behavioral health provider shortfalls. A well-rounded behavioral health workforce would in theory feature streamlined coordination between primary care providers and mental health professionals with teams comprised of a range of providers accessible face-to-face and via telehealth. Such providers could include: licensed clinical providers (e.g., primary care physicians, psychiatrists, psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, marriage and family therapists, and licensed addiction counselors) and certified providers (e.g., certified addiction counselors, prevention specialists, peer recovery specialists), as well as non-certified providers, such as psychiatric aides. But in reality, the majority of Americans face a convoluted system with a dearth of providers….

Public Health and Disaster Preparedness

There is perhaps no better bellwether of the strength and resilience of a community's health infrastructure than the status of its public health and disaster preparedness systems. Most recently, this fact has been demonstrated in the spread of COVID-19 and was previously seen through other more localized emergencies, such as Hurricanes Katrina in the Gulf Coast region, Sandy in the Northeast, and Maria and Dorian; earthquakes in the western U.S., Puerto Rico and the Caribbean; fires in California; floods along the Mississippi River; and tornados across the Midwest.

Figure A. Examples of Non-Medical Factors Presenting Health Challenges in Underserved Rural and Urban Communities

Transportation	Poverty/Unemployment
Food deserts	Structural Racism and Xenophobia
Education/literacy	Social isolation
Air quality	Physical Violence
Geography/Topography	Infrastructure (e.g., Broadband)
Housing	Classism
Language Preference	Homophobia

DOCUMENT 33

"The Fullest Look Yet at the Racial Inequity of Coronavirus," by Richard A. Oppel, et al., New York Times. July 5, 2020. https://nyti.ms/3f286n9

...[T]he new federal data — made available after The New York Times sued the Centers for Disease Control and Prevention — reveals a clearer and more complete picture: Black and Latino people have been disproportionately affected by the coronavirus in a widespread manner that spans the country, throughout hundreds of counties in urban, suburban and rural areas, and across all age groups.

Latino and African-American residents of the United States have been three times as likely to become infected as their white neighbors, according to the new data, which provides detailed characteristics of 640,000 infections detected in nearly 1,000 U.S. counties. And Black and Latino people have been nearly twice as likely to die from the virus as white people, the data shows….

The data also showed several pockets of disparity involving Native American people. In much of Arizona and in several other counties, they were far more likely to become infected than white people. For people who are Asian, the disparities were generally not as large, though they were 1.3 times as likely as their white neighbors to become infected….

....In Kent County, which includes Grand Rapids and its suburbs, Black and Latino residents account for 63 percent of infections, though they make up just 20 percent of the county's population. Public health officials and elected leaders in Michigan said there was no clear reason Black and Latino people in Kent County were even more adversely affected than in other parts of the country….

Experts point to circumstances that have made Black and Latino people more likely than white people to be exposed to the virus: Many of them have front-line jobs that keep them from working at home; rely on public transportation; or live in cramped apartments or multigenerational homes….

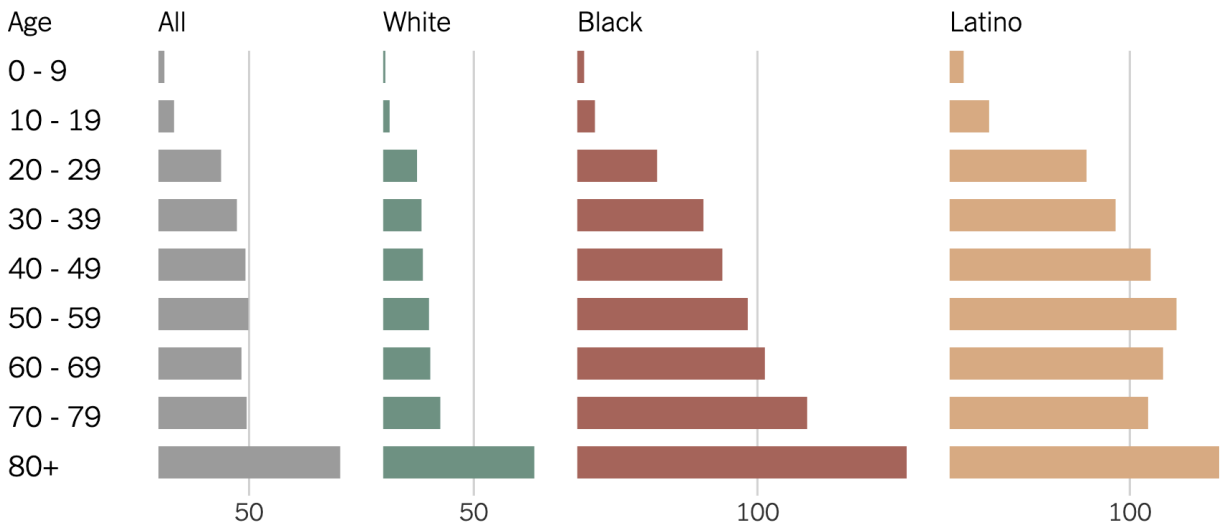
At Culmore Clinic, an interfaith free clinic serving low-income adults in Fairfax, about half of the 79 Latino patients who tested for the virus have been positive.

"This is a very wealthy county, but their needs are invisible," said Terry O'Hara Lavoie, a co-founder of the clinic. The risk of getting sick from tight living quarters, she added, is compounded by the pressure to keep working or quickly return to work, even in risky settings.

The risks are borne out by demographic data. Across the country, 43 percent of Black and Latino workers are employed in service or production jobs that for the most part cannot be done remotely, census data from 2018 shows. Only about one in four white workers held such jobs.

Also, Latino people are twice as likely to reside in a crowded dwelling — less than 500 square feet per person — as white people, according to the American Housing Survey….

Coronavirus cases per 10,000 people, by age and race



Source: Centers for Disease Control and Prevention | Note: Data is through May 28.

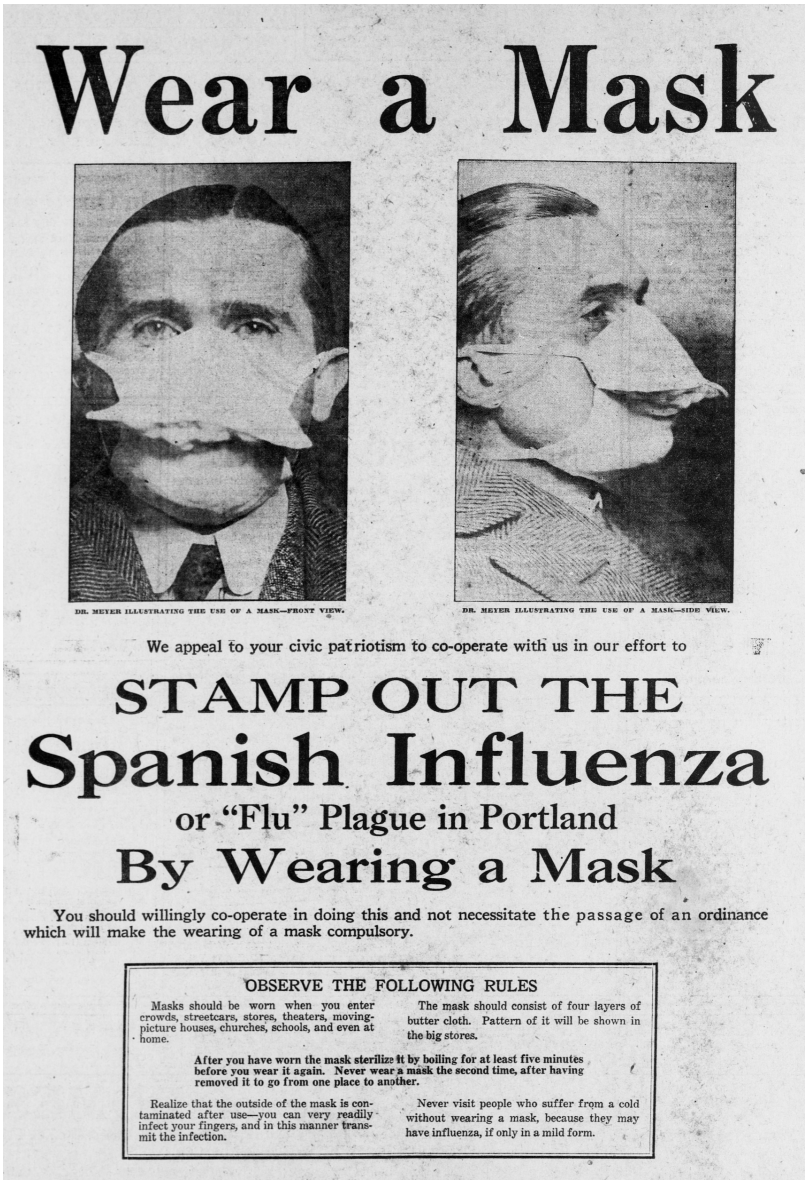
The higher rate in deaths from the virus among Black and Latino people has been explained, in part, by a higher prevalence of underlying health problems, including diabetes and obesity. But the new C.D.C. data reveals a significant imbalance in the number of virus cases, not just deaths — a fact that scientists say underscores inequities unrelated to other health issues.

The focus on comorbidities “makes me angry, because this really is about who still has to leave their home to work, who has to leave a crowded apartment, get on crowded transport, and go to a crowded workplace, and we just haven’t acknowledged that those of us who have the privilege of continuing to work from our homes aren’t facing those risks,” said Dr. Mary Bassett, the Director of the FXB Center for Health and Human Rights at Harvard University….

Extension Activity: Comparing Public Awareness Posters for Pandemics

DOCUMENT 34A: SPANISH FLU AND COVID-19 COMPARISON

Advertisement, "Wear a Mask," ***The Sunday Oregonian,*** **January 12, 1919.**
https://oregonnews.uoregon.edu/lccn/sn83045782/1919-01-12/ed-1/seq-23/



Wear a Mask

DR. MEYER ILLUSTRATING THE USE OF A MASK—FRONT VIEW.

DR. MEYER ILLUSTRATING THE USE OF A MASK—SIDE VIEW.

We appeal to your civic patriotism to co-operate with us in our effort to

STAMP OUT THE

Spanish Influenza

or "Flu" Plague in Portland

By Wearing a Mask

You should willingly co-operate in doing this and not necessitate the passage of an ordinance which will make the wearing of a mask compulsory.

OBSERVE THE FOLLOWING RULES

Masks should be worn when you enter crowds, streetcars, stores, theaters, moving-picture houses, churches, schools, and even at home.

The mask should consist of four layers of butter cloth. Pattern of it will be shown in the big stores.

After you have worn the mask sterilize it by boiling for at least five minutes before you wear it again. Never wear a mask the second time, after having removed it to go from one place to another.

Realize that the outside of the mask is contaminated after use—you can very readily infect your fingers, and in this manner transmit the infection.

Never visit people who suffer from a cold without wearing a mask, because they may have influenza, if only in a mild form.

Small text reads:

“You should willingly co-operate in doing this and not necessitate the passage of an ordinance which will make the wearing of a mask compulsory.

OBSERVE THE FOLLOWING RULES:

- *Masks should be worn when you enter crowds, streetcars, stores, theaters, moving-pictUre houses, churches, schools, and even at home.*
- *The mask should consist of four layers of butter cloth. Pattern of it will be shown in the big stores.*
- *After you have worn the mask sterilize it by boiling for at least five minutes before you wear it again.*
- *Never wear a mask the second time, after having removed it to go from one place to another.*
- *Realize that the outside of the mask is contaminated after use-you can very readily infect your fingers, and in the manner transmit the infection.*
- *Never visit people who suffer from a cold without wearing a mask, because they may have influenza, if only in a mild form.*

Signed: The Consolidated Health Bureaus by E.A. Sommer, Director-General.

DOCUMENT 34B: SPANISH FLU AND COVID-19 COMPARISON

Infographic, "How to Wear a Non-Medical Fabric Mask Safely," *World Health Organization,* June 19, 2020.
https://www.who.int/images/default-source/health-topics/coronavirus/clothing-masks-infographic--web---part-1.png?sfvrsn=679fb6f1_26

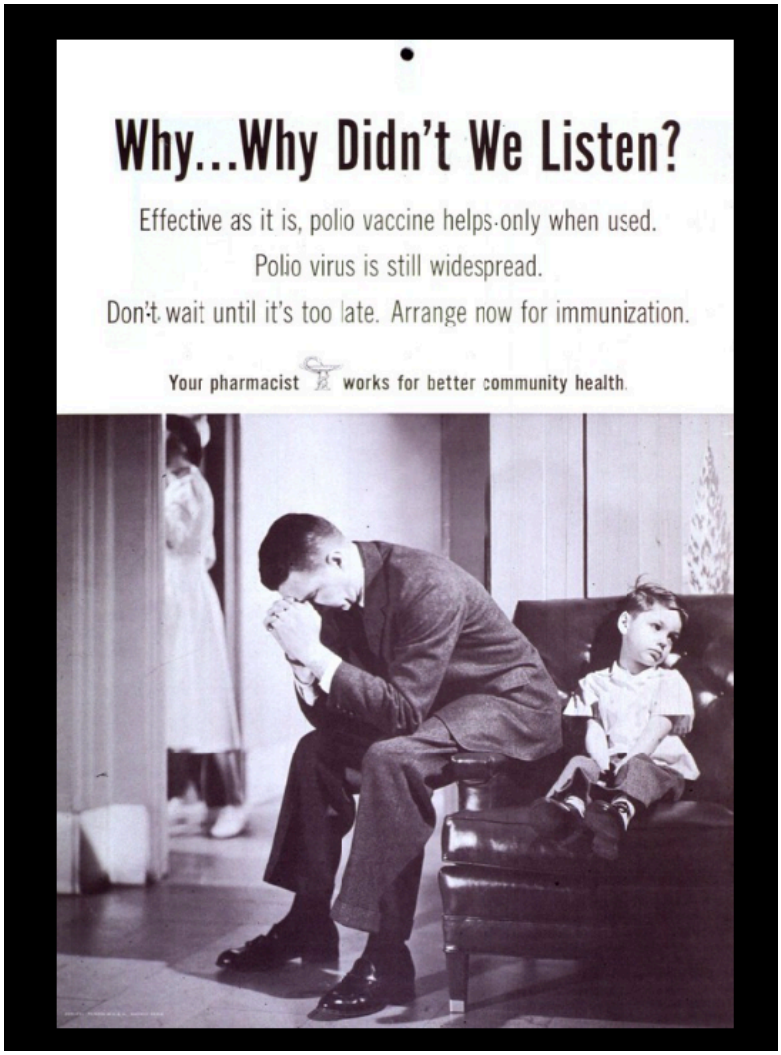
Small text reads:

- *Clean your hands before touching the mask.*
- *Inspect the mask for damage or if dirty.*
- *Adjust the mask to your face without leaving gaps on the sides.*
- *Cover your mouth, nose, and chin.*
- *Avoid touching the mask.*

- *Clean your hands before removing the mask.*
- *Remove the mask by the straps behind the ears or head.*
- *Pull the mask away from your face.*
- *Store the mask in a clean plastic, resealable bag if it is not dirty or wet and you plan to re-use it.*
- *Remove the mask by the straps when taking it out of the bag.*
- *Wash the mask in soap or detergent, preferably with hot water, at least once a day.*
- *Clean your hands after removing the mask.*

DOCUMENT 35A: POLIO AND COVID-19 COMPARISON

Poster, "Why Didn't We Listen?" maker unknown, circa 1955.
https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101454762-img

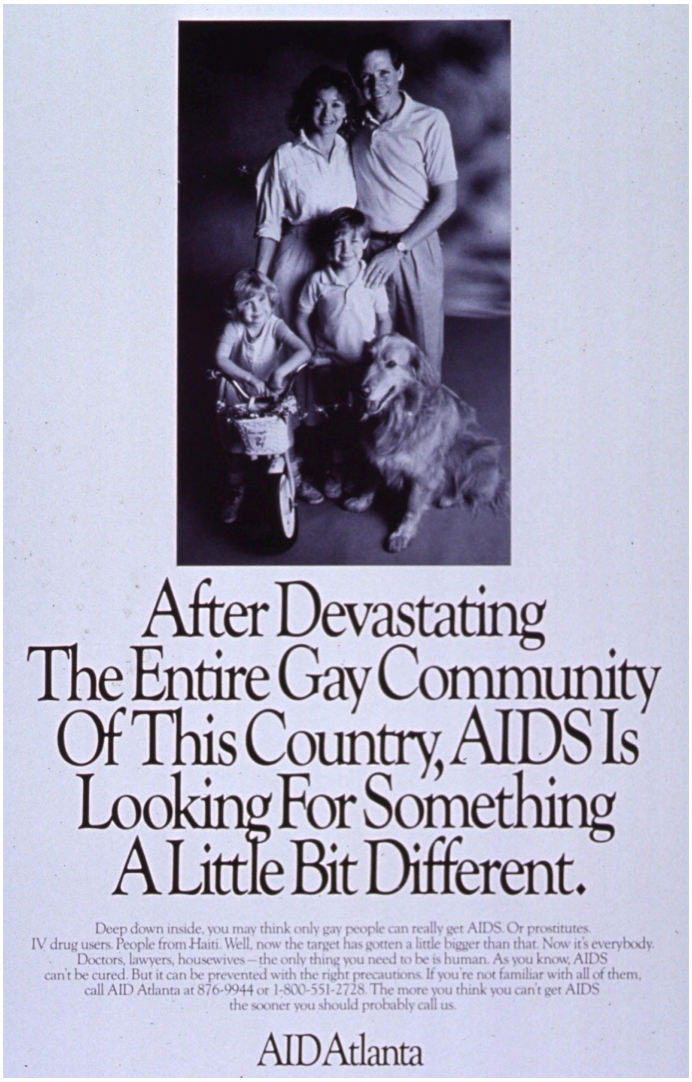


DOCUMENT 35B: POLIO AND COVID-19 COMPARISON

Advertisement, "Together We Won't Stop Protecting Children," UNICEF, July 2020. https://www.unicefusa.org/mission/covid-19

DOCUMENT 36A: HIV/AIDS AND COVID-19 COMPARISON

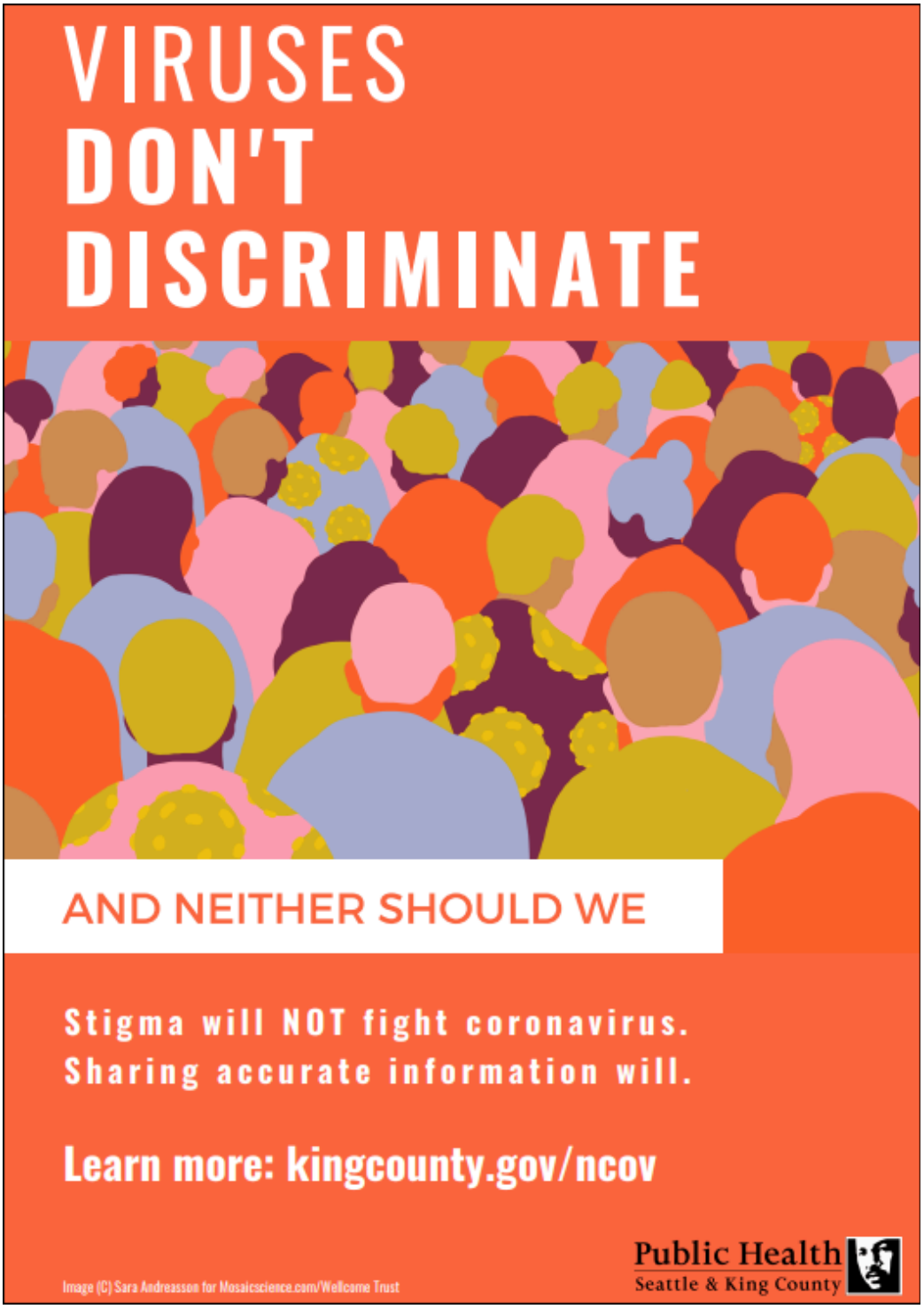
Advertisement, "After Devastating…," AID Atlanta, circa 1980s.
https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101438788-img



Small text reads:
Deep down inside, you may think only gay people can really get AIDS. Or prostitutes. IV drug users. People from Haiti. Well, now the target has gotten a little bigger than that. Now it's everybody. Doctors, lawyers, housewives-the only thing you need to be is human. As you know, AIDS can't be cured. But it can be prevented with the right precautions. If you're not familiar with all of them, call AID Atlanta at 876-9944 or 1-800-551-2728. The more you think you can't get AIDS the sooner you should probably call us.

DOCUMENT 36B: HIV/AIDS AND COVID-19 COMPARISON

Poster, "Viruses Don't Discriminate," King County Washington Department of Health, 2020. https://kingcounty.gov/depts/health/covid-19/care/anti-stigma.aspx



OWN YOUR HISTORY®

Health Crises and Health Inequities in the United States, 1900-Present

Appendix II
Additional Resources

Description:

Below are documents and resources that students and teachers can consult for additional background information related to the module. Articles are listed topically. This appendix is neither comprehensive nor exhaustive, but is meant to serve as a starting point for students and teachers wanting to learn more about healthcare, health crises and health inequities in the United States. The full version of each document can be accessed by clicking on the link provided.

ADDICTION

- “How The Opioid Epidemic Became America’s Worst Drug Crisis Ever, In 15 Maps And Charts,” by Sarah Frostenson and German Lopez, Vox, March 29, 2017. https://www.vox.com/science-and-health/2017/3/23/14987892/opioid-heroin-epidemic-charts

ASIAN AMERICANS AND PACIFIC ISLANDERS

- “Testimony on The Disproportionate Impact of Covid-19 on Communities of Color,” by Douglas Holtz-Eakin, House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Holtz-Eakin_Testimony.pdf
- “Field Lessons: Chinese Immigrants Face Huge Challenges In Getting Access To Health Care,” by Peiwen Jing, Center for Health Journalism, USC, October 11, 2016. https://www.centerforhealthjournalism.org/2016/10/09/chinese-immigrants-face-huge-challenges-getting-access-health-care.
- “Addressing Health Disparities Among Older Asian-Americans: Data and Diversity,” by Grace J. Yoo, Elaine Musselman, Yeon-Shim Lee, and Darlene Yee-Melichar, American Society on Aging. https://www.asaging.org/blog/addressing-health-disparities-among-older-asian-americans-data-and-diversity
- “Statement of Raynald Albert Samoa, M.D,” House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Samoa_Testimony.pdf

BLACK AMERICANS

- “Why Are Black Women At Such High Risk Of Dying From Pregnancy Complications?” American Heart Association News, February 20, 2019. https://www.heart.org/en/news/2019/02/20/why-are-black-women-at-such-high-risk-of-dying-from-pregnancy-complications
- “U.S. Pregnancy Deaths Are Up, Especially Among Black Women,” by The Associated Press, NBC News, May 9, 2019. https://www.nbcnews.com/news/nbcblk/us-pregnancy-deaths-are-especially-among-black-women-n1003806
- “Charles Hudson Bynum Biography,” by David Rose, The March of Dimes Archive, February 24, 2011. http://www.polioplace.org/people/charles-hudson-bynum
- “The Burdens of Race and History on Black People’s Health 400 Years After Jamestown,” Erica Casper and Stephen B. Thomas, American Journal of Public Health, September 19, 2019. https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305290

- “Racial Health Disparities Already Existed In America— The Coronavirus Just Exacerbated Them,” by Courtney Connley, CNBC, May 15, 2020. https://www.cnbc.com/2020/05/14/how-covid-19-exacerbated-americas-racial-health-disparities.html
- “Racism and Medicine,” by Austin Frakt, New York Times, January 13, 2020. https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html
- “Ways & Means Committee Hearing Written Testimony,” by James E.K. Hildreth, House Ways and Means Committee. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Hildreth_Testimony.pdf
- “African-Americans, Vaccines and a History of Suspicion,” by D. Amari Jackson, Atlanta Black Star, April 26, 2017. https://atlantablackstar.com/2017/04/26/african-americans-vaccines-history-suspicion/
- “Suicide Attempts Among Black Children And Teens Increasing At Alarming Rates, Study Finds,” Ayanna Runchie, CBS News, October 14, 2019. https://www.cbsnews.com/news/suicide-attempts-increasing-among-black-children-and-teens/
- “Myths About Physical Racial Differences Were Used To Justify Slavery-and Are Still Believed By Doctors Today,” by Linda Villarosa, New York Times, August 14, 2019. https://nyti.ms/38RE95Y
- “The 1910 Report That Disadvantaged Minority Doctors,” by Jessie Wright-Mendoza, J-STOR Daily, May 3, 2019. https://daily.jstor.org/the-1910-report-that-unintentionally-disadvantaged-minority-doctos/

COVID-19/CORONAVIRUS

- “U.S. Response to COVID-19 is Worse than China’s. 100 Times Worse,” by Dean T. Jamison and Gavin Yamey, Time, June 10, 2020. https://time.com/5850680/u-s-response-covid-19-worse-than-chinas/
- “Socially Distanced Medicine,” by Allison Bond, American Medical Association, June 16, 2020. https://jamanetwork.com/journals/jama/fullarticle/2767164
- “The Price Of Being ‘Essential’: Latino Service Workers Bear The Brunt Of Coronavirus,” by Andrew J. Campa, Hailey Branson-Potts, and Alejandra Reyes-Velarde. Los Angeles Times, May 17, 2020. https://www.latimes.com/california/story/2020-05-17/latino-essential-workers-coronavirus
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- “U.S. Government Response To COVID-19 Was Slow. But How Does It Compare To Other Countries?” by Jacquelyn Corley, Forbes, April 10, 2020.

https://www.forbes.com/sites/jacquelyncorley/2020/04/10/us-government-response-to-covid-19-was-slow-but-how-does-it-compare-to-other-countries/#734609196dc2
- "For Many San Franciscans, Covid-19 Recalls The HIV Crisis — And That May Have Helped The City Respond," by Christina Farr, CNBC, May 10, 2020. https://www.cnbc.com/2020/05/10/san-francisco-covid-19-response-may-be-guided-by-1980s-hiv-experience.html
- "Testimony," [Latino and immigrant disparities] by Alicia Fernandez, House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Fernandez_Testimony.pdf
- "Testimony," [Black Medical Schools] by James E.K. Hildreth, House Ways and Means Committee. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Hildreth_Testimony.pdf
- "Testimony on The Disproportionate Impact of Covid-19 on Communities of Color," by Douglas Holtz-Eakin, House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Holtz-Eakin_Testimony.pdf
- "What the History of Polio Can Teach Us About COVID-19," by Jeffrey Kluger, Time, May 5, 2020. https://time.com/5831740/polio-coronavirus-parallels/
- "The Deadly Polio Epidemic and Why It Matters for Coronavirus," Carl Kurlander Discover Magazine, April 2, 2020. https://www.discovermagazine.com/health/the-deadly-polio-epidemic-and-why-it-matters-for-coronavirus
- "Native American Tribes' Pandemic Response Is Hamstrung By Inequities," by Stephanie Mallin, Joshua Sbicca, and Lindsay Scheider, The Conversation, May 7, 2020. https://theconversation.com/native-american-tribes-pandemic-response-is-hamstrung-by-many-inequities-136225
- "How Many Needless Covid-19 Deaths Were Caused By Delays In Responding? Most Of Them," by James K. Sebenius and Isaac Senenius, STAT, June 19, 2020. https://www.statnews.com/2020/06/19/faster-response-prevented-most-us-covid-19-deaths/
- "Polio Epidemic Offers Guidance for Getting Through Covid-19," by Robin Young, WBUR, March 16, 2020. https://www.wbur.org/hereandnow/2020/03/16/polio-epidemic-covid-19-coronavirus

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- "Field Lessons: Chinese Immigrants Face Huge Challenges In Getting Access To Health Care," by Peiwen Jing, USC Center for Health Journalism, October 11, 2016. https://www.centerforhealthjournalism.org/2016/10/09/chinese-immigrants-face-huge-challenges-getting-access-health-care.

- “Testimony,” by Thomas Sequist, House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Sequist_Testimony.pdf
- “How Medicare Was Made,” by Julian E. Zelizer, New Yorker, February 15, 2015. https://www.newyorker.com/news/news-desk/medicare-made

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- “America’s HIV Outbreak Started In This City, 10 Years Before Anyone Noticed,” by Nsikan Akpan, PBS Newshour, October 26, 2016. https://www.pbs.org/newshour/science/america-hiv-outbreak-origins-nyc-gaetan-dugas
- “Cultural Perspectives on Vaccinations, ” The College of Physicians of Philadelphia. January 10, 2018. https://www.historyofvaccines.org/content/articles/cultural-perspectives-vaccination

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- “How America Has Racialized Medicine During Epidemics,” by Brentin Mock, Bloomberg CityLab, April 14, 2020. https://www.citylab.com/environment/2020/04/coronavirus-health-impacts-black-people-mab-segrest-book/609910/
- “Field Lessons: Chinese Immigrants Face Huge Challenges In Getting Access To Health Care,” by Peiwen Jing, Center for Health Journalism, USC, October 11, 2016. https://www.centerforhealthjournalism.org/2016/10/09/chinese-immigrants-face-huge-challenges-getting-access-health-care.
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- “What are Medicare and Medicaid?” by Nicole Galan, Medical News Today, March 3, 2020. https://www.medicalnewstoday.com/articles/323858

- “Health Care Reform and Social Movements in the United States,” Beatrix Hoffman, American Journal of Public Health 93, no.1 (January 2003): 75-85. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447696/
- “The Struggle Over Employee Benefits: The Role of Labor in Influencing Modern Health,” by Gerald Markowitz and David Rosner, The Milbank Quarterly 81, no. 1 (2003): 45-73. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690201/pdf/milq0081-0045.pdf
- “Native Americans Feel Invisible In U.S. Health Care System,” by Eric Whitney, NPR, December 12, 2017. https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system
- “How Medicare Was Made,” by Julian E. Zelizer, New Yorker, February 15, 2015. https://www.newyorker.com/news/news-desk/medicare-made
- “The High Cost of Insulin in the United States: An Urgent Call to Action,” by S. Vincent Rajkumar, Mayo Clinic, January 1, 2020. https://www.mayoclinicproceedings.org/article/S0025-6196(19)31008-0/fulltext

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- “The Price Of Being ‘Essential’: Latino Service Workers Bear The Brunt Of Coronavirus,” by Andrew J. Campa, Hailey Branson-Potts, and Alejandra Reyes-Velarde. Los Angeles Times, May 17, 2020. https://www.latimes.com/california/story/2020-05-17/latino-essential-workers-coronavirus
- “Testimony,” by Alicia Fernandez, House Ways and Means Committee, May 27, 2020. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Fernandez_Testimony.pdf
- “CDC Releases 1st National Study On Latino Health Risks, Causes of Death,” by Patricia Guadalupe, NBC News, May 5, 2015. https://www.nbcnews.com/news/latino/cdc-releases-1st-natl-study-latino-health-risks-causes-death-n354001
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Health Crises and Health Inequities in the United States, 1900-Present

Appendix III California CCSS Standards and C3 Framework

Description:

Below are the specific standards that this module satisfies for California CCSS Standards and C3 Framework (Connections to California Common Core State Standards for English Language Arts & Literacy in History/Social Science and The College, Career, and Civic Life (C3) Framework for Social Studies State Standards).

California Common Core State Standards: English Language Arts & Literacy in History/Social Studies, Science, and Technical Subjects. **(March, 2013)**	***The College, Career, and Civic Life (C3) Framework for Social Studies State Standards: Guidance for Enhancing the Rigor of K-12 Civics, Economics, Geography, and History*.—NCSS**
● Cite strong and thorough textual evidence to support analysis of what the text says explicitly as well as inferences drawn from the text, including determining where the text leaves matters uncertain. (RI.11-12.1) ● Analyze a complex set of ideas or sequence of events and explain how specific individuals, ideas, or events interact and develop over the course of the text. (RI.11-12.3) ● Integrate and evaluate multiple sources of information presented in different media or formats (e.g., visually, quantitatively) as well as in words in order to address a question or solve a problem. (RI.11-12.7) ● Conduct short as well as more sustained research projects to answer a question (including a self-generated question) or solve a problem; narrow or broaden the inquiry when appropriate; synthesize multiple sources on the subject, demonstrating understanding of the subject under investigation. (W.11-12.7) ● Initiate and participate effectively in a range of collaborative discussions (one-on- one, in groups, and teacher-led) with diverse partners on grades 11–12 topics, texts, and issues, building on others' ideas and expressing their own clearly and persuasively. (SL.11-12.1)	● D2.His.1.9-12. Evaluate how historical events and developments were shaped by unique circumstances of time and place as well as broader historical contexts. D2.His.3.9-12. Use questions generated about individuals and groups to assess how the significance of their actions changes over time and is shaped by the historical context. ● D2.His.5.9-12. Analyze how historical contexts shaped and continue to shape people's perspectives. ● D2.His.14.9-12. Analyze multiple and complex causes and effects of events in the past. ● D2.His.15.9-12. Distinguish between long-term causes and triggering events in developing a historical argument.

● Cite specific textual evidence to support analysis of primary and secondary sources, connecting insights gained from specific details to an understanding of the text as a whole. (RH.11-12.1) ● Determine the central ideas or information of a primary or secondary source; provide an accurate summary that makes clear the relationships among the key details and ideas. (RH.11-12.2) ● Evaluate an author's premises, claims, and evidence by corroborating or challenging them with other information. (RH.11-12.8) ● Integrate information from diverse sources, both primary and secondary, into a coherent understanding of an idea or event, noting discrepancies among sources. (RH.11-12.9)	

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Appendix IV
Extension Activity

EXTENSION ACTIVITY: Comparing Public Awareness Posters for Pandemics

Background:
Posters, advertisements, infographics, and internet memes all may be effective tools for communicating important information about healthcare and illness. These can help educate the public about disease prevention and important safety measures. At the same time, they may also incorporate stereotypes or underlying messages on matters of color, ethnicity, sexual orientation, socioeconomic class, or family structure. In this extension activity, students will critically analyze and compare contemporary COVID-19 posters with posters about the Spanish flu, polio, and HIV/AIDS.

NOTE: It is suggested that students begin this extension activity after completing Activity II in the module. A brief review of the readings and handouts from Day One and Day Two may be a helpful warm-up.

Suggested Time Frame: One 50-minute class period

Keywords: COVID-19; polio; Spanish flu; HIV; AIDS; discrimination; disease prevention; health

Supporting Questions:

1. How have health related posters and advertisements been used during the 20th and 21st centuries?
2. What messages, both explicit and implicit, do these images present?
3. How do these posters and advertisements help us understand health inequities in the United States?

Procedures:

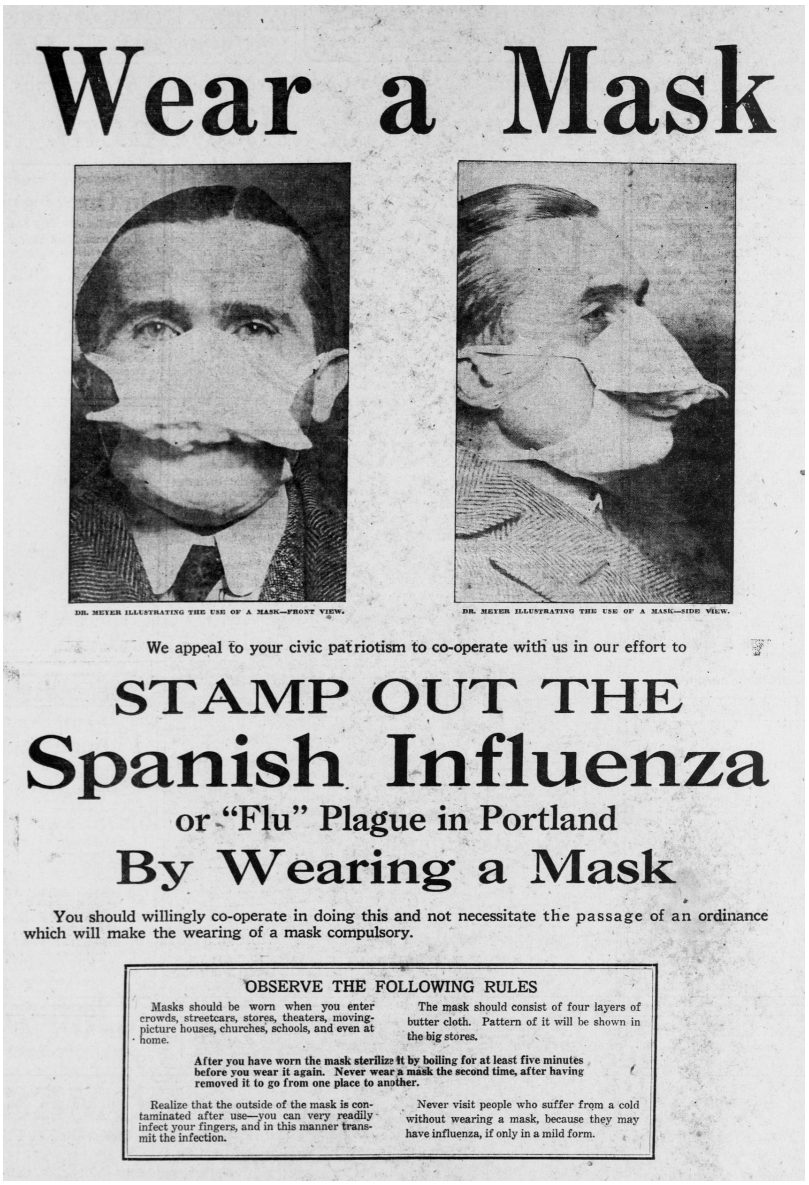
1. Divide students into three groups.
2. Distribute **Documents 34A/B, 35A/B, or 36A/B** to one group each.
3. Give students a few minutes to analyze their assigned images individually. Encourage them to take notes about what jumps out at them.
4. Have each group meet together and discuss answers the following questions:
    a. Who appears to be the target audience(s) of each poster? (i.e. children; middle class adults; healthcare professionals; a particular ethnic and/or social community, etc.)
    b. Describe the people featured in the poster. What do you notice about them? Would you describe the people in the poster as meant to represent various racial, social, or economic backgrounds? Why or why not?
    c. What do you know about the persons or organization that created the poster/advertisement? What do you think their goal and intent were?
    d. What type of information or message is the poster conveying? (i.e. informative, opinion, etc.) Do you think it is effective and persuasive?
    e. Do any of the posters contain biased or discriminatory language, messages, or perspectives? If so, what kind of biases or discrimination are present (ethnic, racial, socio-ecnomic class, religious group, etc.) Are there any groups or communities that this poster appears to exclude for a discriminatory purpose?
    f. How does the poster make you feel? (i.e. scared, empowered, informed, nervous, curious, etc.) What aspect of the poster do you think is influencing your reaction?
5. Post all the posters for the class to see and compare to the others. What similarities or differences can you identify between the pairs of posters considered by a different class group?
6. Have a class discussion, moving from one set of images to another. Have students share their reactions to the posters and responses to the questions.
7. To end, ask the class what they learned about posters as a form of communication.

Materials:

- Documents 34A/B, 35A/B, 36A/B

DOCUMENT 34A: SPANISH FLU AND COVID-19 COMPARISON

Advertisement, "Wear a Mask," ***The Sunday Oregonian,*** **January 12, 1919.**
https://oregonnews.uoregon.edu/lccn/sn83045782/1919-01-12/ed-1/seq-23/



Wear a Mask

DR. MEYER ILLUSTRATING THE USE OF A MASK—FRONT VIEW.

DR. MEYER ILLUSTRATING THE USE OF A MASK—SIDE VIEW.

We appeal to your civic patriotism to co-operate with us in our effort to

STAMP OUT THE Spanish Influenza

or "Flu" Plague in Portland

By Wearing a Mask

You should willingly co-operate in doing this and not necessitate the passage of an ordinance which will make the wearing of a mask compulsory.

OBSERVE THE FOLLOWING RULES

Masks should be worn when you enter crowds, streetcars, stores, theaters, moving-picture houses, churches, schools, and even at home.

The mask should consist of four layers of butter cloth. Pattern of it will be shown in the big stores.

After you have worn the mask sterilize it by boiling for at least five minutes before you wear it again. Never wear a mask the second time, after having removed it to go from one place to another.

Realize that the outside of the mask is contaminated after use—you can very readily infect your fingers, and in this manner transmit the infection.

Never visit people who suffer from a cold without wearing a mask, because they may have influenza, if only in a mild form.

Small text reads:
"You should willingly co-operate in doing this and not necessitate the passage of an ordinance which will make the wearing of a mask compulsory.

OBSERVE THE FOLLOWING RULES:

- *Masks should be worn when you enter crowds, streetcars, stores, theaters, moving-pictUre houses, churches, schools, and even at home.*

- *The mask should consist of four layers of butter cloth. Pattern of it will be shown in the big stores.*
- *After you have worn the mask sterilize it by boiling for at least five minutes before you wear it again.*
- *Never wear a mask the second time, after having removed it to go from one place to another.*
- *Realize that the outside of the mask is contaminated after use-you can very readily infect your fingers, and in the manner transmit the infection.*
- *Never visit people who suffer from a cold without wearing a mask, because they may have influenza, if only in a mild form.*

Signed: The Consolidated Health Bureaus by E.A. Sommer, Director-General.

DOCUMENT 34B: SPANISH FLU AND COVID-19 COMPARISON

Infographic, "How to Wear a Non-Medical Fabric Mask Safely," *World Health Organization,* June 19, 2020.
https://www.who.int/images/default-source/health-topics/coronavirus/clothing-masks-infographic--web---part-1.png?sfvrsn=679fb6f1_26

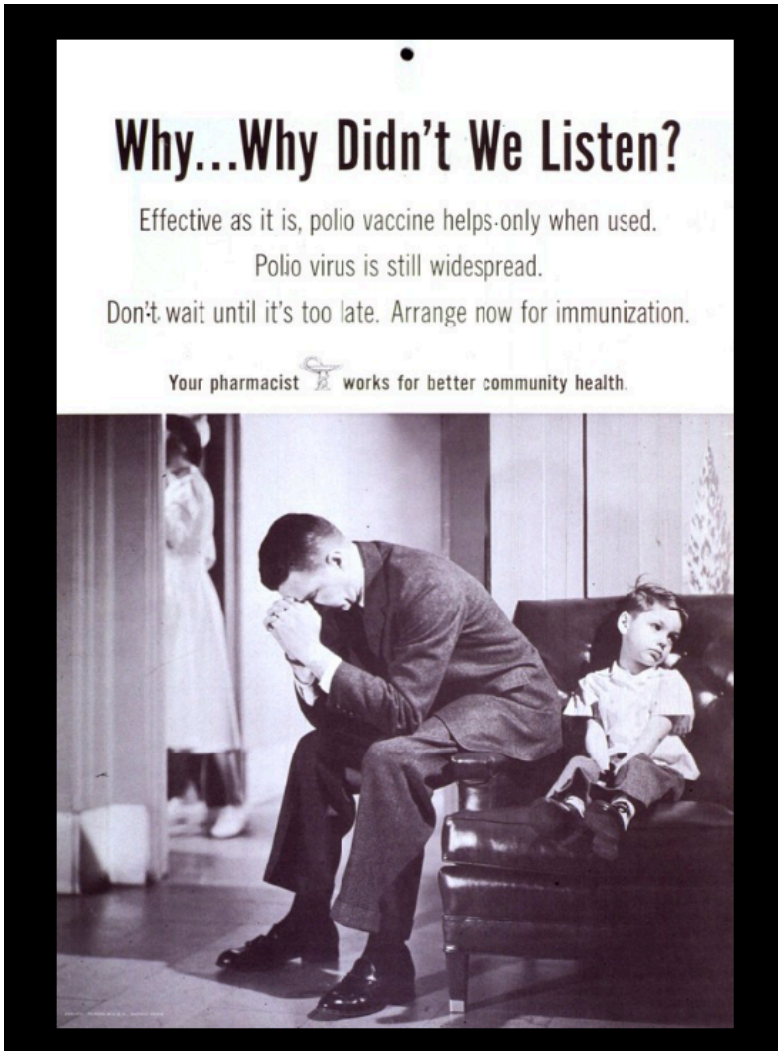
Small text reads:

- *Clean your hands before touching the mask.*
- *Inspect the mask for damage or if dirty.*
- *Adjust the mask to your face without leaving gaps on the sides.*
- *Cover your mouth, nose, and chin.*

- *Avoid touching the mask.*
- *Clean your hands before removing the mask.*
- *Remove the mask by the straps behind the ears or head.*
- *Pull the mask away from your face.*
- *Store the mask in a clean plastic, resealable bag if it is not dirty or wet and you plan to re-use it.*
- *Remove the mask by the straps when taking it out of the bag.*
- *Wash the mask in soap or detergent, preferably with hot water, at least once a day.*
- *Clean your hands after removing the mask.*

DOCUMENT 35A: POLIO AND COVID-19 COMPARISON

Poster, "Why Didn't We Listen?" maker unknown, circa 1955.
https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101454762-img

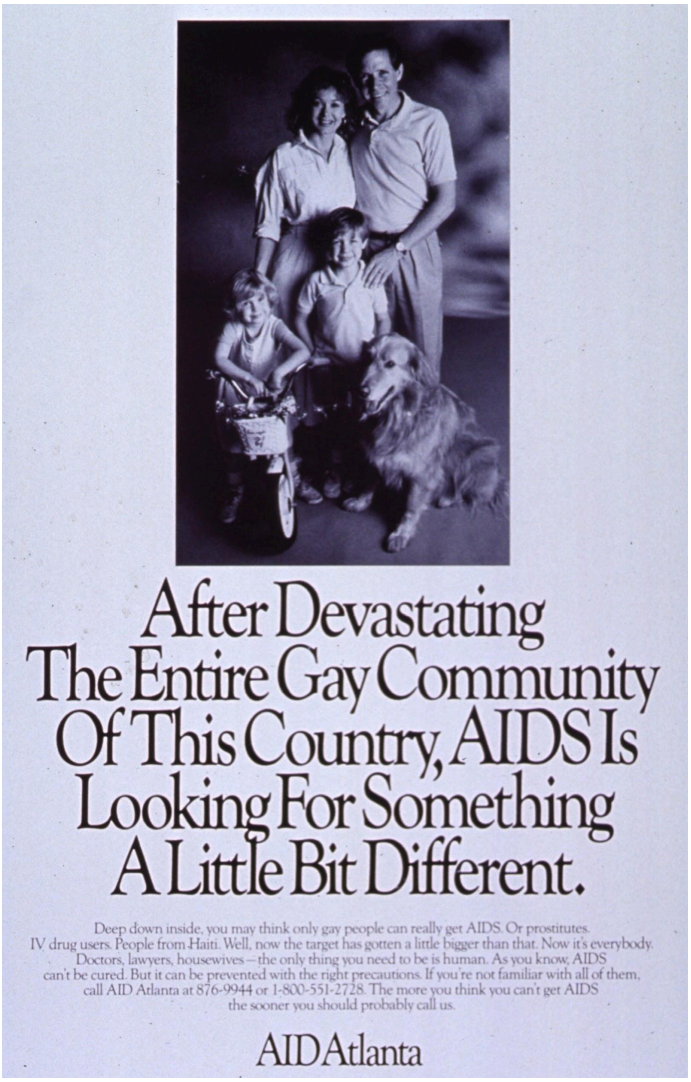


DOCUMENT 35B: POLIO AND COVID-19 COMPARISON

Advertisement, "Together We Won't Stop Protecting Children," UNICEF, July 2020. https://www.unicefusa.org/mission/covid-19

DOCUMENT 36A: HIV/AIDS AND COVID-19 COMPARISON

Advertisement, "After Devastating…," AID Atlanta, circa 1980s.
https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101438788-img



Small text reads:
Deep down inside, you may think only gay people can really get AIDS. Or prostitutes. IV drug users. People from Haiti. Well, now the target has gotten a little bigger than that. Now it's everybody. Doctors, lawyers, housewives-the only thing you need to be is human. As you know, AIDS can't be cured. But it can be prevented with the right precautions. If you're not familiar with all of them, call AID Atlanta at 876-9944 or 1-800-551-2728. The more you think you can't get AIDS the sooner you should probably call us.

DOCUMENT 36B: HIV/AIDS AND COVID-19 COMPARISON

Poster, "Viruses Don't Discriminate," King County Washington Department of Health, 2020. https://kingcounty.gov/depts/health/covid-19/care/anti-stigma.aspx