



News & Views

**A Publication of the
American Public Health Association
Student Assembly**

President's Pen

By Kristy A. Siegel, Chair APHA-SA

Congratulations to all recent graduates! I wish you all the best and great success in future endeavors. Just a PSA: When you renew your APHA membership, don't forget about the greatly reduced Transitional Membership category. You can continue to receive your APHA member benefits at a reduced cost, as well as register for the APHA Annual Meeting at a lower price!

Those of you that are graduating (in addition to all of us still studying) have probably been asked, "What is public health?", when discussing your degree and studies. The recent H1N1 (swine) flu may have helped us with the discussion of public health issues and workforce needs. But it also highlights the fact that when we do our job right (no one gets sick), then the public doesn't know who we are. However, when something goes wrong (there is a flu outbreak), everyone looks to us to find the solutions – with some believing that our inadequacies might have been the cause of the problem. We, public health professionals, are the oft-invisible warriors fighting for the safety and welfare of the public – sometimes thankless, always underpaid.

But of all the fields we could have selected, why not choose the best? There isn't a person in the U.S. that hasn't had their welfare improved by public health. And yet, we continue to strive for better welfare for all. If you haven't had a chance yet, make sure to look at APHA's campaign "Healthiest Nation in 1 Generation" - <http://www.generationpublichealth.org/>. The video captures what it is we do and want to accomplish. Please forward the video to all family and friends to begin the discussion of what public health does for everyone – not just the poor or marginalized. Your family and friends will be even more proud of you for being a part of the greatest workforce. The road ahead of us will be difficult, tiring, and as I said earlier, underpaid, but the rewards of a healthy nation, clean environment, walkable community, and children free from infectious diseases such as smallpox or measles are immeasurable. The public health workforce is strong and will continue to be so, with all of us working towards a healthy nation in one generation.

To close, I just have to share that while writing this piece, I was eating Dove dark chocolate (yum!). For those that don't know, inside each wrapping there are words of wisdom similar to a fortune cookie. My piece of chocolate said, "Your strength is inspirational." So I want to extend this fortune to all of us in public health – continue to inspire the public with your strength and resilience.

Spring 2009

Editing and Layout By:

**Olivia Wackowski
and Kimberly Rogers**

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APHA



Note from the Editors...

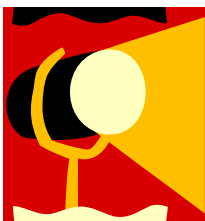
Dear Students,

Welcome to the third edition of our annual Special Student Supplement Issue! In addition to posting brief articles featured in our regular quarterly newsletters, such as Student Assembly committee profiles and public health related news and opportunities, this special issue allows students the opportunity to use a more open format to highlight topics interesting to them—research projects, public health advocacy efforts, opinion articles—anything within the realm of public health. Our intent with this particular issue of our newsletter is for students to gain publication experience, so that later in your career, you can submit and publish your work in journals and other professional publications.

So sit back and enjoy our fullest newsletter this year, filled with articles we hope you will find useful, relevant, and interesting—all written with the student in mind. Please contact us at newsletter@aphastudents.org if you are interested in submitting an article for publication in a future edition of the newsletter.

Sincerely,

Olivia Wackowski and Kimberly Rogers,
Editors/Newsletter Committee Co-Chairs



SPOTLIGHT ON:

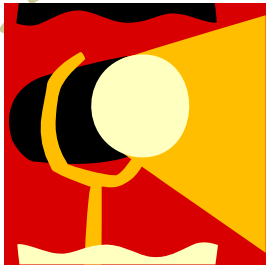
The Student Assembly Nominations Committee

By Cameron Culver, Committee Chair

The purpose of the Nominations Committee is to ensure that the APHA Student Assembly (APHA-SA) continues to operate under responsible and strong leadership in order to maintain the integrity and health of the organization. The Nominations Committee solicits, receives, and reviews applications for APHA-SA Committee Chair positions and makes recommendations to the APHA-SA Executive Board for these positions. The Nominations Committee works in conjunction with the Website Sub-Committee in keeping the APHA-SA membership informed of election news and encouraging their involvement. In addition, the Nominations Committee also provides information about and promotes APHA-SA members for leadership and award opportunities.

Currently, the Nominations Committee is completing the review of applications for Chair/Co-Chair positions of Advancement, Campus Liaison, Diversity, Membership, Mentoring, and Newsletter Committees, and although the deadline for these Committees has passed, please keep an eye out for additional committee chair positions opening in the future. These are typically announced in the Opportunities email sent out by the Student Assembly, with accompanying instructions on how to apply.

In the meantime, if you have any questions on getting involved, please e-mail Nominations@aphastudents.org.



SPOTLIGHT ON:

The Student Assembly Development Committee

By Jamie Lok and Yoonhee Ha, Co-Chairs

The Development Committee establishes and maintains a strong financial base, supporting administration of all fundraising activities within APHA-SA. The Development Committee supports each APHA-SA committee in their efforts to acquire funding for various projects and programs. Whether it be expanding the sophistication of the web site, printing striking APHA-SA promotional literature, or sending delegates to relevant conventions and conferences, adequate funds are necessary. The Development Committee cooperates with the Treasurer and Treasurer-Elect to assess the financial needs of the APHA-SA and will then formulate supplemental fundraising programs. Co-chairs are also involved in the annual scholarship drive to help fund outstanding student researchers to the Annual Meeting.

The Development Committee works to obtain grant funding for APHA-SA programs and initiatives, particularly the annual APHA Student Assembly Conference at the APHA Meeting and Exposition. In past years, the APHA-SA was awarded grants from the Centers for Disease Control and Prevention and the Josiah Macy, Jr. Foundation to support the annual conference for students in public health. For 2008-2009, the Development Committee is in the process of reapplying for previously successful grants and identifying new sources of financial support for the midyear leadership development meeting and the annual meeting conference.

How to Get Involved

If you have a desire to help secure monetary resources for APHA Student Assembly efforts, consider joining the Development Committee. Throughout this season, the Development Committee will be actively seeking out potential sources of discretionary funding. At the same time, however, the Committee will continue in its role by being a key avenue by which to obtain resources and services for APHA-SA operations. Experienced individuals are welcomed, but experience is not necessary to be placed on the Committee. Prospective committee members need only motivation, creativity, and a willingness to work. Please contact the co-chairs if you would like to get involved at development@aphastudents.org

Feature Article

Looking for a Public Health Job? Four Points to Keep in Mind.

By Kimberly Rogers, Newsletter Committee Co-Chair

Springtime is upon us once again, and depending on where you are in your studies, this can only mean one of two things: you're looking forward to a summer of freedom before yet another year of classes, or you're finishing your final degree requirements for your upcoming graduation. If this second scenario applies to you, congratulations! Your graduation (whether undergraduate or graduate) is a significant milestone in each of your lives, and you should take time to appreciate your success.

But what comes next? That's the question I was asking myself just one year ago after receiving my MPH, and I'm sure the same applies to you all. By now, many of you have laid the foundation for your plan—searching for internships, fellowships, full-time positions, or perhaps furthering your education by applying for a doctoral degree. While these goals are extraordinarily different, they all carry similar application processes: the search, the application, the (phone or in-person) interview, and (hopefully) a job offer. I am certainly no expert on any of these processes, but I have been through this long and tortuous job application cycle, and my hard work *eventually* paid off—I am about to complete my first year of a three-year fellowship with the CDC. Here are some tips to the Class of 2009 on surviving the whirlwind of the job application process:

1. Search for the jobs that are most applicable to you—and keep your expectations in check.

First ask yourself goal-oriented questions: Internship vs. Fellowship? School vs. full-time job? Decide on these goals based on your experience and education level. For example, I had received an MPH, but had little paid public health experience. Thus, I had the best chance of obtaining a paid fellowship rather than searching for a career position. Full-time positions usually require three to five years of paid experience; paid fellowships have educational requirements but carry less experience requisites—in fact, these fellowships *provide* the experience to eventually land that career position. If you don't have the experience or a graduate degree, there are still many opportunities available—just broaden your search. A wonderful site for all positions is available through the “Public Health Employment Connection” site (<http://cfusion.sph.emory.edu/PHEC/phec.cfm>), offered by Emory University's Rollins School of Public Health. Search mainly for things that are applicable to your skills, but allow yourself a couple of “fall backs” (jobs that may be one step below your levels of experience and/or education). In this economic climate, more people than ever are in the application pool, and you may not be offered your first, second, or third choices in positions. Thus, it is necessary to have a back-up plan; accepting a position lower than your goals is not ideal, but it may be necessary for a temporary period of time. And who knows—maybe this “fall back” job can lead to something extraordinary down the line!

2. Read every internship/fellowship/job description, and cater your application to it.

Of course, don't take this to the extreme; you cannot change your education or experience, or embellish your resume in any way to meet a position's criteria. However, you *can* play up your application (whether that be an essay you're writing for a position, or your resume itself) for what

(feature article, continued...)

a job offers. You can cater one experience position a plethora of ways; an executive-board position in an extra-curricular organization at your school could be construed as leadership experience, organizational, verbal, or written skills (perhaps you spoke at several public functions and then composed memos or sent letters on behalf of your organization to the dean)—or all of the above.

This rule also applies to your references. Speak to each of your potential references, and ask them if it would be okay if they could write a potential recommendation letter or accept a potential phone call on your behalf. Obtain more references than are necessary—you'll want to interchange them depending on the position.

3. Understand that an interview is not a time to promote your resume, but to promote YOU.

Making it to an interview can sometimes be a success in itself—your application has clearly risen to the top of the pile. If you do land an interview, keep in mind that your interviewer has at the very least skimmed over your resume—you wouldn't be there otherwise. Now is not the time to recite every bullet point on your resume, but rather to expound upon these points—and to show them who you are in the process. Prepare for the usual interview questions, but don't appear static and by-the-book prepared—everyone does that. You have to set yourself apart; if your interviewer is receptive, engage in their discussion. Don't be afraid to smile and laugh (if appropriate).

While in-person interviews carry the reputation as being more nerve-racking, I would argue that telephone interviews are more difficult. Telephone interviews don't offer you the advantage of body language, and thus you have to really listen to vocal cues to understand if your interviewer likes (or dislikes!) what you're saying. Thus, never take phone interviews lightly; a good phone interview will likely land you an in-person interview.

4. Be patient. Know that job offers take time, and again keep your expectations in check.

I started seriously searching for fellowships in January 2008, and submitted my application for my current job in February. In March, I received a call for an interview, and braved my first (phone) interview in April. I got another call back for an in-person interview in May, and received a job offer in late June. My position started in late July 2008. That's almost a seven-month time frame from start to finish, and at times, it seemed much longer. It's important to stay patient and remain hopeful, but know that rejections may come your way, and be prepared for them. If you are lucky enough to receive multiple offers, weigh them carefully on more than simply income. You must consider location (i.e. cost of living), promotion potential, work environment, and your personal life. This may be your first "real" job in the field, but it can be the beginning of the rest of your career. If you're on the other end of the spectrum and did not receive offers, initiate your back-up plan you formulated months before, and begin the process again—hopefully the second time around will generate a wonderful job offer.

We'll all go through this process many times throughout our lives, but getting through the first go around is the toughest part. If you do your homework, take your time with your applications, and are prepared for all outcomes (i.e. having that back-up plan), you'll be more successful than most. Good luck in your search!

Public Health Nursing Section Seeks Students

The APHA Public Health Nursing Section is encouraging students to join or just try out the section this year in Philadelphia at the 2009 Annual Meeting. Getting involved in the section is an excellent way to get to know APHA and to stay up to date on the latest and greatest public health nursing research. “I’ve been coming to APHA since I was an undergraduate. It’s the most inspiring public health collaborative ever!” says Maria Gilson Siström, RN MSN PhD, Assistant Professor at Oregon Health & Sciences University School of Nursing. The Public Health Nursing section is working this year to develop student-friendly business meetings and it recently established a student engagement committee to assist students in finding a place to contribute within the section. In addition, the section is seeking nominees for the Beverly C. Flynn Public Health Nursing Legacy Leadership Program which mentors nursing students in community health. “Come join us,” says Dr. Siström, “you’ll be in the company of the best and brightest public health nurses interested in environmental health, global health, curriculum, maternal-child health and human rights: the research and presentations will feed your public health passion, and inspire your education and practice for the whole year!” If you need encouragement, please feel free to e-mail Maria at sistromm@ohsu.edu and/or Rita Lourie at rlourie1@gmail.com. For more information on the Beverly C. Flynn program, see application forms on the APHA PHN Section website, or contact Anne Belcher, abelche@iupui.edu.

Help Make America the Healthiest Nation in One Generation

Let’s face it – as a nation we’re not nearly as healthy as we should be. Compared to other developed nations, we’re lagging far behind. But it doesn’t have to be this way. With your help, we can make America the healthiest nation in just one generation.

As a central component of this year’s National Public Health Week (NPHW) observance, APHA launched an exciting, new viral video campaign. The [Healthiest Nation in One Generation](#) video tells the story of the many ways that public health touches our lives. Nearly 25,000 people have already viewed the video online and the numbers continue to grow each day. If you haven’t checked out the video, [watch it today](#) and be sure to share it with your colleagues, family and friends. And stay informed by visiting www.generationpublichealth.org – NPHW 2009 is over, but our campaign to make America the healthiest nation in one generation is just beginning...

We all have to do our part. **What will you do?**

Public Health CareerMart—over 1000 jobs listed!

The American Public Health Association has created the Public Health CareerMart to be the online career resource center in the field of public health. Here, you'll find only qualified, industry professionals. Job Seekers: instead of searching through hundreds of sites looking for the perfect jobs in public health, you will find it all at Public Health CareerMart, Career Development Center at www.apha.org/about/careers.

Employers: instead of being inundated with stacks of unrelated, irrelevant resumes, you're much more likely to find the candidates with the skills and experience you're looking for—and *spend less time doing it!* After all, where better to find the best public health professionals than the association that represents them?

Public Health CareerMart is a member of the National Healthcare Career Network.

New Book On Disability Studies

"Disability and Public Health," published by APHA, will be available in June . The publication is an important and overdue contribution to the core curriculum of disability studies in public health education. It is a particularly timely book because, as our nation ages, disability is an increasingly significant interdisciplinary area of study and service domain in public health. Visit the APHA online bookstore at www.aphabookstore.org/. APHA members can also take advantage of a 30% member discount whether ordering online or via our toll-free number: 1-888-320-2742.

Alcohol Screening and Brief Intervention Manual

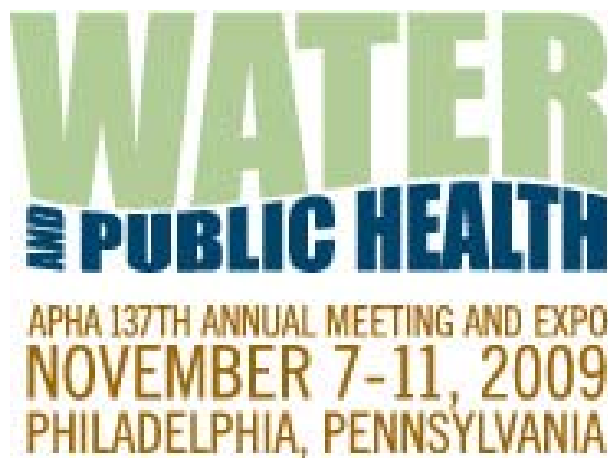
APHA is proud to announce the release of "Alcohol Screening and Brief Intervention: A Guide for Public Health Practitioners". This manual provides public health professionals with information, skills and tools needed to conduct screening and brief intervention (SBI) to help at-risk drinkers reduce their alcohol use. Download the manual for free online: <http://www.apha.org/programs/additional/progaddNHTSI.htm>

APHA wants to know your opinion on whether you would use an online version of the Control of Communicable Diseases Manual. Help us by taking a survey at http://www.surveymonkey.com/s.aspx?sm=53858582nfNS699PLteHvg_3d_3d

We appreciate your input!

APHA Annual Meeting

From November 7-11, 2009 thousands of public health professionals will convene in Philadelphia, PA for the APHA 137th Annual Meeting and Exposition. Over 1,000 cutting edge scientific sessions will be presented by public health researchers, academicians, policy-makers and practitioners on the most current public health issues facing the nation today. To ensure that no public health professional misses this opportunity, this year's Annual Meeting will be more affordable than ever. Hotel rates have been slashed so that no rates are higher than \$195. Eleven of the 15 contracted hotels are offering rates between \$149 and \$179. Registration and Housing Open June 1st. Save up to \$115 on registration by registering before August 28. Take advantage of these discounts and join your colleagues in a meeting you won't want to miss. For more information about the Annual Meeting and the role your Section or SPIG will play in its success visit www.apha.org/meetings! We're on Twitter: APHAAnnualMtg



APHA Student Assembly Presents

The 5th Annual National Student Meeting:

“Looking Back, Moving Forward: Transforming Our Health Care System”

The meeting provides an opportunity for students from all backgrounds and schools to come together to discuss Health Care Reform and possible solutions to the existing problems within health care with a focus on Health IT. The meeting will include a panel discussion, advocacy training, career development workshops, and exhibitor sessions.

For more information, please contact the Student Meeting director, Christy M. Lawson, at studentmeeting@aphastudents.org

2009 Wisconsin Public Health Simulcast: Post-Event Summary

By Kaija Zusevics, Public & Community Health Dept., Medical College of Wisconsin

In order to kick off Public Health Week, over 80 residents at 7 different sites across the state of Wisconsin participated in the second annual state-wide public health simulcast event on Friday, April 3rd, 2009, with a focus on water and public health. The simulcast featured the film "FLOW" followed by a panel discussion with water and public health experts representing academia, policymakers, grassroots organizations, and governmental agencies. The simulcast came on the heels of the recently passed Great Lakes Basin Compact, which has a myriad of implications for Wisconsin's fresh water. Additionally, concerns about the "health" of bodies of water and Wisconsin's ground water supply espoused the need to educate the public about the connections between water and public health. To enhance public awareness and policy action in the state, the Wisconsin Public Health Association collaborated with local health departments, universities, and community organizations to plan, promote, and implement this unique learning and networking opportunity that was broadcast to seven sites around Wisconsin. It was clear that "FLOW" provoked relevant water-related discussions, as questions from participants centered on water technology, safe-water policies, privatization concerns, and the human rights issues surrounding water and public health. The turnout and positive feedback highlight the benefits of using technology to bring geographically dispersed communities together to learn about water and public health both locally and globally and take necessary action to protect and improve this valuable resource. Truly, this public health simulcast proved to be a galvanizing and energizing experience for organizers and attendees across Wisconsin.

A New Student Orientation Celebrates its First National Public Health Week

By Kristina Davis, Benedictine University

In January, a group of Benedictine University MPH students joined together to form an MPH Student Advisory Panel (MPHSAP). The group hopes to be able to bring more awareness of public health to their school's campus through advocacy, education, and community service. So far the group has organized a panel of guest speakers to talk about careers in public health and celebrated National Public Health Week. The group is currently soliciting others for low budget project ideas they could plan in the future.

For National Public Health Week, MPH students decorated the campus with signs and banners and sent daily themed e-mails suggesting ways students could impact public health. MPHSAP also collaborated with the student newspaper to write an article addressing the importance of public health. This was a modest start, but the MPHSAP felt that it was a great success for a first try. They hope to expand and improve on it next year.

Public Health Leaders of Tomorrow: How University at Albany Students are Using Public Health to Impact their Local Community

By Jacqueline Pinder, University at Albany School of Public Health

The University at Albany School of Public Health, Public Health Leaders of Tomorrow (PHLOT) CORE group consists of 12 Masters-level students competitively selected to participate in a leadership development program. With a mission to "build leadership skills through community involvement, hands on experience, and an inclusive look at state and local government in the field of public health," the program was founded to cultivate student leadership and strengthen the infrastructure of the public health workforce.

When challenged to develop a community service program, the CORE 2009 class wanted to create a program that utilized their specific skills in public health, rather than just volunteering their time. Consequently, the students created an evidenced based nutrition and physical activity curriculum to implement at their local Boys and Girls Club (BGCA) in Rensselaer, New York. The group conducted a needs assessment to tailor pre-existing evidence based interventions specifically to the population at the BGCA and incorporated club staff into the lessons in order to establish sustainability. The weekly program, currently being implemented, is split into kid-friendly nutrition and physical activity sessions aimed at enabling the children to make healthier choices in their everyday lives.

The program will end on May 3 with a community-wide health exposition and 5K race to benefit the BGCA. The event was designed to link community members to health organizations available to serve them. The health fair will feature local organizations, health screenings, demonstrations and games to facilitate the development of healthier habits in the lives of community members.

UC Irvine Celebrates National Public Health Week

By Steven Tate, University of California, Irvine

The Public Health Association at University of California, Irvine celebrated National Public Health Week by informing students of the public health discipline, encouraging a healthier campus and raising money for cancer research.

All week members of the Public Health Association set up a booth in the heart of UC Irvine to offer an array of brochures, flyers, and information about the many opportunities in public health. The booth also allowed fellow UCI students a chance to pledge what they would do to build a healthier America. On Monday, the Public Health Association hosted a "Public Health Mixer" in which faculty of the UCI Program in Public Health offered their insight into the growing field of public health and interacted with students. Similarly, on Wednesday, the Public Health Association at UCI hosted six panelists representing various Masters in Public Health (MPH) programs from UCI, UCLA, Loma Linda University and Cal State University Fullerton. Throughout the Graduate School Panel, panelists responded to questions from undergraduate students regarding opportunities in public health

The highlight of the week was on Thursday during the Concert for Charity. Local UC Irvine bands raised money for the American Cancer Society. The week ended with a movie showing of *Flow* on Friday, a documentary film about the dwindling supply of fresh water in the world, and a hike at the local state park on Saturday. National Public Health Week 2009 at UC Irvine was a huge success and the Public Health Association plans to expand upon the event in 2010.



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News & Views
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A Publication for Students by Students

Ad Hoc Interpreters Endanger Patient Safety

By Judy Ou, Brigham Young University

Using ad hoc medical interpreters endangers patient safety and creates disparities in care given to low English proficiency patients. The 2000 US Census shows that the number of limited English proficiency people in the United States increased from about 32 million in 1990 to around 47 million in 2000. The increasing number of limited English proficiency (LEP) people in the United States demonstrates an increased need for medical interpreters. Currently, health facilities can use ad hoc interpreters or professional interpreters. However, the frequency and types of mistakes ad hoc interpreters make result in dire medical and ethical situations.

Medical Issues

Two major assumptions taken while using ad hoc interpreters are that the interpreter has total command of both languages and that the interpreter knows enough of both languages to translate medical terminology. These assumptions lay the foundation for inadequate care. A study done on professional and ad hoc interpreters found that 77% of errors made by the ad hoc interpreters had potential clinical consequences (Flores et al, 2003). The frequency of ad hoc interpreting errors include omission of information (52%), false fluency in the language (16%), substitutions of wording (13%), editing of the doctors' information (10%), and addition to the information (8%). Errors of false information include instructing the patient to take antibiotics through the ear instead of the mouth, and applying hydrocortisone cream to the entire body rather than just one area (Flores et al, 2003). A more recent tragedy involves a Hmong man's amputation of the incorrect leg. Hospitals relied on the Hmong man's son to interpret the surgery's consent form. This misinterpretation led to the faulty amputation (asiaone.com, 2008).

Errors of clinical consequence place a burden on both the patient and the health care system. Complications from the misuse of treatments result in multiple return visits to the emergency room. The complications also lead to higher costs in treating the mistakes of miscommunication. Using trained medical interpreters can mitigate the negative effects of ad hoc mistakes. Patients that had access to trained medical interpreters have fewer emergency department visits, fewer complications after treatment, and lower charges made in the emergency department (Bernstein, 2002).

Ethical Issues

Ad hoc interpreters, also known as improvised interpreters, are most commonly friends or relatives that speak both the patients' language and the doctors' language. However, the ad hoc interpreters used have not been trained in the HIPPA patient confidentiality requirements. If a breach in patient confidentiality does occur, the medical facility does not have a method to provide consequences for breaches of disclosure.

Because there are not methods to ensure full confidentiality when using ad hoc interpreters, patients may be hesitant to disclose sensitive medical information. Questions about sexual activity, number of children, and domestic violence may not be answered correctly if a family member acts as the interpreter. The lack of correct information disables the physician's ability to make an accurate diagnosis based on patient answers.

The use of children as medical interpreters poses its own set of problems. Current and former children were interviewed on NPR talk radio. Former child interpreters expressed stress and guilt when interpreting. The children understood the gravity of their interpreting work, and felt responsible for the outcomes of their parents' health:

"Well, I was always rather nervous when I was translating for my mother. You know the guilt and the anxiety that you feel... did you translate accurately, did you harm your mother, did you do anything wrong that might make your mother a little bit sicker than she should be?" (Jauregui, 2006)

(continued on next page...)

Moving Forward or Backward: History, Culture, and the Transition to Private Healthcare in Turkey

By Sonny Patel and Luke Manley, University of Southern California

Amid the ongoing dramatic and critical problems in the Middle East, the issue of health care in the region is often largely ignored. It is our hope to shine a spotlight on this vital, yet woefully underrepresented and poorly understood area.

We recently spent a month in Istanbul intensely researching the Turkish health care system and focusing on the current transition from mainly public, community-based, socialized medicine to a more private scheme, reminiscent of the United States. Throughout our stay, we conducted 12 official interviews with health practitioners across a range of occupations (e.g. health officers, medical directors, pharmacists, clinical psychologists, and herbal practitioners) and in each of the major sectors of health care (private, public, or both). Understandably, the experience has left us with an even greater respect for the immense complexity of balancing all of the different aspects of healthcare development and provision, especially in such an intricate society.

The primary struggle for Turkey is to simultaneously “Westernize” without losing the old Ottoman values of community and cooperation and its relationship to the sharing of health risks. This illustrates the unique complexities that exist in a society with such an ancient culture, central geographical location, and distinctively secular political structure. Preliminary data shows that this current transition marks an intense period of change for the government, business, and the people of Turkey, with strong, informed, and conflicting opinions dominating all sides of the evolution of health care.

We look forward to continuing our research in Istanbul and the other major regions of Turkey in the near future, as it has become apparent that modern Turkey provides limitless opportunity. Nowhere is this truer than in the realm of healthcare. Currently we are in the process of analyzing and organizing our data into a number of different presentations with the intent of publishing a paper on the subject later in the year.

For more information, please contact the authors: Sonny Patel (sonny.patel@usc.edu) and Luke Manley (luke.manley@keck.usc.edu).

(Ad Hoc Interpreters, continued from previous page...)

Solutions

Providing a standard level for medical interpreters would prevent errors found in ad hoc interpreting. Passage of legislation that provides a method for state-wide certification would aid in this effort. If ad hoc interpreters must be used, the passing of universal certification or training for ad hoc medical interpreters would provide some standardization of interpretive services given by family.

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Health Literacy: *Be the Agent of Change!*

By Denise H. Britigan, University of Cincinnati

Our understanding of health literacy and its definition is evolving from an individualized focus to one which includes organizations and communities. According to Zarcadoolas, Pleasant, and Greer (2006), health literacy is defined as “*the wide range of skills and competencies that people develop over their lifetimes to seek out, comprehend, evaluate, and use health information and concepts to make informed choices, reduce health risks, and increase quality of life.*” William Smith, Institute of Medicine (IOM) committee member, recently offered an updated version, [health literacy is the]... “*capacity of individuals, organizations and communities to obtain, process, understand and share basic health information and services needed to make appropriate health decisions.*’... The word services places emphasis not on what we say, but on what we do to help people make appropriate health decisions.”

Consider this scenario: Imagine that you have received information that is intended to promote or improve your health...it may even be considered vital information. Yet the written information may be many pages long and in small print, written at a high education level of readability, in a language not native to you, doesn't show pictures or illustrations that you understand, and doesn't depict or respect your culture, values, or beliefs. Would you read all of it? Would you understand and use the information? I doubt it. And, what if the information was given orally, without a handout for future reference or opportunity for follow-up questions?

You may have experienced a situation similar to the one I have just described. The majority of citizens in the United States face this dilemma regarding health information on a daily basis due to reading below a ninth grade level. One size does not fit all for our community members because, according to the National Assessment of Adult Literacy (NAAL), we are at various literacy levels—88% of Americans are below the proficient level!

The research literature shows that *everyone* benefits from health information that is brief, focused, and easy to understand. This means offering information in a variety of communication channel formats (audio, visual, written, interactive, etc.), languages, and cultural perspectives. It also means leaving white space on the written material, using bulleted points for highlighting the important facts, and finding out if a single sheet, bi-fold, or tri-fold pamphlet or photo novella is best. How is that determined? Ask your target audience for their input! And, is the information that you offer current? Have *you* read it lately? Rather than use medical jargon, does the explanation use familiar terms to describe the meaning? There are instruments available to determine the grade level of readability, too.

What can we do to learn more about health literacy and incorporate improved materials into our workplace? Having health literacy curricula included at academic institutions is one place to start. This will help upcoming health providers and professionals gain the knowledge, skills, and available tools necessary to create health information for clear health communication appropriately tailored for targeted audiences. Very few textbooks are solely dedicated to health literacy and to understanding the wide variety of complex, inter-related topics of literacy, various communication loops and formats such as media literacy, computer literacy, civic literacy, socio-cultural literacy, etc.

There are initiatives in place to encourage clear health communication between patients and providers. Begin with addressing the three simple questions of the National Patient Safety Foundation / Partnership for Clear Health Communication, “Ask Me 3” program (<http://www.npsf.org/askme3/>). Follow that with a visit to download Helen Osborne's Health Literacy Out Loud podcasts <http://www.healthliteracyoutloud.com/> and participate by sharing your story for Health Literacy Month (October) – a worldwide campaign to raise awareness about the importance of understandable health information. Next, download the DHHS Office of Disease Prevention and Health Promotion's Health Communication Activities “Quick Guide to Health Literacy” (<http://www.health.gov/communication/literacy/quickguide/>). Join a listserv such as the Health Literacy Discussion List, a service of the National Institute for Literacy (<http://nifl.gov/lincs/discussions/discussions.html>), which is facilitated by World Education, Inc., and moderated by Julie McKinney.

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Applying a Life Course Perspective to the Investigation of U.S. Racial/Ethnic Health Inequalities in Infant Mortality

By Madina Agénor, Harvard School of Public Health

In the U.S., profound racial/ethnic health inequalities exist in a range of health outcomes, including infant mortality. For example, in 2005, the infant mortality rate—which refers to the number of deaths among children under the age of 1 per 1,000 live births—was approximately 2.5 times greater among African Americans than whites (MacDorman & Mathews, 2008). While the U.S. infant mortality rate generally declined during the 20th century, the annual infant mortality rate ratio between African Americans and whites remained unchanged or increased (Buescher & Mittal, 2006; MacDorman & Mathews, 2008).

Despite a number of studies on this issue, the etiology of racial/ethnic health inequalities in infant mortality remains largely unknown (Bell et al., 2006; MacDorman & Mathews, 2008). However, in 1992, Geronimus suggested that racial/ethnic inequalities in a range of women's health outcomes, including infant mortality, could best be explained by the "weathering framework." This model postulates that African American women, especially those living in high-poverty areas, face worse health outcomes than their white counterparts as a result of the cumulative effects of repeated exposure to social, economic, or political exclusion. Specifically, Geronimus (1992, 2001) showed that, while infant mortality rates decreased with increasing age among whites, they were significantly lower among younger black women than older black women. Since then, various other researchers have tested Geronimus' "weathering hypothesis," finding similar results (e.g., Buescher & Mittal, 2006; Reichman & Pagnini, 1997).

Moreover, a number of studies have explored the impact of various dimensions of maternal socioeconomic status (SES) on infant mortality disparities between African American and white women. For example, using vital records from North Carolina, Din-Dzietham and Hertz-Picciotto (1998) found that, the adjusted black/white odds ratio for infant mortality increased with increasing maternal education. They also found that, although further education reduced the risk of infant mortality among white women, it had no protective effect among African Americans.

Only a handful of studies have examined the influence of contextual factors on racial/ethnic inequalities in infant mortality. For example, LaVeist (1993) conducted multivariate analyses estimating the impact of residential segregation, poverty, and political empowerment on infant mortality rates among whites and blacks, as well as the black-white infant mortality rate ratio. He found that the black infant mortality rate, as well as the infant mortality rate ratio between blacks and whites, was higher in highly segregated cities compared to less segregated cities—although segregation, as measured in this study, had small effects on infant mortality rates.

Overall, existing studies investigating racial/ethnic inequalities in infant mortality display three major limitations. First, because of their reliance on vital records, the majority fails to consider the role that neighborhood- and community-level characteristics may play in shaping infant mortality disparities. Second, most also fail to examine potential mediating and moderating factors in the relationship between social, economic, and behavioral factors and racial/ethnic disparities in infant mortality—thus missing an important opportunity to identify the mechanisms through which they operate, as well potential points of intervention. Third, the majority of the research in this area is cross-sectional and, in turn, yields no information about how the factors that shape infant mortality inequalities operate over time and space (Hessol & Fuentes-Afflick, 2005).

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The Influence of City Design on Obesity

By John J. Byrne, University of Texas School of Public Health

A recent rise in obesity prevalence has many Americans looking toward our nutritional and physical environments as key culprits in this surging epidemic¹. City planning – the built environment around you and me – influences the obesity rates in each community markedly by dictating both our nutritional and physical environment². From the amount of parks per capita to the amount of time spent commuting to work, community members are limited by the external environment in which they live. Also involved in this obesogenic trend is the high availability of relatively inexpensive, yet highly palatable foods from fast food restaurants and convenience stores, alongside the limited availability of health-promoting food options³. The question then looms: how is this trend to be reversed?

With the current economic instability, the full reversal of this trend will prove to be a Herculean task. Here's why: stress levels are high, individuals are working late to keep their jobs, and the jobless have to find a way to survive on little to no money. Consequently, individuals may turn to inexpensive food options such as the dollar menu at McDonalds. The increase in stress and late working hours may allow for little time for recreational activity⁴. Yet, there is a positive side to this economic downturn: people may start to look to alternative forms of transportation to get to work - cycling and walking⁵. That leads to another important question - are cities built for such transportation needs?

Bovell-Benjamin et al. studied two different cities in Alabama - Auburn and Tuskegee – and found disparities between city design and opportunities for healthy food and access to physical activity¹. Thirty retail food outlets and twenty-nine physical activity outlets were investigated in this study. The food outlets were defined as “grocery stores, restaurants, carry out and fast-food places,” while recreational facilities were defined as “health clubs, playgrounds, swimming pools, private exercise clubs, parks, walking paths, school gyms, aerobics programs, church and community exercise programs and public recreational areas”. The studies found that none of the convenience stores in both cities carried low-sodium or dark green vegetables, low-fat milk, yogurt or cheese and none of the supermarkets in Tuskegee stocked low-sodium vegetables. Also limited in Tuskegee were free recreational facilities. Unlike Tuskegee, Auburn had a large number of free recreational facilities, along with a greater number of health food opportunities at the grocery stores. Auburn also features a greater number of health food options, and a greater number of physical activity outlets that can subsequently allow for a reduction of disease risk. Differences in poverty levels may bias these findings, though, considering that Auburn has only 14.0% of its population below the poverty line, while Tuskegee has 35.7% of its population below the poverty line.

The idealized solution of rebuilding cities in a health-conscious manner rarely is feasible. Instead, the feasible solution to curb the tide of this raging epidemic is altering the physical environment of the city. As stated by Odoms-Young et al., “researchers and policymakers argue that environmental approaches have the greatest potential to reverse the rising prevalence of obesity”⁶. City and state governments have the ability to increase the number of bike lanes and city parks, allowing for recreational and transportation-based physical activity. Free and safe recreational facilities should be built to improve the opportunities available. Nontraditional retail solutions - farmers markets and urban agriculture sites - should be considered to improve health food options in both urban and rural communities⁶. Fast food restaurants should also look to improving their health food menus, with lower prices for healthy alternatives being of great importance. America's obesity epidemic should not be taken lightly, as increased weight leads to increased susceptibility to cardiovascular problems and soaring health care costs for the treatment of the complications of preventable diseases.

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Applying a Life Course Perspective to the Investigation of U.S. Racial/Ethnic Health Inequalities in Infant Mortality
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Applying a life course perspective to the study of racial/ethnic inequalities in infant mortality would help researchers address many of the aforementioned limitations. Indeed, this framework would allow investigators to examine the range of determinants that shape infant mortality disparities not only in relation to individuals' social circumstances over their lifetime, but also across generations and in historical context. Longitudinal study designs that explore the influence of a range of social, economic, policy, ecological, behavioral, and biological variables (as determinants, potential confounders, mediators, and moderators) on racial/ethnic inequalities in infant mortality over time and in different geographic settings would prove particularly useful in uncovering the etiology of these disparities (Elder, 1998). Moreover, adopting a theoretical framework that addresses how these factors interact with one another and gradually take their toll on women's reproductive capacity through repeated "wear and tear" during their life course—especially during key developmental "windows" such as in utero development, adolescence, and pregnancy—seems most appropriate for the study of racial/ethnic inequalities in infant mortality (Lu & Halfon, 2003).

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Health Literacy: Be the Agent of Change
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In closing, *do something!* Evolve! Be an active participant in creating change on behalf of communicating useful health information to your intended audience. According to Zarcadoolas et al., "The success of health promotion depends on bridging the content of health promotion to individuals. Health literacy skills make that possible."

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Medical Student Collaboration with Local Public Health Unit during Mumps Outbreak

By Gary Yau, Jason Essue, Amina Benlamri, and Pravin Thomas (Schulich School of Medicine & Dentistry, University of Western Ontario), and Bryna Warshawsky (Middlesex-London Health Unit)

Introduction

The mumps virus can cause non-specific respiratory symptoms and swelling of the salivary glands.^{1,2} While most people fully recover, the following rare yet serious complications can occur: meningitis, encephalitis, deafness, oophoritis, orchitis rarely resulting in infertility in males, deafness, and miscarriage in pregnant females.^{1,2} Mumps spreads via droplets from infected individuals.¹ The incubation period is 8-16 days.¹ An infected person is contagious anywhere from 3 days before to 9 days after the onset of symptoms.³ Approximately 30% of infected individuals will not present with any symptoms but they can still be infectious.³

Vaccination

The MMR (measles-mumps-rubella) vaccine can safely prevent mumps, although immunity may wane with time. Two doses of the vaccine appear to provide better protection than one.² Thus, those born in the period after the introduction of the vaccine but before the implementation of a second dose, are at increased risk of contracting mumps due to waning immunity. People in this age group that received only one-dose of MMR vaccine may attend post-secondary institutions and therefore are more likely to be in communal settings and engage in higher risk activities conducive to the spread of mumps.

Mumps Outbreaks

The susceptibility of those born between the years 1969-1996 is consistent with recently documented outbreaks of mumps. In 2007, 555 cases were reported in the Maritime Provinces. Approximately 67% of the cases were between 17-37 years old.⁵ Later in 2007, another 500 cases were reported in Alberta and British Columbia, including many post-secondary students.⁵ In the fall of 2008, the Ontario Ministry of Health and Long-Term Care announced that it would fund and support local public health units to offer free MMR vaccines to students to prevent the spread of mumps in post-secondary settings.

Mumps in Middlesex-London

In 2008, 270 mumps cases occurred in an under-immunized community in Oxford County, Ontario, which originated from a related community in the Netherlands.⁵ In September 2008, the Middlesex-London Health Unit (MLHU) was informed that a student attending Fanshawe College (FC) in London, Ontario was infected with mumps and likely attended school while infectious.⁵ Approximately 12,000 students attend FC and another 35,000 students attend the nearby University of Western Ontario (UWO). The case at FC was concerning because it could have potentially spread through this large group of post-secondary students. Two MMR immunization clinics were held at FC on September 24 and 26, 2008, during which 1,004 doses of MMR vaccine were provided.

Local Response to Mumps

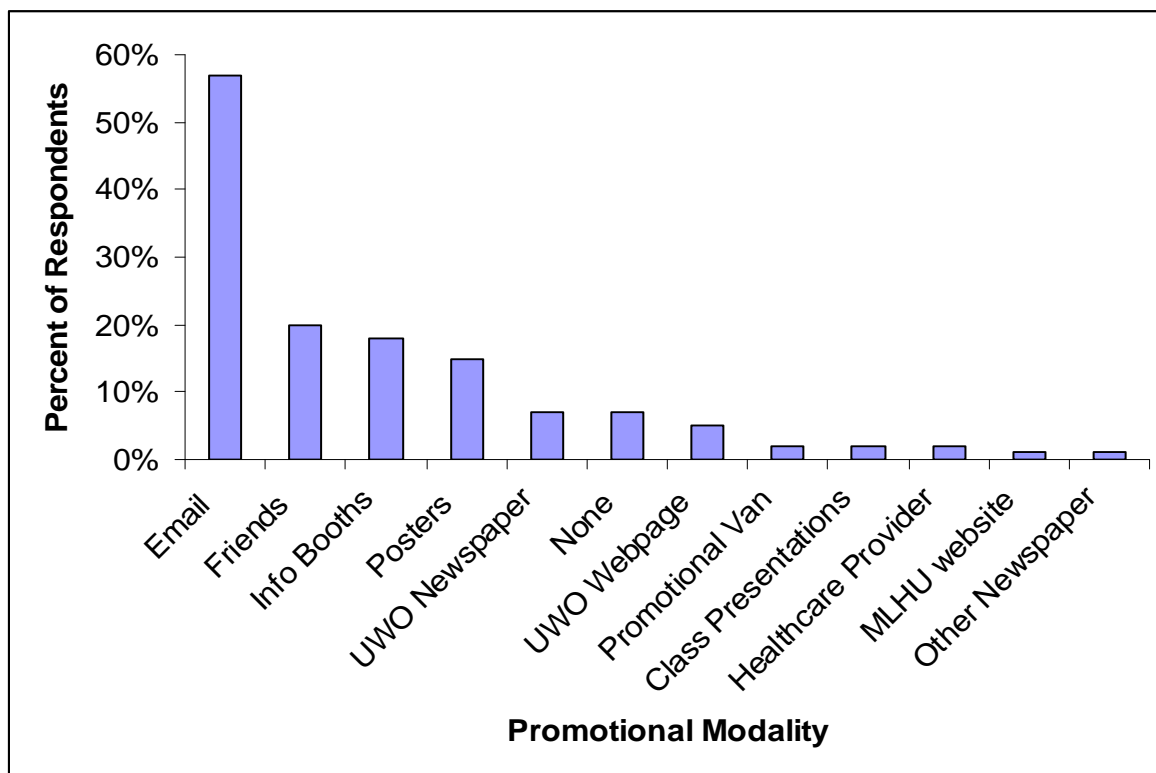
The newly formed Schulich School of Medicine Public Health Interest Group (PHIG), created by four medical students at UWO in September 2008, allied with the MLHU in order to provide its members with opportunities to participate in front-line public health initiatives. When discussing potential opportunities for partnership between the two groups, the promotion of the MMR vaccination clinics planned for UWO was seen as a project which could be worked on collaboratively. Various promotional modalities were planned, sponsored by MLHU and the Ontario Ministry of Health and Long-Term Care in collaboration with UWO. PHIG wanted to know which promotional modalities (Figure 1) would be most effective. Thus, we issued surveys at the UWO vaccination clinics asking, "How did you hear about today's mumps vaccination clinic?"

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(Medical Student Collaboration with Local Public Health Unit during Mumps Outbreak, continued from previous page...)

The clinics at UWO took place on January 29 and 30, 2009 during which a total of 1,120 MMR vaccines were administered. In response to distribution of the surveys at the clinics, 138 responses were received. Of the respondents, 52% were female; respondents had a mean age of 21.3 years. Email appeared to be the most effective means of reaching the students with 57% reporting they heard about the campaign through this medium (Figure 1). This is to be expected since e-mail can efficiently reach a large audience within a post-secondary setting where all students receive institution-affiliated e-mail accounts. However, the link between witnessing a modality and that modality leading to action cannot be assumed. Each person witnessed an average of 1.4 modalities before reaching the clinic. The next most commonly reported modalities were information booths, posters, and friends. These results suggest that a campaign centered on email coupled with auxiliary promotional modalities could be an effective and efficient means to reach an audience with similar characteristics to those documented in this report.

Figure 1. The percent of those surveyed who witnessed each respective promotional modality (n = 138).



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How Does the Threat of Mercury Affect Our Lives?

By Marcia Castano, Walden University

Historically, main sources for producing elemental mercury are the petrochemical industry and coal-powered energy plants. Waste dumping contributes to the contamination of the fish in waterways. Traditional disposal of mercury in waterways continued through mid-1980 when an international effort from industrialized nations to reduce mercury emissions changed long standing waste disposal practices (1). Concerns for public health and safety has led to legislation creating the Clean Water Act, the Clean Air Act, limits on waste disposal, and global monitoring and surveillance programs to map out problem areas advancing appropriate measures that protect public health by cleaning up contaminated areas, reducing mercury emission, and preventing further mercury pollution (2).

Acute neurotoxicity includes but is not limited to, general malaise, tremors, muscular disorder, and hearing loss (4). Long-term exposure in adults causes crippling, coma, and death while infants with chronic exposure show signs of blindness, seizures, cerebral palsy, and psychomotor damage (4).

Fish and mammals consume the contaminated plankton and invertebrates (that feed off contaminated microbes) and through bioaccumulation each subsequent species is exposed to increasing concentrations of mercury (5). Bioaccumulation determines which variety of fish has the higher level of methyl mercury contamination. As predatory fish consume quantities of contaminated lower food chain fish, their concentration of mercury increases in their skin tissue and muscle tissue (6). Similarly, humans consuming predatory fish are going to have a higher concentration of mercury. However, the consumption of fish has many health benefits, and the risk of mercury contamination can be offset by consuming non-predatory fish.

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