American Public Health Association Joint Policy Committee 2021 Spring Meeting

April 29-30, 2021 via Zoom

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Attendees

Action Board Representatives
Anne Dressel, Co-Chair
Celeste Monforton
Shirley Orr
Lori Spruance

Science Board Representatives
Jeffrey Hall, Co-Chair
Danielle Campbell
Ben King
Angela McGowan

Education Board Representatives
Shontelle Dixon, Co-chair
Elaine Archie Booker
Donna Davis
Nizar Wehbi

APHA Staff
James Carbo
Courtney Taylor
Donald Hoppert
Jordan Wolfe

Twelve (12) members of the Joint Policy Committee completed reviews of the proposed policy statements for 2021. All twelve members were present when the meeting was called to order, but at times between 1-3 members were not present due to conflicting commitments. However, at the time of each vote, the Committee attained quorum (7 members).

Business

The meeting was called to order at 3:05PM ET on April 29, 2021 by co-chair, Shontelle Dixon. All members introduced themselves and co-chair, Jeff Hall reviewed the house rules. The entirety of April 29th was spent reviewing proposed policy statements. Each review included a summary of the Science Board review from a JPC Science Board representative, followed by a review from both the first and second reviewers. A co-chair then opened the floor for discussion, followed by a motion and vote by the JPC members. Each proposal was given a maximum of 15 minutes for discussion unless a motion was passed to extend the time further. The meeting adjourned at 6:00 p.m. by co-chair, Anne Dressel.

The meeting was called back to order by the co-chairs on April 30, 2021 at 11:04AM ET by co-chair, Jeff Hall. April 30th began with reviewing proposed policy statements. The format for these reviews was the same as on Day 1. Following the conclusion of the proposed policy statement reviews, the JPC discussed other business including adherence to the author guidelines particularly with regards to number of citations and length of the proposed policy statements; how to address emerging evidence in revisions of proposed policy statements related to COVID-19; and the possibility of suggesting more frequent review of policy statements related to COVID-19 (vs. current standard to archive in 10 years) to ensure they keep pace with emerging evidence, policy, and practice. The members then worked to draft letters and comment tables to proposed policy statement authors. The meeting adjourned at 5:35PM ET.

Proposed policy statements were given an overall assessment of positive, conditional or negative based on adherence to author guidelines and the strength of the arguments and evidence:

- **Positive** - Policy statement meets all guidelines, is scientifically sound and concisely written; any changes necessary are minor and can be addressed in the copyediting phase
- **Conditional** – Policy statement meets most guidelines but requires some revision to strengthen the arguments and evidence presented and improve minor grammatical and formatting issues
- **Negative** - Policy statement does not meet guidelines, lacks or improperly cites scientific evidence, arguments presented are biased or one-sided; contains major grammatical and formatting errors.

Assessment Summary Table

Proposed Policy Statement	JPC Initial Assessment
A1: Supporting physical education for all youth	Conditional
A2: Prevention of lower extremity amputations due to non-traumatic loss of sensation and loss of circulation	Conditional
A3: A Comprehensive Approach to Suicide Prevention within a Public Health Framework	Conditional
A4: Advancing Public Health and Equity through Prevention and Reengagement of Opportunity Youth	Conditional
A5: An Interprofessional Approach for the Prevention and Management of Diabetes and Associated Complications	Conditional
A6: Reduce exposure to excessive level of household debt and conduct more inter-disciplinary research on over-indebtedness and health	Conditional

Proposed Policy Statement	JPC Initial Assessment
B1: Ensuring Support for and Access to Self-Managed Abortions	Conditional
B2: Call for Urgent Action to Address Health Inequities in the U.S. Coronavirus Diseases 2019 Pandemic and Response	Conditional
B3: Adopting a Single-Payer Health System	Conditional
B4: Addressing Coercion in Contraceptive Access to Promote Reproductive Health Equity	Conditional
B5: Sexual and Gender Minority Demographic Data: Inclusion in Medical Records, National Surveys, and Public Health Research	Conditional
B6: The Importance of Universal Healthcare in Improving our Nation's Response to Pandemics and Health Disparities	Conditional
B7: An Equitable Response to the Ongoing Opioid Crisis	Conditional
B8: Structural Racism Is a Public Health Crisis: Impact on the Black/African American Community	Conditional
B9: The Role of Health Departments in Activities Related to Abortion	Conditional

Proposed Policy Statement	JPC Initial Assessment
C1: Environmental Noise Pollution Control	Conditional
C2: Ensuring Equity in Transportation and Land Use Decisions	Conditional
Proposed Policy Statement	**JPC Initial Assessment**
D1: Advancing Public Health Interventions to Address the Harms of the Carceral System	Negative
D2: Preparing the US Public School System for the Next Public Health Emergency: Lessons Learned from COVID-19	Conditional
D3: A Call to Investigate and Prevent Further Violations of Sexual and Reproductive Health Rights in Immigration Detention Centers	Conditional

A1: Supporting physical education for all youth

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 2- Sufficient Scientific Reasoning

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Considering adding "in schools" to the end of the title for clarification that this is a school health issue.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now). If the	The rationale is reasonable and identifies a gap in existing APHA policy. Well written policy statement, however, need to address grammar and punctuation errors throughout the policy statement. There should be more discussion about the spectrum including physical activity, physical education and recreation in the community, with family and at school and with peers. Add something on financing and budgeting to assure feasible recommendations, particularly for local school boards who are often facing substantial budget challenges

proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? a. Are there important facts that are missing from the problem statement? If so, describe them. b. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? c. Identify any relevant ethical[i], equitable[ii], political or economic[iii] issues.	Reduce the redundancy of the statistics on students who do not meet physical activity guidelines. Update references to the 2017 YBRSS and review the CDC references for possible updating as well. Several of the more important stats from the 2016 SHAPE of the Nation report (at pps 3 and 12) relate to the amount spent of PE budgets–the median PE budget for schools in the US is only $764per school per school year, with $460 for elementary schools, $900 for middle schools, and$1,370 for high schools. Mental health, behavioral, and cognitive benefits of physical education and physical education programs should be incorporated into the draft policy statement. Clarify current requirements by state/grade level so it is clear what is being asked to be supported specifically as far as amount of PE per week and length of classes. Add a stronger argument made between obesity and physical activity, particularly in the second paragraph. The majority of this paragraph is focused on obesity versus the issues that correspond with lack of physical activity. Instead of focusing merely on obesity, I would like to see the authors connect lack of physical activity directly to cardiovascular disease, certain types of cancer, high blood pressure, diabetes, etc. Please update the Lee, Burgeson, et al. Citation. This is suggested because it seems outdated given that there are a variety of sources documenting middle school physical activity rates. Consider moving these two sentences “Only 7.9% of middle school students meet the recommended number of physical activity minutes per day (Lee, Burgeson, Fulton, & Spain, 2007). The trend of inactivity continues through high school students, where only 27% meet the physical activity recommendations (CDC, 2015)” to the previous paragraph. The last paragraph belongs as the second to last paragraph. You move from talking about physical activity to physical education back to physical activity. It felt disjointed.

	Ensure that the acronym PA is defined before use and is consistent. Please increase the specificity / present more specific data on age range addressed, schools with large majority or minorities, and disadvantaged youth.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? a. Is/are the proposed strategy/strategies evidence-based? b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. c. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	The proposed strategy is evidence-based, ethical, equitable and reasonable. Another strategy that should be included is the incorporation of Community Health Workers (CHWs)to promote physical activity (PA) both in XI. 4. Culturally Tailored Physical Education & under XI. Alternative Strategies Classroom-based PA. Additional evidence for proposed strategy can be found here:1.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4565764/ 2.https://journals.lww.com/ambulatorycaremanagement/fulltext /2015/10000/community_health_workers_promoting_physical.7. aspx3.https://www.scirp.org/html/6-8203091_50503.htm The discussion in this section could be strengthened if the amount of detail was minimized–the important points and the general thrust of the draft policy statement are overwhelmed by too much detail. Include a section or add to the section titled “improve school-based physical education” the importance of having teachers who are trained in physical education pedagogy, transitions, etc. In some states, it’s not required to have a PE teaching degree/license to teach PE. This would be a major first step in improving PE in schools. Please use MVPA consistently and identify the meaning of the acronym before use. Also consistently use PE or physical education. As are former physical educator myself, I believe “physical education” is more formal and brings respect to the profession. Please define or give an example of what “knowledge-based activities” are. Please define or give an example of what “tactical games model” is Clarify what ESBP stand for in the “increase the frequency and length of physical education requirements.” In the second strategy recommendation consider whether an appropriate conclusion is that we need highly trained teachers

	who utilize teaching strategies to make use of the time they've been given. The argument to key stakeholders that "we don't use our time efficiently for PE" doesn't seem that it would attract a lot of support. Most of this section should be moved to the first section highlighting why good teaching strategies are needed. Leave this section to only talk about the need for daily PE and add studies that discuss the benefits of DAILY physical activity. Re: reduction or removal of waivers/substitutes/etc. section- recommend citing The Centers for Disease Control Whole School, Whole Community, Whole Child model, Every Student Succeeds Act of 2015, the American Heart Association, the U.S. Surgeon General and the National Association of State Boards of Education instead of using the SHAPE citation. In the Culturally Tailored Physical Education section, please clarify how are indigenous peoples different from minority ethnic and cultural groups? Recommend using the phrase "groups from minoritized backgrounds" versus other language use. This is considered people first language. Add certified health workers (CHW) and certified health education specialists (CHES) to promote and educate youth on PA; needs more detail. Also, add importance of having teachers trained in PA. Address the cost of PE in schools. Include alternate PE activities such as dance, performing arts and address gender inclusivity in PE and sports activities. Add more benefits of PA outside of obesity. NHANES- need to extend to younger children. Acronyms – need to be defined and consistent. Strengthen the connection from lack of PA to cardiovascular disease, cancer, etc. 2nd strategy – conclusion needs highly trained teachers vs. time Consider situations in which waivers are appropriate

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. b. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? c. Are alternative viewpoints, ethical, equitable and reasonable? d. Were any opposing views missing?	Arguments need to be developed better and more fully elaborated. Please consider addressing why students participating in sports should not receive waivers from PE. This is not quite clear. Alternative strategies: "after school programs" indicates formal programs that take place after school (e.g. Boys and Girls Club, etc.). Did you mean "time outside of school" or true after school programs? Suggest revising and clarifying. Active transportation to school includes more than walking or biking (e.g. scootering). Recommend using "active transportation" as your catch-all term in this section. Recommend considering that while the CPSFT may not have found evidence, there are ample other studies that suggest that active transportation to school *does* increase PA. (see: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-5005-1#:~:text=Consistent%20evidence%20shows%20that%20children,cardiometabolic%20health%20profile%20%5B3%5D.) The recess section focuses heavily on elementary education, through you state high schoolers would be engaged in "active play" if they were given "recess" time. We suggest revising this for more age-appropriate activities like intramural sports, yoga, walking groups, etc. Comprehensive School Physical Activity Programs (CSPAP) has been a big initiative of SHAPE America. It is based on the CDC Whole School, Whole Community, Whole Child model mentions on page 7. This should be a focus of the alternative strategies. It is based on the CDC Whole School, Whole Community, Whole Child model mentions on page 7.
Action Steps Are the **ACTION STEPS**: a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? b. Focused on policy/principle, and not on specific legislation/regulation?	Action Steps must be externally directed (not speak from APHA). Revise the intro accordingly and in line 31 remove "Therefore APHA urges" Increased funding for physical education at all levels should be specifically recommended. Family and community advocacy and peer pressure should be considered as an action step, not only with schools and school departments but also with respect to state and local legislatures. Soliciting and/or mandating the involvement and expertise of state and local health departments and the positive physical and mental health impact of school-based physical education should also be considered as an action step.

c. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Encourage principals and superintendents to reduce or eliminate policies allowing waivers for physical education. Ensure that there are more detailed mitigations to ensure that physical activity does not promote dangerous infliction upon the students and that if it is medical in nature, that a waiver be considered on a case-by-case basis. No sense in endangering or further injuring students in the hopes of promoting physical activity. Consider opportunities for virtual physical activity. Consider adding an action step to Require credentials for PE teachers. Consider adding a call for increase in funding at all levels Explore the role of family and community advocacy including community and health departments. Focused at state and local level; add national level policy action step. Discuss nutrition and obesity prevention.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	In-text citations did not appear to be correctly cited in APA format (commas after et al., etc.). Citations in the references list also did not follow APA guidelines (e.g. sentence case for titles of journal articles) Several references are more than 5 years old. Replace with more recent literature if available. Consider adding the following references: Trost, Stewart (2006) Public health and physical education. In Kirk, D, Macdonald, D, & O'Sullivan, M (Eds.) Handbook of physical education. Sage Publications, United Kingdom, pp. 163-187. Charles B. Corbin, Pamela H. Kulinna & Hyeonho Yu (2020) Conceptual Physical Education: A Secondary Innovation, Quest,72:1,33-56, DOI:10.1080/00336297.2019.1602780 Overall assessment of proposal Barrett JL, Gortmaker SL, Long MW, et al. Cost Effectiveness of an Elementary School Active Physical Education Policy. Am J Prev Med. 2015;49(1):148-159. doi:10.1016/j.amepre.2015.02.005 Ohinmaa A, Langille JL, Jamieson S, Whitby C, Veugelers PJ. Costs of implementing and maintaining comprehensive school health:

	the case of the Annapolis Valley Health Promoting Schools program. Can J Public Health. 2011;102(6):451-454. doi:10.1007/BF03404198AC64 CDC Guide to PE-https://www.cdc.gov/healthyschools/physicalactivity/physical-education.htm The CDC resource to support schools as the most important places for physical activity intervention on page 5 is from 2013. It would be good to have a more recent source from CDC. There are several other sources that are more than 5 years old and would be best to have more recent studies and sources.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: a. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? b. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? c. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic,	

specifically, the International Human rights Committee and the Ethics Section?	
Member Comments: What are the major comments by APHA units with expertise on the issue?	Strategies on management of classroom statistics to provide impactful physical activity programs during physical education classed should be addressed. The Mental Health Section strongly recommends that the draft policy statement be revised to incorporate more references to the important mental health, behavioral, and cognitive benefits that can result from school-based physical education and physical education programs, and that connections between social determinants of health and physical education are more clearly made. Specific reference should be made to Policy Statement Number 201415 (Nov. 18, 2014), Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health The proposed policy statement needs to take a more comprehensive approach to increasing physical activity, at present seems very narrow that increasing PE time is only option.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization).	Please consult with members from School Health if they have any expertise and are willing to chime in.

A2: Prevention of lower extremity amputation due to non-traumatic loss of sensation and loss of circulation

Science Board Assessment: 3b- insufficient evidence, requires a lot of additional evidence; 3b- insufficient scientific reasoning- requires major revision

JPC Assessment: Conditional

Vote: 12 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existingAPHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the	The authors note that a related policy (20002) "Reducing the incidence of blindness, lower extremity amputation, and oral health complications in minority populations due to diabetes," was archived in 2019. This proposed policy addresses one of the topics in the archived policy statement. Another proposed policy submitted, entitled " A5- An Interprofessional Approach for the Prevention and Management of Diabetes and Associated Complications" may address the other topics that were

author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	previously addressed in the archived policy statement. Collaboration between the two author groups is encouraged The authors indicate in the rationale that there is a rise in NTLEAs. However, there is no clear presentation of data regarding the current and historical incidence of NTLEAs. Please provide evidence to strengthen this section.
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? d. Are there important facts that are missing from the problem statement? If so, describe them. e. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? f. Identify any relevant ethical[iv], equitable[v], political or economic[vi] issues.	Consider defining the differences between non-traumatic lower extremity amputations vs. traumatic lower extremity amputations. Quantify the statement pertaining to NTLEA as a "major public health burden." Clarify/quantify the statement in line 29-31: "Not only do NTLEAs cause a significant financial strain on our healthcare system, they disproportionately affect those of lower SES and are known to be a preventable complication Explain why NTLEAs are increasing (line 31) Provide data to support the statement that the "risk for major amputation is significantly higher for African American, Hispanic, and Native American patients…" (line 6-8). How many people does it impact? Provide more detail on how a healthcare provider reaches the decision to amputate. As currently written, this proposed policy statement reads as a policy for clinical recommendations that may be more appropriate to a professional society advocating for services and reimbursement. Additional emphasis and evidence regarding the public health and prevention aspects are needed, including evidence to inform primary and secondary prevention strategies. Consider including additional evidence from the following sources: • Carls, G.S. et al. (2011). The economic value of specialized lower-extremity medical care by podiatric physicians in the treatment of diabetic foot

	ulcers. *Journal of the American Podiatric Medical Association, 101*(2), 93-115. • Liu, M., Zhang, W., Yan, Z., & Yuan, X. (2018). Smoking increases the risk of diabetic foot amputations: A meta-analysis. *Experimental and Therapeutic Medicine, 15*(2), 1680-1685. https://doi.org/10.3892/etm/2017.5538
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? d. Is/are the proposed strategy/strategies evidence-based? e. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. f. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Consider broadening the provider perspectives (I.e., highlight how other HCPs play a role in diagnosing, deciding to amputate, etc.) It should also be noted the role prevention plays – how do we keep patients who are at-risk for amputation healthy and well? Address the following questions to strengthen the section's content: • Are the barriers to secondary prevention a lack of enough providers or patients not being identified as at risk or patients not having access/ or being seen for follow-up care? • Are there any data to help explain this? • Are there studies with data regarding efficacy of primary prevention strategies mentioned? • Is there data regarding barriers to secondary prevention—is it a lack of providers or patients not being identified as high risk? Include structural racism and broader social determinants that prevent adequate access to care for preventive and specialist care and to footwear; also, social drivers (including housing, transportation, water) that impede access to preventive care and increase risk of complications. Note how these strategies would address the issue that the burden of NTLEAs appear to impact minority groups more heavily. Explain the diversity of podiatrists and their willingness to accept Medicaid and Medicare rates Page 7, line 13: clinical language "…5.07 monofilament…". Please describe whether this is necessary for a general public/public health advocacy.

	Page 7, lines 11-31: would be improved with a reframing. Describe the established recommendations from expert bodies in terms of their effectiveness. Add data showing the effectiveness of multidisciplinary teams to improve Page 8, line 8-14. Page 8, lines 16-26: Revise with a simple statement of value of revascularization and limb salvage, and more focus on the strategies that show this secondary prevention strategy is effective. Page 8, line 25: specify what "loan repayment" program or programs. Also, in responding, please clarify the following: (1) whether this related to Action Step (e); (2) are you referring to the NHSC loan repayment program, DPMs currently included? Page 10, line 10: Does Ref. 44 say that providers choose amputation over preservation due to reimbursement? Please provide more detail regarding issues with the Medicare Therapeutic Shoe Program and how improvements would improve access to care. Are there examples with commercially insured or dually enrolled Medicare/Medicaid patients where access to shoes was improved or worsen and what that meant for the disease/condition? Consider the following reference to develop a strategy re: tobacco as tobacco consumption increases the chance of diabetic foot (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774386/pdf/etm-15-02-1680.pdf), patient education and advise on smoking cessation should be included in the secondary prevention strategy for the smokers.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? e. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.	Consider adding additional information to refute opposing arguments, including mental health and ethical considerations. The cost saving argument for amputation is incomplete as it only discussed amputation vs multidisciplinary teams and does not include long-term financial or social costs of amputation. Include discussion of the mental health aspects of amputation to offer a stronger argument. In the first opposing argument, the authors assert that some NTLEAs are medically necessary. There does not appear to be a refutation to this statement. Please include data on how many

f. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? g. Are alternative viewpoints, ethical, equitable and reasonable? h. Were any opposing views missing?	NTLEAs are considered medically necessary and how many are not to help make the case for a need to reduce NTLEAs that are not medically necessary. The second opposing argument pertains to the idea that NTLEAs can result in cost savings for the healthcare system. Is there evidence that can be included about costs savings from prevention efforts that could refute this? The third opposing argument discusses the idea that Medicaid reimbursement rates are higher for amputations than for vascular procedures to prevent them. This statement could use some strengthening. What does this mean nationwide? And a refutation to this statement is the significant ethical implications of choosing amputation for higher reimbursement.
Action Steps Are the **ACTION STEPS**: e. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? f. Focused on policy/principle, and not on specific legislation/regulation? g. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? h. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Assure that every action step is clear as to whom the recommended action is addressed. For example, who should increase funding? Who is responsible for implementing the action step? Consider including more non-federal action steps. There are no specific action steps that address the disproportionate burden of this issue on minority populations, those of lower SES, and those living in rural/urban areas. Consider adding an action step that would address these disparities. Action step a.–Consider expounding upon and clearly defining what "screening and preventative footcare services" are/look like. Consider the Comprehensive Diabetic Lower Extremity Exam model that includes a comprehensive exam that results in categorization of the patient based on risk that in turn guides follow-up planning (frequency of follow-up) and that these preventive visits, scheduled based on risk categorization, should be covered services. Action step b.– Who is the target of this action step? How does the references used support the action step? Specifically, you have introduced structural violence in this action step as incentivizing amputation over limb preservation and none of the references seem to directly speak to "structural violence." Additionally, it might be beneficial to define the phrase "structural violence" and connect it to the topic of amputation

	prevention prior to the action step section. Consider making the "structural violence" comment its own action step. Action Step (c): Rephrase with CMS as the target for the action. Rephrase to clarify who should finance. Action Step (d): Define the advocate. The assessment, monitoring, etc. of multi-disciplinary teams is not mentioned in the body of the document (problem statement and evidence-based strategies). Is "limb salvage" team the appropriate team, or can it be described as the multidisciplinary team? Action Step (e): What agency should expand? Consider explicitly adding "doctors of podiatric medicine" to the action step to read: Expand the national loan repayment program, including the National Health Service Corps (NHSC) Loan Repayment program, to provide financial incentives for specialists to practice in rural or medically underserved areas of the United States. As well as expand NHSC loan repayment program, generally to include doctors of podiatric medicine as an eligible profession. Action Steps (f): Please clarify who should increase research funding. Action Step (g): Who should do this? The need for this is not mentioned in the body of the document (problem statement and evidence-based strategies). [For example, how will this information get to patients? Will providers be asked to refer patients to it?] Action Step (h): Who would be responsible for making this happen?
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	There were two additional articles that were identified by reviewers that could potentially strengthen the policy statement. Consider including these in the problem statement. Carls, G.S. et al. (2011). The economic value of specialized lower-extremity medical care by podiatric physicians in the treatment of diabetic foot ulcers. *Journal of the American Podiatric Medical Association, 101*(2), 93-115. Liu, M., Zhang, W., Yan, Z., & Yuan, X. (2018). Smoking increases the risk of diabetic foot amputations: A meta-analysis. *Experimental and Therapeutic Medicine, 15*(2), 1680-1685. https://doi.org/10.3892/etm/2017.5538

Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: e. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? f. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? g. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? h. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments: What are the major comments by APHA units with expertise on the issue?	Costing and structural racism should be addressed Data that report race/ethnicity/age disparities in these conditions/disease rates should also be included to support the problem statement. Elaborate on the known/potential social determinants of health that lead to higher amputation rates among African Americans. Address social drivers of barriers to preventive screenings.

	The financial burden of NTLEAs (page 6, line 27) needs to be better articulated. The problem statement could include more information that might show that the topic is not mainly focused on race and socioeconomic factors but also on regions in the US that may not have adequate access to healthcare. MH challenges that could result in loss of limbs is not adequately explored in Problem Statement. Epidemiological data to describe the incidence/prevalence of PAD, CLI, and diabetes mellitus should be included to strengthen the problem statement. This will also help to make the case that this is a major public health problem. Native American should be changed to American Indian/Alaska Native throughout the policy. Include, if in existence, seminal studies on the efficacy of primary prevention strategies that are mentioned. The opposing argument section is missing some information to refute the opposing arguments. Specifically, what is the conflicting evidence against major amputation (page 9, line 16); conflicting government effort on non-traumatic lower extremity major amputation prevention (page 10, line 7) Action steps D and G are not largely mentioned in the problem statement and evidence-based strategies. Detailing these above in the policy statement may help the reader to understand why these steps are needed. There is a clarification/distinction that should be made on page 5, lines 19-25. Specifically, line 21 starts with the idea that "but these services are currently considered optional under many state Medicaid programs." The services are not considered optional for the state administering the program. The patient can get those services by other providers/provider types who are part of the state Medicaid program, just not necessarily by the specialist of their choice, in this case a DPM. The reference to "optional services categorization" is not accurate. The services are not categorized as optional; the specialist/DPM might be a provider type that is considered option or the state administering the Medicaid program. The issue then becomes an access issue in that there may not be enough other provider types offering these preventive foot and ankle services to go around for patients in the need of the care.

	Preventive/routine/at-risk foot care is not consistent, not defined clearly, and not generally covered. It is not clear if the authors are referring to “podiatry services” being optional or “preventive foot care” as being optional. The authors should consider adding the Comprehensive Diabetic Lower Extremity Exam (CDLEE) model to the strategies for Primary Prevention. It is like the HRSA LEAP program’s annual foot screening but more prescriptive in terms of the exam being performed and the resultant risk categorization that guides follow-up frequency. In Financial Burden section of Problem statement list annual health cost for all related conditions, DM, DFUs, PAD, and neuropathy (not just CLI) Highlight/address social drivers of the problem of non-traumatic lower extremity amputations.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	This proposal overlaps with PPS A5, Diabetes Prevention and Management. Recommend that the authors collaborate with the authors of A5 to create one comprehensive PPS that incorporates a strong focus on public health and prevention.
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

A3: A Comprehensive Approach to Suicide Prevention within a Public Health Framework

Science Board Assessment: 3a- Insufficient evidence, requires minimal evidence; 2- Sufficient scientific reasoning

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e.,	

why APHA should adopt a policy on this issue now). If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? g. Are there important facts that are missing from the problem statement? If so, describe them. h. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? i. Identify any relevant ethical[vii], equitable[viii], political or economic[ix] issues.	The problem statement overall provides solid available evidence. The section could benefit from minor clarifications of content in a small number of places and possible additions of a few more current references. Notes to support this appear below. Page 5, Lines 2-7: WISQARS is referenced. However, the statements in lines 2-7 draw on more interpretation that what is available via WISQARS. Please clarify whether this content draws on analyses completed by the authors or another source. Page 5, Lines 24-25: Add more recent data on suicide risk by sexual identity from Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students — Youth Risk Behavior Survey, United States, 2015–2019 | MMWR (cdc.gov) Page 6, Lines 2-4: please clarify the date to which statements from YRBSS data are anchored. Are these for 2018? Page 6, Lines 4-6 : For the statements regarding AI/AN adults and risk for past-year suicide-related thoughts and behaviors, the Substance Abuse and Mental Health Data archive is referenced. Are the statements made based on authors analyses of these data? This should be clarified. Also, to what data year are the statements anchored? 2018? It isn't clear currently. This should be the case for other occurrences where author's unique analyses may be being presented. Page 6, Lines 13-15: Should the reference for the sentence be for WISQARS versus WONDER? Please confirm. The former has info on the factors preceding suicide while the later does not. Page 6, Lines 21-22: An additional meta-analysis that may be relevant is Risk Factors for Suicidal Thoughts and Behaviors (kleimanlab.org) Page 6, Lines 28-30: Suggest including recent references discussing ties of COVID-19 pandemic to suicide risk if space permits. Examples of works covering this included but are not limited to the following. • Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., ... & Yip, P. S. (2020). Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry*, *7*(6), 468-471.

	• Sher, L. (2020). The impact of the COVID-19 pandemic on suicide rates. *QJM: An International Journal of Medicine*, *113*(10), 707-712 • Fitzpatrick, K. M., Harris, C., & Drawve, G. (2020). How bad is it? Suicidality in the middle of the COVID-19 pandemic. *Suicide and Life-Threatening Behavior*, *50*(6), 1241-1249. • Moutier, C. (2020). Suicide prevention in the COVID-19 era: Transforming threat into opportunity. *JAMA psychiatry*. Page 7, Lines 32-34: The premise of the sentence is that suicide prevention requires parity. However, the reference provided does not mention suicide. It only speaks to the framing of parity in the Patient Protection and Affordable Care Act. Suggest including a second reference that more substantially establishes the need for parity. There may be relevant reference, for example, related to the Mental Health Parity and Addiction Equity Act of 2008 and recent efforts to accelerate mental health parity compliance such as those described here: Norcross, Courtney, Kuster, Fitzpatrick Introduce Bill to Enforce Mental Health Parity, Hold Insurance Companies Accountable | Congressman Donald Norcross (house.gov) untitled (house.gov) Parity Enforcement Act of 2021 -one-pager.pdf (house.gov) Page 8, Lines 1-7: Additional, more current references that could strengthen content here include but are not limited to the following: • A Call for Behavioral Emergency Response Teams in Inpatient Hospital Settings | Journal of Ethics | American Medical Association (ama-assn.org) • Transforming Mental Health And Addiction Services | Health Affairs The proposal does not address ethical and political issues or go into detail regarding equity or economic issues. Add relevant ethical, equitable, political or economic issues that could attach given the scope of coverage. Address political barriers when discussing matters such as access to lethal means for those at risk, given the proximity to debates around 2nd Amendment rights. An additional layer of political complexity could also be added if a focus on differences in responses to the prospect of suicide among diverse groups were present. For example, efforts to reduce and eliminate suicide and address suicide related phenomena among LGBTQ youth are occasionally confounded or opposed by those who oppose expansion of rights and inclusion for such youth or for persons who are LGBTQ more broadly.

	Consider addressing the siloing of mental health, public health, behavioral health, and suicide prevention, and how a comprehensive approach could help to address this. Other issues to consider including: the way that suicides can become epidemics or contagion in communities (especially those among youth and focusing on at-risk conditions) and the role of the media. The role of hospitals, ER visits and health care providers could be expanded. Add more discussion of children and youth as we are seeing a trend in children of younger age completing suicide. There is 2019 WISQARS data from CDC for youth which should be quoted as suicide is the second leading cause of death in 10-34-year olds. Expand the discussion of risks and protective factors to discuss both protective and risk factors. Additionally, suicide means including medications, anti-depressants, opioid use disorder, and other should be included. Include studies from CDC and the Community Guide on suicide prevention and especially the need for a comprehensive approach. In this risk and protective factors section, the statement that suicide prevention is underfunded, could also mention CDC's report, the State of State, Territorial, and Tribal Suicide Prevention: Findings from a Web-Based Survey - https://www.cdc.gov/suicide/pdf/State-of-the-States-Report-Final-508.pdf Update data to those most currently available (e.g., WISQARS). In relation to the statistics quoted on 3-year loss life expectancy in the United States between 2015 and 2018 attributed to suicide, drug overdose and alcohol, it would be interesting to pull in the change during 2020 when some of the drivers mentioned in this section have been exacerbated by the COVID-19 pandemic (there have been several articles on this recently). Consider providing additional information on the rates and outcomes for various populations (e.g. the high rates with AI/AN, Asians, and black youth). In para 6, the reference to NSDUH should make it clear that this only includes data for adults. Consider adding discussion about the YRBSS data (at least the trends over time with some responses).

	Add information re: the data-needed to do this work would be helpful. When discussing hurdles in obtaining data-sharing agreements necessary for extra data sources, additional information could be helpful around the hurdles to data-drive decision-making. Include a statement about support for syndromic surveillance which has the potential to provide timely morbidity data. Several projects funded by CDC in Fall of 2020. Funding - https://www.cdc.gov/suicide/programs/ed-snsro/index.html Article on data - Zwald ML, Holland KM, Annor FB, et al. Syndromic Surveillance of Suicidal Ideation and Self-Directed Violence — United States, January 2017–December 2018. MMWR Morb Mortal Wkly Rep 2020;69:103–108. DOI: http://dx.doi.org/10.15585/mmwr.mm6904a3 Discuss the role of the media (especially social media) and its influence on suicide beliefs and culture as well as contagion. CDC has guidance about how to address a suicide in the news, but it's not always followed appropriately. Additional information for the problem statement: Medications, such as psychotropic medications, anxiolytics, antidepressants and stimulant medications are estimated to account for 20% to 30% of suicides. Brown TL et al. J Clin Psychiatry 2018;79(6): 17m11982. Access to psychotropic medication via prescription is associated with choice of psychotropic medication as suicide method: a retrospective study of 27,876 suicide attempts. Tadros A, Layman SM, Davis SM, Davidov DM, Cimino S. J Emerg Med. doi: 10.1016/j.jemermed.2015.06.035 Suicide risk factors include opioid use disorder, chronic pain or mood disorder Volkow ND, Jones EB, Einstein EB, Wargo EM. Consider discussing law enforcement response and lack of training for mental health crises could have been included since they are often the first responders in these situations. There is a training specifically for law enforcement, one is from Columbia Lighthouse Project: the Columbia Suicide Severity Rating Scale. There are different versions for various settings such as law enforcement, hospitals, emergency rooms, etc. This screening tool was used with the Department of Defense as well as many settings around the world. It can be used by community members such as school personnel. The MSPI grant for the Cass Lake Hospital used it throughout the community (Leech Lake Band of Ojibwe) to facilitate earlier access to mental health counseling and reduce unnecessary emergency room visits for

	suicidal ideation. This grant was a five-year period ending in September of 2020. If possible and evidence (i.e., intervention studies on the societal and economic impact) exists to support the statement "the absence of [a strong state] infrastructure almost certainly compromises suicide reduction efforts to a significant degree",18 it would be helpful to include this evidence to support funding at the federal and local levels.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? g. Is/are the proposed strategy/strategies evidence-based? h. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. i. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	The strength of the evidence is limited by the depth of coverage possible given the choice of comprehensive approach that covers many different nuanced domains of suicide prevention. Add evidence for the effectiveness of the strategies proposed. Ex) • Hegerl U, Wittmann M, Arensman E, et al. The 'European Alliance Against Depression (EAAD)': a multifaceted, community-based action programme against depression and suicidality. *The World Journal of Biological Psychiatry.* 2008;9(1):51-58. • Shand F, Torok M, Cockayne N, et al. Protocol for a stepped-wedge, cluster randomized controlled trial of the LifeSpan suicide prevention trial in four communities in New South Wales, Australia. *Trials.* 2020;21(1):332. There are reviews cited that are bases for faith in the approaches proposed. Page 8, Lines 21-22: The sentence and others prior to this one cite a reference that is currently in press. Update when new version is published. Page 8, Lines 26-28-: Several statements are made before this sentence. It is not clear which reference the statements are linked to. Reference 25 focuses on risk of suicide and related adverse outcome after exposure to a suicide prevention program in the U.S. Air Force. Does this reference support the more broadly construed argument made? Do its findings tie substantively to the more general statements made here? Page 9, Lines 5-8: An additional reference for this statement that is a bit more current might be this item: **Preventing suicide: A global imperative** 9789241564779_eng.pdf;jsessionid=C3854E163903F87E37CE7ED023D80C13 (who.int) Page 9, Lines 9-12: What constitutes "appropriate infrastructure"? What is this referring to concretely? Is this

	saying organizational structures within systems that have robust education and training capacities? Please clarify. Also, the general discussion of infrastructure in the section is very abstract. What are specific examples of infrastructure components or elements that could be engaged or improved for suicide prevention? Page 9, Lines 23-26: The statement here would benefit from elaboration to clarify its potential relevance for the paragraph's statements regarding machine learning. What elements of the bill highlighted in particular might afford this specific opportunity? Beyond the general possibilities for expanded firearms research that might be present? Page 10, Lines 2-4: Are there additional multicomponent approaches implemented in the U.S. that could also be mentioned? Beyond the specific space occupied by the U.S. Airforce example, it might be helpful to have one instance of a broader general population model for interested parties to consider. Add discussion of the CDC suicide prevention strategy. https://www.cdc.gov/suicide/strategy/index.html. These are well researched recommendations, evidence-based and equitable, and have been disseminated widely. Discuss economic supports in the strategies elsewhere in the proposal. Add information about community health workers and providers, advocating for trauma-informed social policy, trauma care from a population health perspective, and ensure service delivery systems are trauma informed which might have downstream implications, teach coping and problem-solving skills. Discuss the costs of the strategies could be included for reference. Consider further calling out the need to provide educational interventions at the individual level. This is included in the action steps, but perhaps calling it out clearly here shows the importance of individuals in the care of those they are close to/can intervene for if necessary. The American Psychiatric Association has advocated limiting access of at-risk individuals to lethal quantities of prescription medications, (APA, 2019) American Psychiatric Association. Reducing Patient Access to Lethal Quantities of Medication.

	2019. Accessed at www.psychiatry.org/File Library/Psychiatrists January 16, 2021. Consider adding strategies around restricting access to prescription medications in lethal doses and proper storage. Add Proper medication storage as an additional reduction strategy. Expand the strategies around the built environment Consider adding additional evidence to cover Mental Health First Aid, Youth First Aid and Teen First aid, widely used programs. Data should focus more on better quality and use of basic data by local and state practitioners and public health departments. In addition to the CDC Suicide Prevention resources, this could be a good place to reference the: Well-established infrastructure section, the sentence "Appropriate infrastructure can also support strategic, culturally informed public health campaigns" could provide the opportunity to cite Might also be an opportunity to cite Transforming Communities by the NAASP. National Action Alliance for Suicide Prevention: Transforming Communities-Community-Based Suicide Prevention Priority Group. (2017). *Transforming communities: Key elements for the implementation of comprehensive community-based suicide prevention.* Washington, DC: Education Development Center, Inc. https://theactionalliance.org/resource/transforming-communities-key-elements-implementation-comprehensive-community-based-suicide Add information about Extreme Risk Protection Orders. References suggested for inclusion in relation to evidence for strategies: • Bowen EA, Murshid NS. Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy. Am J Public Health. 2016;106(2):223-229. doi:10.2105/AJPH.2015.302970 • Magruder KM, Kassam-Adams N, Thoresen S, Olff M. Prevention and public health approaches to trauma and traumatic stress: a rationale and a call to action. Eur J Psychotraumatol. 2016;7:29715. Published 2016 Mar 18. doi:10.3402/ejpt.v7.29715 • Tebes JK, Champine RB, Matlin SL, Strambler MJ. Population Health and Trauma-Informed Practice: Implications for Programs, Systems, and Policies. Am J Community Psychol. 2019;64(3-4):494-508. doi:10.1002/ajcp.12382

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? i. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. j. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? k. Are alternative viewpoints, ethical, equitable and reasonable? l. Were any opposing views missing?	The 3 opposing views are noted but it's not clear as to from where they were derived. Please provide additional supporting evidence and references. In the first opposing view, include the feasibility of pulling all the strategies through at a national level (not just absolute costs, but pull-through perspective – how to operationalize the approach, who would led, how to roll out at state, local, territorial, tribal levels would be helpful.) In the 2nd example, consider citing evidence from GL Smith Memorial Youth Suicide Prevention program (section 1 on educating the general public). Garraza LG, Kuiper N, Goldston D, McKeon R, and Walrath C. Long-term impact of the Garrett Lee Smith Youth Suicide Prevention Program on youth suicide mortality, 2006–2015. In example b about messaging campaigns, cite evidence that awareness and education changes attitudes/beliefs about the preventability of suicidal behavior. The third opposing view could be made stronger with more information about how it has been "debunked." Consider as an alternative strategy a purely mental illness only approach to suicide prevention. Gun safety strategies are cited as an important step that can be taken in a way that can "meet the needs of the firearm community without infringing on Second Amendment concerns." Add an example of how this has been done successfully, such as creating a time delay in access to firearms. Rajan S, Branas CC, Hargarten S, Allegrante JP. Funding for Gun Violence Research Is Key to the Health and Safety of the Nation. Am J Public Health. 2018;108(2):194-195. doi:10.2105/AJPH.2017.304235 Although the policy statement describes the strategies to be employed, it fails to address the confluence of suicidal behaviors and substance use. The focus seems to be on firearm safety.

	While firearms are a primary means for suicide in males, substance use, which is a primary means for female, should also be addressed.
Action Steps Are the **ACTION STEPS**: i. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? j. Focused on policy/principle, and not on specific legislation/regulation? k. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? l. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Page 12, Line 13: The content should be revised slightly. This would entail indication of specific external entities that APHA calls upon to take the actions presented, where this is not done currently. It is acknowledged that this can be challenging. The mix of different actors potentially identifiable is considerable. But providing at least some greater specificity would be beneficial and align the section's content more directly with expectations for the action steps per the author guidelines. Which specific actors should APHA urge to take what actions to achieve strategy implementation and policy change? Page13, Lines 4-5: The stem for the section begins with "APHA urges:". Please consider revision to tie back to this stem. For example, "APHA urges national, state, territorial, Tribal and local public health agencies; health and behavioral healthcare systems; and educational institutions to improve data quality for suicide prevention by:...". This would address part of the prior revision recommendation. Most of the actions are feasible. One exception relates to an element on Page 13, Lines 6-9: The actions sought— "dedicating funding to strengthen and expand existing surveillance systems" has an additional, unacknowledged precondition: having funding available for dedication to support expansion and strengthening. The action would be strengthened if this requirement were addressed actively within the larger set of action steps. The appropriate actors for engagement should also be explicitly accounted for and noted. In the first step focused on the national strategy, it could be helpful to mention CDC's funding as an example: https://www.cdc.gov/suicide/programs/csp/index.html. Consider the advantage of incorporating recruiting the help of gun shop/firearm owning community. This could help to sway those who believe any strategies of this nature might violate the 2nd A. Consider an action step to engage community health workers and behavioral health colleagues. Consider calling for increased trauma-informed education among public health professionals, implementing trauma-informed

	public health system strategies (1) and trauma-informed public policies (2). • 1. Loomis B, Epstein K, Dauria EF, Dolce L. Implementing a Trauma-Informed Public Health System in San Francisco, California. Health Educ Behav. 2019;46(2):251-259. doi:10.1177/1090198118806942 • 2. Bowen EA, Murshid NS. Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy. Am J Public Health. 2016;106(2):223-229. doi:10.2105/AJPH.2015.302970 In addition to the entities name in section 2d, CMS (public payer) should also be included. For 6e, it is suggested that adding in the tie to the ACA as was heavily focused on care coordination – these suicide prevention and treatment action steps should be included in the concept of care coordination, that despite the ACA, is still a prominent gap in our healthcare system. Consider adding Action Steps to: • Improve Data quality and funds for prescription overdose databases • Promote lethal means safety – include controlled substances or medications as a means for suicide, and think about approaches including safe storage and disposal, specific prescription practices, etc. • Address to the media and online coverage of suicides • Support for expansion of successful programs (e.g., Air Force program) to other military groups, or the Asabaskin Tribal nation to other tribal communities, or MH First Aid programs.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	References were connected to the text and were mainly complete, up-to-date and peer reviewed. There are a few places where they should be updated (e.g. 2019 data is available, and you should reference CDC guidance since focused on a comprehensive suicide prevention approach). These are mentioned above where relevant.

Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: i. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? j. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? k. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? l. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	The proposed policy is supported by statistical data, strategies, and action steps, but limited information as to the "why" an individual would commit suicide and how could it have been prevented. Add specific examples of how to implement the proposed strategies Spell out acronyms on page 9 – EHR and HIPAA

	On page 10, line 11, there is no final 's' on Indian Health Service. It is a collective noun. This is a common mistake made by people outside the IHS. Expand discussion about stigma of mental health and the influence of childhood ACEs which can also increase risk of suicide.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization).	

A4: Advancing Public Health and Equity through Prevention and Reengagement of Opportunity Youth

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 3b- Insufficient scientific reasoning, requires major revision

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	There is an expressed lack of familiarity with the term – opportunity youth. Consider changing it to the title to: …reengagement of 'opportunity' or disconnected youth OR Advancing Public Health Equity through Disconnection Prevention and Engagement of Youth Opportunity, or something similar to give a reader a better an idea about what 'opportunity' youth are from the start.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the	

proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? j. Are there important facts that are missing from the problem statement? If so, describe them. k. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? l. Identify any relevant ethical[x], equitable[xi], political or economic[xii] issues.	Include reference to CDC's Youth Risk Behavior Survey: Data Summary and Trends Report 2009-2019 Add more data connecting the plight of disengaged youth to public health issues. There are a few connections but not as extensive as anticipated. Opportunities to connect opportunity youth to economic issues exist. Because these youth are not working or going to school, please clarify what type of economic impact may exist because of this. Include some data on opportunity youth within the LBGTQ community Revise "55 billion" should be "$55 billion" or "55 billion U.S. dollars." Identify that the proposal is talking about US-based youth. Add clearer definitions of connected, disconnected. Does connected mean in or having completed school and working? What is this group of youth doing when disconnected – what else should we know about them? Reasons are needed along with rates of disconnection. Utilize peer reviewed or government sources if possible. Provide supporting evidence for statements made in problem statement, e.g. lines 37-41 on page 2 and lines 3-12 on page 3. Explain in more depth the relationships between negative social determinants of health which are mentioned in the stratified strategies such as teen bullying, unplanned teen pregnancy, lack of accessible health care, lack of accessible healthy food, adequate housing and/or homelessness, lack of social support, low socioeconomic status, hazardous environmental condition, and the lack of secondary and postsecondary educational attainment and full employment to experience a high quality of life/health.

	Expand on evidence for facts related to the connection between the opioid crisis, LGBTQ+ identity, bullying and opportunity youth It is acknowledged that later in the statement that data related to LGBTQ+ students are needed; still there is considerable research related to LGBTQ+ student outcomes to connect the two issues. Address in more depth how mental health and alcohol, tobacco, and drug abuse affect obtaining adequate educational attainment and full employment.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? j. Is/are the proposed strategy/strategies evidence-based? k. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. l. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Stage or arrange the strategies and action steps from younger to older youth (i.e., kindergarten, followed by K to 12) to make the reasoning easier to follow. Sometimes opportunity youth is capitalized and other times it's not. Be consistent, and spell out acronyms (PAHTS, GBG). The sub-headings and many parts of this section read like Action Steps. For example, "Invest in Policies, Systems and Structures that Support Youth Transitions" states that an Action should be taken ("invest"). Again, rewording will clarify that the authors are discussing evidence-based strategies in this section. Deleting the words, "Invest in," would clarify that this sub-section is about evidence-based policies, systems, and structures..." *"Every Student Succeeds Act (ESSA)* – The federal government should provide funding grants to fully" - this is an Action Step and should be moved to that section. Revise the wording so this section reads like evidence-based strategies to address the problem, and not like action steps. For example, you wrote, "Public health professionals must prioritize opportunity youth and youth at risk for disconnection to strengthen the health, well-being and socioeconomic stability of our nation." This could be reworded as, "Research demonstrates that prioritizing opportunity youth and youth at risk for disconnection strengthens the health, well-being and socioeconomic stability of our nation [add citation]." Development of a policy agenda is also an Action Step, but include who should take that action: "It is imperative that we develop a *policy agenda focused on targeting multiple systems that touch the lives of these young people*, including not only education and employment sectors but also sectors addressing mental and physical health care, job training, housing, food availability and transportation."

	Delete the following statement because it's part of the Rationale: "As such, this policy statement addresses a critical gap in APHA's policy statement database." Provide evidence that the strategies will have an impact on reducing the problem. The policy statement states, "...few of the many youth affected by trauma have access to adequate mental health services to address their mental health needs, another key barrier to successful transitions in educational and occupational settings. Resources and supports are also scarce for parenting youth and youth who transition out of foster care or the justice system." Please add the scientific sources upon which these statements are based / that support these statements. Add data here from studies that have included student voices Consider addressing health care transition which could be mentioned in the section for improvements. Check out the youth section (among others) on the Got Transition site: https://www.gottransition.org/youth-and-young-adults/ Provide references within the Young People as Partners section [for instance, how do young people view the term 'Opportunity Youth'?] Regarding the grants and programs described on pg. 4 – discuss why are these not well funded. This will help understand what needs to be done. Address how does the ACS reach those not in school or employed? Would a national database and tracking system be harmful to these youth? Pg. 7 line 7 – what are the publicly funded options? Pg. 8 line 3 – prevention models – Elaborate on what is being prevented. Who is implementing these programs and who is evaluating?

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? m. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. n. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? o. Are alternative viewpoints, ethical, equitable and reasonable? p. Were any opposing views missing?	Provide additional opposing arguments. For example, are there opposing viewpoints or alternative strategies related to financing for workforce development, or Pell Grant support? Add evidence beyond the high cost of universal pre-K instruction. Re: Healthy Equitable discipline in k-12 - *"It is the view of the authors that the evidence of poor behavioral, health and equity outcomes associated with exclusionary school discipline is clear; thus, this element of the statement is unlikely to be challenged."* (p. 11, lines 3-5). Refute this argument.
Action Steps Are the **ACTION STEPS**: m. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? n. Focused on policy/principle, and not on specific legislation/regulation? o. Supported by the evidence or rationale documented in the	Include more information related to LGBTQ+ identities and the impact of bullying on opportunity youth in the problem statement. What actions should be taken to address such experiences? Explore the usefulness of restorative justice practice for retaining both offender and victims in educational programs. Explore educational workforce diversity as a means of improving retention and success of minoritized opportunity youth. Explore/articulate what state and local entities can do even without Federal funding and policy change. Proposal calls on "Congress" in the Action Steps. However, some of the Action Steps may be better situated within other entities. For example, the U.S. Department of Education would be more

proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? p. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	appropriate for establishing "a new class of student." Please consider linking the actions to such other more proximal entities. Add steps related to "Opportunity Youth" that are out there now. What can be done to support them?
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Provide additional evidence supporting research in the first part of the evidence-based strategies section. Replace news and general website references with peer-reviewed sources wherever possible. Young People as Partners: <u>there are 0 references in this section</u>, though youth have been engaged in talking about these issues; this knowledge and those additions to this section would be very helpful [for instance, how do young people view the term 'Opportunity Youth'?] Citations for the description of the problem are not peer reviewed or government sources. Many of the statements of fact are not supported by reference information, eg. lines 37-41 on page 2 and lines 3-12 on page 3. Please update. Provide additional evidence for opposing arguments Update reference #21(2002) #23 (2005) if new evidence if available.
Social justice and human rights metrics Does the proposal **<u>primarily</u>** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below:	

m. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? n. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? o. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? p. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	"Opportunity youth" – Have only heard this group described as "at risk" or "in risk"; one term doesn't seem less stigmatizing than the other. As described here, opportunity seems to suggest that youth have had opportunities but did not make use of them. Yes, it's beneficial to be engaged and connected, but these youth do not seem to have much "opportunity" for either, largely related to/because of the oppressive forces described in the statement. Consider adding more discussion about the need to address self-management of care and how engagement at 12-14 years of age as a process will help less youth fall through the cracks when they transition from pediatric to the adult health system and other systems of care.

	The statement made about "reducing the population of opportunity youth" is unclear – this term is being used to say something positive, but then the statement states that the aim is to reduce the number of them. Please take steps to align the framing and messaging. Some of the factors leading to disconnection or the causes of the causes or drivers of poor school performance, unplanned pregnancy and incarceration seem to be stated but the link between them could be made clearer – particularly in the 'problem' statement'; for example, poverty and residence in low-income, highly segregated communities are driven by racism. This section makes it mostly seem as if these youth can do nothing, have no assets – while it presents strong reasons for why youth may be disconnected, they are positive assets in themselves. What is this group of youth doing when disconnected? What else should we know about them? We don't just need the rates of disconnection we need the reasons. Adding such information would make the policy statement content more compelling and support deeper understanding of the importance of acting. Re: PreK in Strategies: Consider other reasons families are not able to enroll children in pre-K. What kind of debt are families and youth experiencing? What link is there to economic segregation and income disparities? For Pre-K data on opportunity youth who did/did not attend pre-K are needed. More also needs to be addressed where the quality of any proposed programs is concerned. In some cases, the school climate is the problem – schools can have all of the same adverse qualities as being disconnected, and the result can be a poor education vs. poor education outcomes. Keeping kids in low performing schools to say that we are keeping them connected may feel very defeating. Outside of schools, there are still several factors that intentionally keep youth disconnected from society, i.e., racial and economic segregation, and oddly enough in the past some also labelled this 'social distance'. Mental Health Section: Problem Statement: Unaddressed mental health (MH) needs and resulting consequences are mentioned only briefly. Expand on these consequences and approaches to address them because addressing mental health concerns are essential for achieving good public health and equity for this group.

	Opposing/Alt Views: The ESD section could use strengthening – de-funding ESD and associated persons, like Resource Officers (and removal of abstinence-only education) might be one of the biggest barriers to implementing this policy statement. No mention of financial implications of improving the data is discussed which could be an opposing view to consider. Action Steps: Expanding mental health resources in schools should be an action step. ATOD Section: Problem Statement: Provide information on the prevalence of substance use disorders in disconnected youth, contributing factors, and ways to address the issue. (see: Kim, H. K., Buchanan, R., & Price, J. M. (2017). Pathways to Preventing Substance Use Among Youth in Foster Care. Prevention Science, 18(5), 567–576. https://doi.org/10.1007/s11121-017-0800-6). Include should include risk of substance use among Opportunity Youth and the physical and mental outcomes associated with use of substances (e.g., Alcohol, Tobacco, and Other Drugs). For example, cigarette use is highest among opportunity youth. Hilley, C. (2002). *Risk and protective factors in the mental health and substance use of opportunity youth* [Unpublished doctoral dissertation]. Arizona State University. Strategies: Strategies seem to skip around and not clearly linked. Inclusion of strategies to address substance use disorders and mental health issues related to COVID-19 pandemic in opportunity youth. (1) Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. Psychiatry research, 293, 113429. https://doi.org/10.1016/j.psychres.2020.113429; (2) Guessoum, S. B., Lachal, J., Radjack, R., Carretier, E., Minassian, S., Benoit, L., & Moro, M. R. (2020). Adolescent psychiatric disorders during the COVID-19 pandemic and lockdown. Psychiatry Research, 291, 113264. https://doi.org/10.1016/j.psychres.2020.113264 Include strategies to address substance use disorders in the population of opportunity youth. (1) Perker, S. S., & Chester, L. E. (2021). The justice system and young adults with substance use disorders. Pediatrics, 147(Supplement 2), S249-S258. (2) Kim, H. K., Buchanan, R., & Price, J. M. (2017). Pathways to Preventing Substance Use Among Youth in Foster Care. Prevention Science, 18(5), 567–576. https://doi.org/10.1007/s11121-017-0800-6

	Consider encouraging substance use cessation services be used to replace ESDs for students who violate purchase, use, and possession laws both in a K-12 setting and in the broader society. More information, including citations, can be found at the following link that provides a fact sheet about PUP laws, https://www.changelabsolutions.org/product/pup-smoke#:~:text=Do%20laws%20that%20prohibit%20youth,smoking%20rates%20and%20improve%20health%3F&text=Instead%20of%20holding%20Big%20Tobacco,may%20be%20addicted%20to%20tobacco. Also, a recent policy statement that was endorsed by several major organizations (including APHA) recommends tobacco control policies be decriminalized to ensure that vulnerable populations are not punished (e.g., PUP laws). https://sph.cuny.edu/wp-content/uploads/2020/10/Tobacco-Control-Enforcement-for-Racial-Equity_FINAL_20201007.pdf Opp/Alt Views: For sex education, the authors refer to there being an earlier position statement on issue but include no other information. Consider these additional opposing views on 1) Invest in Policies, Systems and Structures that Support Youth Transitions, 2) Every Student Succeeds Act (ESSA), 3) Workforce Innovation and Opportunity Act (WIOA), 4) Pell Grants, 5) Registered Apprenticeships, 6) Enhance Data, and 7) Expanding Opportunity Youth Engagement: Young People as Partners. Opposing views discussion of 'Healthy, Equitable Discipline in K-12 Schools' needs at least one citation for justification. Consider the impact alcohol, tobacco, and other drugs has on the morbidity and mortality among opportunity youth, who are highly affected by these substances. MCH Section: In the definitions of measures, shouldn't this be: Post-secondary disconnection rate: the rate of young people with a high school degree or GED, without a post-secondary credential**, not enrolled in post-secondary education, who are not working** -- to be consistent with the other 2 definitions? Strategies: Suggest addressing health care transition which could be mentioned in the section for improvements. Check out the youth section (among others) on the Got Transition site: https://www.gottransition.org/youth-and-young-adults/

	Suggestions: Overall needs edits for clarity as several sections are not clear. Consider more discussion about supports to increase use of health care transition efforts (such as from Got Transition) which includes transition from pediatric to adult health care as well as transition in school, work, independent living and other areas for youth especially for youth with special health care needs (which includes disabilities). Consider including a short history of where the phrase "opportunity youth" came from. Culturally that this may be a difficult term and also for literacy reasons? Medical Care Section: Problem Statement: Mention of "latchkey" youth, which also contributes to the failure of re-engagement opportunity youth. We recommend including the following reference: Journal of Adolescence DOI 10.1016/j.adolescence.2016.01.001. Strategy: Some states (DC, MD)have legislature that allows pharmacists to prescribe oral contraceptives(DC, MD), which helps increase access to teens to help prevent teen pregnancy.(line 22 page3) ref: dchealth.dc.gov Action Steps: Add there should be more grant "seed funding" for high school students to go to public community colleges for free. This gives an incentive for high school graduates to improve their college potential and also improve their wage potential post college, whether 4 year or 2 year.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	

Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

A5: An Interprofessional Approach for the Prevention and Management of Diabetes

Science Board Assessment: 3b- insufficient evidence, requires a lot of additional evidence; 3b- insufficient scientific reasoning, requires major revision

JPC Assessment: Conditional

Vote: 12 yay; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Given that the policy only focuses on vision care, podiatry, pharmacy (only a little) and dental care the title is too broad as there are more disciplines involved in prevention and management. This policy focuses more on preventing complications of diabetes than preventing diabetes. The title of the archived policy was more appropriate, although neither addresses how this model can be implemented effectively in terms of referrals, communication etc. and especially how it would work for minority and undeserved populations. A new title that reflects the actual policy statement is needed.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the	

author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? m. Are there important facts that are missing from the problem statement? If so, describe them. n. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? o. Identify any relevant ethical[xiii], equitable[xiv], political or economic[xv] issues.	Given that the apparent purpose of this policy is to advocate for the important roles that Eye Doctors, Podiatrists Pharmacists and Dentists can play in the prevention and management of diabetes and its complications, the problem statement should focus on the contribution these professionals can make in the context of a broader team effort. This context is not provided except as mentioned on Page 4lines 28-31 and Page 6 Lines 3-10 (not referenced). There needs to be discussion of team-based care—how does it work, how do team members communicate and what are their roles especially in cases where specialty care such as vision, podiatric and dental care is not available to low income and/or uninsured individuals. What are the barriers to podiatric, vision and dental services reaching persons with diabetes? Better address role in prevention. There is very little evidence that these professionals are the ones who would prevent diabetes---they are important in early diagnosis and in prevention and management of complications. Describe lifestyle programs in more specifics including decreasing blood pressure and stress, limiting alcohol use, quitting smoking, and getting enough sleep, in addition to diet and physical activity. Correct Page 3 line 6 to give the rank of DM as a leading cause of death Page 3 line 12: should be Severe not Sudden Regarding awareness of prediabetes (2nd paragraph of problem statement) a numerical % or quantitative figure would strengthen the case being made. Add more on underlying issue of DM = food/nutrition and provide more attention on pre-diabetes. Page 4 line 18: IwD- this isn't clear what this is. Please spell out acronyms

	Page 4 line 28: the ADA acronym is utilized, but could be introduced earlier (Page 4, line 7) Explore additional economic issues relating to the cost of diabetes on the U.S health care system. The statement on lines 17-18 on page 4 refers to the reciprocal nature of a few different diseases (oral, eye, foot) but only one of those components are supported by a reference. How are eye and foot disease reciprocal in nature to the diabetes? Please add relevant supporting references to add support for the statements made. Discuss impact in detail on minoritized populations and expand on issues of access to care and expand on the causes and details of disparities (p.4 L.11-15). Consider discussing of the risk of T2D in pregnancy, which can be a gateway to T2D. While the needs are the same, this could be mentioned as a component of the public education campaign and inclusion of prenatal providers in the intra-professional network. Define Diabetic retinopathy on page 5, line 20. Add a reference to support the statement: "IwD may be reluctant to visit a healthcare provider and share relevant information due to fear of disease diagnosis and stigma." Consider adding the following references BMJ. 2000 Feb 26; 320(7234): 569–572. doi: 10.1136/bmj.320.7234.569 **The role of patient care teams in chronic disease management** Edward H Wagner, director J Multidiscip Healthc. 2014; 7: 333–339. Published online 2014 Aug 5. doi: 10.2147/JMDH.S66712**The difficulties of interprofessional teamwork in diabetes care: a questionnaire survey** Miyako Kishimoto[1,2] and Mitsuhiko Noda[2,3] Am J Prev Med. 2019 Jul;57(1):e17-e26. doi: 10.1016/j.amepre.2019.02.005. **Team-Based Care to Improve Diabetes Management: A Community Guide Meta-analysis** Timothy W Levengood [1], Yinan Peng [2], Ka Zang Xiong [1], Ziwei Song [1], Randy Elder [1], Mohammed K Ali [3], Marshall H Chin [4], Pamela

	Allweiss [5], Christine M Hunter [6], Alberta Becenti [7], Community Preventive Services Task Force National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) - https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5429867/pdf/nihms857333.pdf; Lavdaniti, M. (2020). The Impact of Smoking on Individuals with Diabetes Type 2. International Journal of Caring Sciences, 13(3), 2304–2308.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? m. Is/are the proposed strategy/strategies evidence-based? n. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. o. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Add primary prevention strategies like promoting physical activity and health eating, and addressing social determinants of health that prevent equitable opportunities for physical activity and healthy eating. Consider including other public health professionals Community Health Workers, social workers, and/or nurses. Add sub headers and grouping topics by content area such as foot care; eye care; etc., if this can be done with page limits. Add strategies to promote team work, how to overcome barriers to access or address how to provide these services for low income populations. Clarify how the interconnections will be achieved in the interprofessional approach intervention. Page 6 line 15: T2DM defined as an acronym. Please clarify. Provide more scientific support. Review: Busetto L, Luijkx KG, Elissen AMJ, Vrijhoef HJM. Context, mechanisms and outcomes of integrated care for diabetes mellitus type 2: a systematic review. BMC Health Serv Res. 2016 Jan 15;16:18. doi: 10.1186/s12913-015-1231-3. PMID: 26772769; PMCID: PMC4715325. Renders CM et al. Interventions to Improve the Management of Diabetes in Primary Care, Outpatient, and Community Settings: A systematic review. Diabetes Care 2001 Oct; 24(10): 1821-1833. https://doi.org/10.2337/diacare.24.10.1821 Baldo V, Lombardi S, Cocchio S, Rancan S, Buja A, Cozza S, Marangon C, Furlan P, Cristofoletti M. Diabetes outcomes within integrated healthcare management programs. Prim Care

	Diabetes. 2015 Feb;9(1):54-9. doi: 10.1016/j.pcd.2014.03.005. Epub 2014 Apr 16. PMID: 24746417. Albright RH, Fleischer AE. Association of select preventative services and hospitalization in people with diabetes. J Diabetes Complications. 2021 Mar 3:107903. doi: 10.1016/j.jdiacomp.2021.107903. Epub ahead of print. PMID: 33691987. Preventive Measures for Patients at Risk for Amputation From Diabetes and Peripheral Arterial Disease. Philip P. Goodney, Asha McClurg, Emily L. Spangler, Benjamin S. Brooke, Randall R. DeMartino, David H. Stone, Brian W. Nolan. Diabetes Care Jun 2014, 37 (6) e139-e140; DOI: 10.2337/dc14-0034
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? q. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. r. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? s. Are alternative viewpoints, ethical, equitable and reasonable? t. Were any opposing views missing?	Provide evidence associated with the assertion made in the opposing argument and refute them Provide a solution to the system level problems of a multi-disciplinary approach Address the key role of primary care providers (ex. in rural areas as well as services in many poor urban areas) Address the barriers to integrated care such as coordination of multiple organizations and individuals Address cost and long-term effectiveness as concerns

Action Steps Are the **ACTION STEPS**: q. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? r. Focused on policy/principle, and not on specific legislation/regulation? s. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? t. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Action steps need to be re-written so that they flow from the evidence-based strategies proposed (3,4,5,6,8,9,10,11 are not addressed in strategies and should be if they remain) Provide more specificity as to who should carry out the actions Address cost and access issues within actions steps
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	References were not correctly cited using AMA. For example, some references did not use sentence case for the journal article title. Please review and revise.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no,	

proceed no further. If yes, see below: q. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? r. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? s. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? t. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments: What are the major comments by APHA units with expertise on the issue?	Explain what NDPP earlier in the narrative More strongly articulate that controlling for diabetes as well as complications from diabetes is way more expensive than preventive measures. In reference to the statement (page 3, lines 14-16), "There is no APHA policy statement that recognizes the major public health problem of the multisystem complications of diabetes managed by dental care providers, podiatrists, pharmacists, and eye doctors." The Pharmacy, Podiatry, Optometry, Dentistry (PPOD) intervention model can increase awareness of the role that each discipline can play in identifying and treating patients with diabetes and should be referenced as an important additional strategy.

	(https://www.cdc.gov/visionhealth/programs/vision-health-toolkit/section-three/integrate-vision-eye-health.html) For those with diabetes, cost of care is a major issue and limiting factor. Opponents of a public health approach to preventing diabetes are concerned with the increasing costs of care in a multi-disciplinary setting. The most expensive of which occurs at the later stages of the disease. Address this Specify “eye doctors” as “eye doctors (optometrists or ophthalmologists).” Consider including how MD and DO could encourage their patients to visit podiatrists, optometrists, pharmacists, etc. Provide some additional information on the economic burden of diabetes on the healthcare system. Expand on the role of the pharmacist in the interprofessional approach Add acknowledgement of inequities in the prevalence of diabetes in marginalized groups, inequities in access, and inequities in the delivery of quality care. The integration of care is contingent upon patients having access to services. Address the lack of access to the care in the identified disciplines. Describe more specifically what and how pharmacists could treat diabetic patients. Include more content related to novel approaches in the community to screen for diabetes. Additionally, describe more related to the social determinants of health and ways to address healthcare inequities. Consider adding the Comprehensive Diabetic Lower Extremity Exam (CDLEE) as something APHA would advocate for as well. The CDLEE is an exam, as described in the policy statement, that includes vascular, dermatologic, neurologic and musculoskeletal components. Based on the results of the exam, patients would be risk categorized and then put on a follow-up schedule guided by how ‘at-risk’ they were deemed to be. This type of exam and risk categorization is not currently a reimbursable service and such preventive care should be covered for all IwD and could improve quality of life and reduce costs associated with ulceration, infection, hospitalization, and amputation by preventing diabetic foot complications.

	Clarify the basis for having only eye doctors perform the retinal exams. Could NPs or primary care folks be trained to do this to expand care? The same comment applies regarding foot exams by podiatrists.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Given the importance of needing additional focus that is culturally sensitive and appropriate, consulting with CHW section is needed.

A6: Reduced exposure to excessive levels of household debt and conduct more inter-disciplinary research of on over-indebtedness and health

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 3b- Insufficient scientific reasoning, requires major revisions

JPC Assessment: Conditional

Vote: 10 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.*
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Change title to reflect statement content. Based on what the authors wrote about in the policy statement, a more appropriate title would be, "The Impact of Individual and Household Debt on Health and Wellbeing."
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	Reexamine the existing APHA policy statements that you cite. For example, #200026 has to do with multilateral and bilateral agreements between/among countries to provide debt relief to poor nations. Look at each APHA policy statement (and not just the title) to ensure that it is appropriate to include.
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e.,	

why APHA should adopt a policy on this issue now). If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? p. Are there important facts that are missing from the problem statement? If so, describe them. q. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? r. Identify any relevant ethical[xvi], equitable[xvii], political or economic[xviii] issues.	The major source of confusion throughout the policy is the interchangeable use of terms that are mostly undefined: e.g. "unhealthy debt" vs "over-indebtedness" vs "inequitable excessive household debt", and "unfair lending practices" vs "extractive debt" (assuming this refers to debt associated with a negative lending practice). This issue is rooted in the problem statement which should define the terms used, but only defines "Over-indebtedness" without a reference. Please add definitions for other terms to enhance broad understanding and appreciation of these terms. The proposed policy also does not adequately characterize what constitutes "good" and "bad" debt. "Bad" debt is obviously the intended focus of the paper, but this line is not clear. Is it based on the source? The amount? Greater emphasis on and clarification of what constitutes "good" will also help to define "bad" debt. It is difficult to understand the problem, given that the data provided is in total, aggregated dollar amounts. Provide information about how household debt has changed over time as a percent of household income, for example. That would make the problem more understandable. Some of the information provided does not lend itself to explaining the problem. For example, you state:"68% of household debt in the US is from mortgages, 11% from student loans, 9% from auto loans, 6% from credit cards, 3% from home equity loans, and 3% from other loans. 70% of Americans have credit cards, 63% have mortgages, 44% have auto loans, 31% have medical debt, 14% have student loans, 12% have a home equity line of credit, 8% have alternative financial system loans (e.g. payday loans), and 6% have court debt." This says where debt comes from, but not if it's burdensome for families to pay back. Knowing that "70% of American have credit cards" does not tell the reader anything about the average amount of debt each person owes per credit card or the average amount of interest a person pays on that debt. Address the burden of repayment.

	Related to above comments, the policy states: "Student loans have risen from a total of $590 billion in 2007 when 47% of the total was borrowed from the Federal government to $1.7 trillion in 2020 when only 25% was borrowed from the Federal government, with the remainder from private lenders." The large, aggregated dollar amounts in this paragraph are inadequate because the increase could be consistent with inflation. Find meaningful data (as a percent of individual or household income, for example) to support the case you are trying to make. Be consistent with the statement's verbiage/style (White and Black, for example, should always be capitalized when referring to groups of people). While a statement about ethical, economic, economic, and political issues is included, it does not address them. Discuss, for example, the ethics involved in unequal and inequitable access to credit, among different populations. Strengthen the connection between debt and health. This relationship is alluded to in blanket statements, and a few references to specific mechanisms, however it is missing the details that would make it stronger. In three places, the blanket claim relies on a strong systematic review (refs 2, 4, & 13), but does not follow up with details of pathways proposed (e.g. stress mentioned elsewhere in examples). Please elaborate. Problem statement (or potentially the opposing arguments) should include a section clarifying and describing the types and use of debt that contribute to health, wealth, and opportunity (mentioned on p3, line 1-2). This is critical to establishing the boundary of what "bad" debt consists of (which is not clearly defined in this policy). Add additional citations. Some sentences likely rely on a nearby or subsequent sentence's reference #. p2 line 34-45: "It is a significant feature in most Americans' lives at levels not experienced…" Statement is not substantively supported by the reference (1). A "significant feature" is an ambiguous term not supported by the graph cited. The phrase, "at levels by many" is unclear if this means the amount of household debt (total debt shown in graph cited), or the numbers in debt. Also after reviewing the reference it's unclear why 2000 is described as a tipping point when debt growth has accelerated since ~1970 with a spike feature around 2008.

	Overall recommendation is that this sentence should be clarified and expanded upon if necessary to specify the "significance" or drop it. P3 line 1-2: "Some types of debt can…" requires a reference (unclear if #2 or 4 is intended), but this is a substantive claim that needs to be expanded. P3 line 5: "most of the public can distinguish between "good debt" and bad debt". This is not supported by the citation which includes a poll where people make the distinction, however "good and bad" are not defined anywhere or tested for accuracy by a poll question. The poll also does not measure the proportion of the public that can distinguish the types accurately. Please add appropriate citations/references. P3 line 9-10: Add a reference for the definition of over-indebtedness. P3 line 6-9: The statement about what "This policy statement addresses" belongs in the Rationale not the problem statement (self-referential). Please add it there or reconsider its use in the current section. It is also very hard to imagine how ref #4 supports a statement about what the policy statement addresses. Please clarify this connection or replace with a more appropriate supporting reference. P3 line 19-21: A reference is missing (assuming #7 which is cited in subsequent sentence). It is unclear if the proposal is claiming that "online payday lending has grown" overall or just the proportion of payday lending coming from online lenders. Please add an appropriate reference and clarify the above. P3 line 22-23: "Publicly-imposed debt…". Reference is missing (assumes #8 which is cited in subsequent sentence). Ref 8 seems specific to COVID-era debt. If referencing a citation used in that paper, please provide the original reference that supports the claim of "…has risen as a burdensome form of household debt in the last 20 years". P3 line 29-31: Citation #9 appears to be more appropriate for prior sentence (where it is missing). Please use the reference within #9 that they use to describe the health outcomes of debt, if it is not directly supported in this reference. Also the section supported by ref #9 should clarify that the source of evidence is a single-county study sample, not national.

	P4 lines 4-7: This reference is specific to using payday lending services, not "debt" as the claim is worded. Please provide a reference that more directly supports the statements made. P4 lines 13-15: This reference is a systematic review. Please provide the original source from within the systematic review that this statement is referring to. P4 lines 22-31: Strongly recommend cutting the qualitative anecdote. It's okay to cite qualitative evidence and/or reference themes/experiences themselves, but this anecdote is not evidence of a public health problem. Subsection e includes a single sentence, making a substantive claim without any citation. This discussion should be expanded. Systematic reviews and/or specific, original research that addresses equity should be used to support the statement and expand upon it. The single sentence provided is also phrased as a Strategy not a problem statement ("Restricting …sources of inequitable excessive household debt …has been shown to…" Please revise the sentence to better align it with the section and add a relevant supporting reference. Describe the disparity in "unhealthy debt"/"over-indebtedness" that occurs across racial and other demographic lines (in addition to disparities in payday lending which is implicitly but not explicitly offered as "bad debt"). Go beyond describing the differences in amount of debt by type.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? p. Is/are the proposed strategy/strategies evidence-based? q. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. r. What other strategies, if any, should be considered? Should	Re-write the Evidence-based Strategies section. Right now, it reads like what one would expect to see in the section for Action Steps. What's been done to address many of these issues that is evidence-based? For example, the statement asserts, "... Medical debt is the leading cause of personal bankruptcy and is associated with the risk of becoming homeless. The fear of medical debt is a barrier to access to health care services." Please add the sources and evidence supporting these statements to strengthen the claims made. In general, the connection of these proposed strategies to improving health / public health is missing. The strength of the evidence is relatively weak, with some statements of strategy (more like an action step) completely unsupported with neither evidence statements or references. Please strengthen these connections to improve the section. The overall section is a little confused by the fact that the subheadings are buried as the first sentence of each strategy subsection a-j. These should be reworded to be evidence-based

additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	claims of effectiveness or cut and moved to the Action Steps Section where the wording is more appropriate. The proposed policy states, “Have a third party pay off loans. Groups like the Debt Collective have pooled funds to purchase consolidated debts from lenders and then have cancelled that debt rather than seeking to collect. They have raised over $700,000 and have cancelled $32 million in debt.” What has the impact of those actions been on the health of individuals or households? Please describe and provide support for these impacts. Some of the strategies included have no citation. For example, “Re-establish policies that prohibited payday loans in the US before 1980. From the 1920s to the 1980s, states had strong banking regulations in place that essentially prohibited payday lenders and other high-interest short-term loans. Given the evidence on the adverse health effects of these loans, populations were protected from extractive lending practices in past decades and should be again. In addition, regulations are needed to protect consumers from high-cost online lenders.” What is the evidence here? What is the actual strategy? Please address these questions to help strengthen the proposal. Recommended additions to strategies: • Social services provided by the federal government /states are not mentioned until the Action steps but these are fundamental, current interventions to preventing (or maintaining, according to some) poverty situations: SNAP, WIC, CHIP, Medicaid, etc. • Universal basic income, and/or living-minimum wage policies would be very appropriate in limiting the impacts of the debt industry. • Additional community-based programs are being designed and tested to address poverty and over-indebtedness at state and community levels, including the Annie Casey Foundation, Southern partnership. Discuss the ability/capacity and the evidence for community and consumer empowerment. p6 line 14-16: This is a major point that is largely missing from the problem statement, made in two un-referenced sentences. This

	should be expanded and described thoroughly, with references, in the problem statement. However these lines do not fit in a description of the evidence-base supporting the strategy proposed. p6 lines 17-28: In both of these sections, please include the evidence for any benefit this had /impact on low-income /vulnerable groups in particular. Also, please connect both of these strategies to available evidence (supported with citations) of the public health impact: economic and health outcomes that are expected from this strategy. P6 line 19-20: please make explicit how this reduced cost ($700k) can be used to purchase the larger debt valuation ($32M). P7 line 1-2: “Fines and fees have been…” is more appropriate for the Problem Statement, not evidence supporting the proposed strategy, as the previous sentence does well. Please move that to PS in order to set up the need for this proposed strategy. P7 line 3-7: Equating “Islam” and “China” is problematic as one is a religion and the other a nation-state. Please consider rewording. Also, is China the best example/evidence to propose as a corollary for US economy? Perhaps there are other socialized democracies that could serve as an example of debt protection and lending regulation. P7 lines 24-26: Is there evidence to support this substantive claim about the role financial literacy has to play “as part of a comprehensive approach”. Please include more details and an appropriate reference. P7 lines: 26-28: The Health Impact pyramid is an insufficient reference to support this statement of the weakness of financial education. There is lots of evidence that financial literacy interventions help. The reviewer would recommend avoiding calling this a “weak” intervention, but supporting the notion that this is part of a comprehensive approach instead, with evidence. The final paragraph (no letter) is a mix of action steps and opinion without supporting evidence referenced. Consider moving certain statements (that are then also supported by evidence in the problem statement and strategies) to the Action Steps instead.

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? u. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. v. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? w. Are alternative viewpoints, ethical, equitable and reasonable? x. Were any opposing views missing?	Similar to the 2nd half of the Evidence-Based Strategies section, the opposing arguments are made as declarative sentences and then not supported with any statements of evidence or references at all. In particular, the Response to Opposing Argument 1 is lacking many necessary references as substantive claims are made about support from multiple national organizations. Evidence and appropriate references need to be added. P9 line 1-2: this is an important claim and needs to be supported with a strong reference (currently missing). Please add such references. The entire Alternative Strategies section is unreferenced, appearing to contain narrative /opinion without any evidence of who advocates for what and the evidence of insufficiency of financial literacy. Evidence needs to be added.
Action Steps Are the **ACTION STEPS**: u. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? v. Focused on policy/principle, and not on specific legislation/regulation? w. Supported by the evidence or rationale documented in the proposal? Are the	The Action Steps, and the statement overall needs general editing. Right now, it reads like a draft, and much of the language is "loose." For example, what are "low-cost loans" or "low-cost student loans?" Do you mean "low interest" or that there are "low fees" to secure the loans? Maybe both? Clarifying terms throughout and using them consistently would strengthen the statement. The action steps are not supported by the Evidence and Rationale documented in this proposal, because of the limitations of the evidence in earlier sections. The Action Steps wording should be more detailed about the accountable party / who should take various steps described to make them more feasible.

action steps evidence-based, ethical, equitable and feasible? If not, please explain? x. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	References are missing from the document. The numbering in the document, which seems to refer to the missing citations, is in both Roman numerals and Arabic numerals. This needs to be fixed. Also, the citation # is often used after only one sentence (typically, but not always the last) when there are multiple sentences relying on the same reference together. The citation should be used after every claim that relies on that reference. The times when the strength of cited evidence falls short are cited in sections above.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: u. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? v. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? w. Is the proposal consistent with the WHO Commission on	The proposal is supported by Human Rights law, consistent with the Universal Declaration of Human Rights and the WHO Commission on Social Determinants of Health but this is not discussed. Input from the Ethics Section and IHRC would be helpful.

Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? x. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	**Problem Statement:** On p. 3 the communication seems a little disjointed. There are many statistics on indebtedness presented and it seems like there needs to be some disentangling of "reasonable debt" versus "harmful debt". Likewise, it seems like some transition statements are needed to disentangle people taking on debt, being forced into debt (e.g. publicly-imposed debt), and the practices of those seeking to profit off others' debt. The statement does not differentiate between debt due to institutions and debt owed to individuals (child support). Forgiving child support debt has very different impacts from forgiving of other types of debt. Please consider the implications of such differences. The policy relies on references and cites many statistics that appear to be several years old. The references and the related data should be updated to be as current as possible. Historical references to the treatment of debt is not particularly relevant to present day issues. The definition of debt included on lines VIII 36-37 seems that it would be more appropriate on lines VIII 30-31. The sub-section titles on p. 4 seem to be author guiding notes, not the final sub-section titles. The claim made on p. 6 lines 3-6 does not have a reference. The author may consider expanding on the political discord surrounding public assistance programs and debt relief within sub-section E. A greater integration of the current financial disruption due to COVID-19, as the 'she-cession' is being well discussed in the

	media as women are severely impacted by deaths, morbidity due to COVID-19, direct or indirect household-level job loss, reduction and decisioning making to step out of the workforce, is needed. Include the disproportionate role of medical debt for those who are uninsured or underinsured and the relationship between being a part of a minority or underserved population and being uninsured or underinsured. Medical expenses would benefit from clearly calling out costs of pharmaceuticals, insurance copayments, and deductibles for medical and dental visits. Public Health does have the capacity to address these 'medical establishment' issues that contribute to indebtedness. In addition to addressing, social determinants of health such as affordable housing, childcare and closing the digital divide for families, especially female-headed households. For page 4, line 30, are there additional data that demonstrate how often people forgo medications because of cost? Perhaps this is covered in a separate APHA policy statement that you could refer to. Adding such data would strengthen the statement. **Evidence-Based Strategies:** Exploring further regulation of medical debt, healthcare price transparency, and access to affordable medical care may beneficial strategies as well. There may also be data surrounding reparative/restorative justice that speaks to promoting economic security. Under the additional inter-disciplinary research it is recommended to expand upon this to be clear about what disciplines could work together even if in a theoretical sense. Consider CHWs having a role in addressing over-indebtedness with their communities—not only for education (which I understand is a minimal focus of this policy), but also for advocacy to empower their clients and communities to advocate for the strategies mentioned. Local policy strategies that address greater availability of affordable childcare, housing and rent control along with efforts to close the digital divide among low-wage earners and/or communities of color are recommended. Point E needs to be rewritten slightly. Islam is a religion not a country. It would be more specific if the proposed statement discussed Muslim-majority countries that successfully practices this area of Islam.

	Opposing Views: Importantly, social determinants of health are mentioned for the first time, and one of the few times in the draft policy statement, in this section. This is an important concept that should be developed and incorporated throughout the draft policy statement. The argument against the proposal to cancel the debt for lower income and other targeted groups isn't full addressed. Cancelling the debt of any social group at the exclusion of other groups seems counter to the dominate cultural beliefs in the US and would face stiff opposition from all levels of the dominate culture. The opposing views are refuted by presenting evidence that debt is associated with poor health and mental health care outcomes and that addressing health disparities due to debt should include expanding public health and safety net programs. More of an economic case for this proposal should be incorporated as well. **Alternative Views:** Consider adding the alternative viewpoint regarding education as part of the overall strategy as education call alleviate exposure. **Action steps:** There is also some new information in the action steps. Action steps should be informed by the evidence-based strategies and problem statement so that new information should be moved accordingly. For example, page 9, line 30 is where social services are really first mentioned. They can be mentioned here but should be explained above with their evidence. Other examples can be found at page 10, line 16; page 10, line 23, page 11, line 8; page 11, line 21 ,line 22. Families and caregivers are missing from the list, however. Some element of personal responsibility should be addressed particularly for individuals who are not considered included in low or middle income and underserved populations and the draft policy statement is intended to apply more broadly to the general population. Consider including an action step around student debt especially because a degree tends to be important for getting a job and having access to higher paying jobs. Recommend against the step: "Cancel student, auto, ..." The article cited (25) discusses student debt is actual less of a

	concern. Think this should be reframed to address more predatory/excessive loans as noted in article.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Seek review from the Ethics Section.

B1: Ensuring Support for and Access to Self-Managed Abortions

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, requires minor revision

JPC Assessment: Conditional

Vote: 9 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	The authors should consider revising the title to consider appropriate context. The title generally reflects the evidence provided, but is missing the more explicit piece about opposing criminalization. Recommend adding language around opposing criminalization.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed	Page 2, line 31, states that "self-managed abortion is as safe as clinic-based care." Suggest changing that to say that "self-managed abortion can be as safe as clinic-based care" because there are circumstances under which it would not be. These include dishonest vendors and "fake" websites who do not supply the accurate dosages, and potential lack of access to follow-up care in emergencies. Suggest that you argue the case that without de-criminalization of SMA, these fakes sites will proliferate and will be harmful to women who lack access to care in their states.

policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? s. Are there important facts that are missing from the problem statement? If so, describe them. t. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? u. Identify any relevant ethical[xix], equitable[xx], political or economic[xxi] issues.	Recommend including a statement that this policy statement 1) opposes all criminalization of SMA regardless of method and 2) supports broader access to methods that can be safe and effective, including broader access to mife and miso in particular and supports for other methods (e.g. herbs) that may also be safe and effective. The fact that most recent research finds that few people in the U.S. who report attempting SMA use mife or miso indicates that this distinction matters. Consider whether this may also be an argument for expanding access to mife & miso outside of the clinical setting. Consider adding reference to mental health issues related to self-managed abortion or access to this method of abortion-we suggest this be added. Make more specific the barriers faced by those seeking this care was not entirely clear. It would strengthen the statement if this were addressed more thoroughly, for example, how does REMS pose barriers to individuals seeking self-managed abortion? Does is affect the price of the drug? Incorporate evidence in the problem statement regarding the ramifications of limited access to abortion especially in minority communities. The proposal mentioned there are other drugs that have more dangerous side-effect profiles that are not subject to this level of regulation, but it would be helpful to perhaps describe an example of that more in-depth. It was particularly critical that you highlighted the ways in which barriers to abortion care have been exacerbated due to COVID. It could be helpful to provide an example of a drug or service that has been more successfully transposed to telemedicine and remained accessible despite COVID-related restrictions. Regarding the definition of “Self-managed abortion,” it is important to be wary of including methods such as “herbs” and “inserting objects into the vagina” in the definition, without clearly stating that this proposal does not support those

	strategies which lack evidence-based efficacy and are potentially unsafe. The beginning of the problem statement refers to "...nearly 500 abortion restrictions ... is the statement discussed laws that were misapplied by policy and prosecutors to punish people for self-managing abortions? A stronger argument could possibly be made if a delineation existed between policies targeting self-managed abortions and those targeting abortion in general. P. 4, lines 8-19. Suggest adding data to strengthen the assertion that "Laws.... Are likely to be disproportionately used against people of color ... "p. 4 lines 17-19.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? s. Is/are the proposed strategy/strategies evidence-based? t. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. u. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	There are limitations of the evidence that may limit how proposed strategies are likely to have an impact on reducing the problem. Recommend more explicitly naming the strength of the evidence for the different recommended strategies, and acknowledge some of the nuance and complexity that exists as well as recent evidence that may be helping to resolve it (e.g. related to gestational age estimation; related to ectopic pregnancy detection). Better distinguish the places where there are one or two decent quality studies that find something versus places where there is a lot of evidence. Also, a recent paper looking at the safety of pharmacist dispensing of medication abortion (that just came out) should be added: Grossman, D; Baba, FC; Kaller, S; Biggs, MA; Raifman, S; Gurazada, T; Rafie, S; Averbach, S; Meckstroth, KR. Micks, EA; Berry, E; Raine-Bennett, TR; Creinin, MD. Medication Abortion With Pharmacist Dispensing of Mifepristone, Obstetrics & Gynecology: April 2021 -Volume 137 - Issue 4 -p 613-622 Consider addressing the literature that finds that SMA with mife/miso is less common than other approaches and explicitly name how these approaches to make mife/miso more available and support people using self-sourced mife/miso can help improve safety and efficacy of SMA. In terms of the ongoing research agenda, some of these might already be occurring; it's also not completely clear what the logic model is for doing these studies in particular. There might be other relevant studies. If you think these are the correct studies to support, they should spell out why. Otherwise, they might consider an alternative strategy of federal government financial support for research on this topic where the research, policy, and public health community can weigh in on the specific priorities

	Consider mentioning the work previously/currently being done on these issues, such as the ACLU's efforts to challenge REMS requirements for mifepristone during COVID. Also encourage the authors to be more specific however, for example, in how they intend to influence decriminalization policy. It seems as though cost of the medication (specifically mifepristone) and the overall potential economic burden could be included in the described action plans. Community Health Workers (CHWs) employed by culturally-specific community- based organizations are particularly qualified to promote health in individuals and communities most impacted by the criminalization of self-managed abortion. Consider engaging culturally-specific doulas and CHWs On page 7, line 16 on, it should be explained for clarity sake that some of the anti-choice laws mentioned older, pre-Roe laws. That does not make them any less nefarious but I believe it needs to be clear to the reader that many different laws exist that make it difficult to access safe abortion services in general, not specifically self-managed abortion.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? y. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. z. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? aa. Are alternative viewpoints, ethical,	Recommend adding other opposing arguments, i.e. that a) people (rightfully) worry that pills obtained online might not work or might include harmful ingredients; b) people worry about how this will financially impact abortion clinics and thus affect availability of clinic-based abortion care for people who need it; c) some people do use SMA approaches that harm themselves and are not effective at ending a pregnancy; this delays abortion care or leads people to continue pregnancies they otherwise would have ended and may (depending on the SMA method they use) harm the fetus in the process. P10. line 17-18; since recent research finds that most people in the US are not self-managing with mife/miso, this isn't really an accurate statement. Recommend editing it for nuance. Also, the citations for the statements in lines 19 – 22 are from documents from a (well-respected) legal advocacy group. recommend acknowledging this rather than writing it as if it is based on significant research evidence. One area in the rebuttal that could be expanded on is how potential negative outcomes would be handled if the patient can access the medication without a doctor's appointment.

equitable and reasonable? bb. Were any opposing views missing?	
Action Steps Are the **ACTION STEPS**: y. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? z. Focused on policy/principle, and not on specific legislation/regulation? aa. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? bb. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Some of the action steps in the policy statement could be more specific. For example, what specific steps should be taken to work through and with the FDA towards removal of the REMS restrictions? And what steps should be taken in order to meet the ultimate goal of making mifepristone accessible over the counter? Action step 6 seems premature at this point, given the current evidence – recommend removing. Action step 7 seems like it should just reference other existing abortion policies; consider editing in this way. Recommend that action step 8 call on federal funding bodies to fund this research rather than call on researchers to do this work without funding. Recommend adding additional action steps about (financially) supporting abortion clinics through this transition to maintain clinic-based access to care for those who need it. For action step 3, recommend noting that this needs to apply even when it is not clear that people have attempted to self-manage an abortion…i.e. when they present with a fetal demise or when they present having ingested a substance while pregnant. Consider additional strategies to promote equitable [re]distribution of funds to culturally-specific community-based organizations (CBOs) that employ CHWs and doulas serving Black, Indigenous, & People of Color (BIPOC) communities. Suggest actions related to support for mental health once the Problem Statement expands on this.
References Are the **REFERENCES** connected to the text? Are references	In a few places, the references are from ACOG statements or legal advocacy groups. Recommend seeking published research when possible instead and, when not possible, naming that these are the sources in the text.

complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: y. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? z. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? aa. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? bb. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments	Additional data and references should be provided to strengthen the assertion on P. 4, lines 8-19 “Laws.... Are likely to be disproportionately used against people of color ...”

What are the major comments by APHA units with expertise on the issue?	Provide appropriate citations for statements on Page 6, Lines 25 –27 state: "The term "reproductive justice" was coined by a group of U.S. Black women human rights activists and organizers in 1994 who saw that the needs of communities of color were being ignored by pro-choice advocates." Are there modifications to REMS that can make it possible to remove the in-person requirement for in person dispensing but can continue to collect adverse reaction data? Consider if additional modifications can be made, how this may or may not affect action steps Citations needed for opposing views Address the limitations of supporting evidence provided in the proposed policy statement. i.e. "a nationally representative sample" whereas demographics representative of 57.4% non-Hispanic white participants and a combined 33.5% Black and Hispanic participants. Same considerations for p5 lines 15-18, Accurately represent scientific study findings (link to reference 15 is not functional).
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

B2: Call for Urgent Action to Address Health Inequities in the US Coronavirus Disease 2019 Pandemic and Response

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 2- Sufficient scientific reasoning

JPC Assessment: Conditional

Vote: 10 yea; 0 nay; 0 abstaining

* Revision must include most recent evidence/context as of July 1, 2021

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	

Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	Rationale mentions the need for involvement from multiple federal agencies (CDC, DoL, SAMHSA, IHS, USDA) that are not mentioned in the Strategies or Action Steps section. These should be removed or their involvement should be made explicit in the relevant sections by clarifying which agencies should be responsible for which functions recommended in Strategies and Action Steps.
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? v. Are there important facts that are missing from the problem statement? If so, describe them. w. Document any disproportionate impact on underserved populations? For example, what is the burden of the	There are several instances where the landscape has changed, and the policy does not yet reflect new circumstances: • Strongly consider taking out line 29 of page 9 as the 'public charge rule' no longer holds as of March 9,2021 • Page 9, lines 1-5 needs to be revised or truncated as the statement is presently outdated. There is currently an OSHA-Guidance document on preparing workplaces for COVID-19 (https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf). Please consider keeping the characterization of initial refusal and non-response (as contributory to the evolving problem, IF it can be cited with evidence (a non-peer-reviewed source might be acceptable here to document this) that these actions were not taken/avoided) but add/update to reflect new guidance. Missing from problem statement:

problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? x. Identify any relevant ethical[xxii], equitable[xxiii], political or economic[xxiv] issues.	• Issues of equity with vaccine distribution which are addressed by Action Steps 2 & 3 are under-discussed. Understanding that this is a rapidly evolving subject with minimal data back in February, it is still important to update the Problem Statement and Strategies with evidence-supported claims of inequity and characterization of solutions that feed into the Action Steps as currently written. • Please consider expanding the discussions of incarcerated populations (currently 1 pgph, 3 refs) and homelessness as particularly high-risk for transmission/infection. The paragraph (page 7, lines 7-11) on homelessness includes reference to APHA policy #20178, which is thorough but predates the COVID-19 outbreak by 3 years. Please find another reference to support the 2nd half of the statement (page 7, line 9). As mentioned, supporting evidence on vaccine inequity are scarce. Though one strong CDC citation is offered at the end of the section on page 10. Please consider additional examples and citations: - Growing Gaps in COVID-19 Vaccinations Among Hispanic People (KFF, Feb 22, 2021) - COVID-19 Among African Americans An Action Plan for Mitigating Disparities (AJPH, Feb 2021) The statement does not address COVID inequities among health vulnerable populations like people with HIV or autoimmune disorders. Please address these during statement revisions. https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html Health Communication and the level of health literacy is a major intersectionality of SDOH not mentioned as a factor in the problem statement. Also Disabled populations see Andrews,E.E., Ayers, K.B., Brown,K.S., Dunn,D.S., &Pilarski,C.R. (2020,July23). No Body Is Expendable: Medical Rationing and Disability Justice During the COVID-19 Pandemic. American Psychologist. Advance online publication. http://dx.doi.org/10.1037/amp0000709 Page 4, Lines 26–28 states: “Limited available data document that both morbidity and mortality from COVID-19 is higher among Black, Latinx, and Indigenous communities along with the elderly and people with

	disabilities living in congregate care, incarcerated populations, and essential workers" but there is not citation at the end of the sentence. Please provide a reference. On page 5, line 4-the authors should add "avoid crowds and poorly ventilated indoor spaces" to its' list of essential nonpharmacologic prevention measures for COVID-19. Page 5, Lines 28–29 state: "Reports also show a disproportionate impact of COVID-19 cases and death on Hispanic and Latinx communities" with no citation at the end of the sentence. Page 6, Lines 4–6 state: "These communities represent 1.3% and 0.2% of the population respectively and experience disproportionately worse health outcomes even prior to COVID 19" with no citation at the end of the sentence. Page 6, Lines 11–13 state: "A prior examination of Western U.S. areas found that COVID-19 case rates in Native Hawaiian, and Pacific Islander populations were higher than other racial and ethnic groups. Native Hawaiian, and Pacific Islander have some of the highest rates of essential workers in California and Hawaii" with no citation at the end of the sentence. Page 6, Lines 28–30 state: "Underserved and disenfranchised communities and their intersection with determinants of health: Due to explicit government actions and private sector disinvestment to enforce racial segregation and poverty, underserved communities are more likely to live in densely populated housing" with no citation at the end of the sentence.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? v. Is/are the proposed	This section does not discuss and does not establish sufficient evidence to support multiple Action Steps as written. We recommend checking each of the action steps and ensuring that they are clearly, explicitly supported with evidence in this section. In particular, issues of equity with vaccine distribution which are addressed by Action Steps 2 & 3 are under-discussed. Understanding that this is a rapidly evolving subject with minimal data back in February, it is still important to update the Problem Statement and Strategies with evidence-supported claims of inequity and characterization of solutions that feed into the Action Steps as currently written.

strategy/strategies evidence-based? w. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. x. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Please also describe and support with references the need and evidence for monitoring the long-term health impacts and related inequities mentioned in Action Step 2a (see below for more): • The first Action Step calls for public health infrastructure, but NOT integration of healthcare systems or health data. The first strategy discussed should either be narrowed to focus on public health system and data or an Action Step should be added calling for appropriate healthcare infrastructure (including transparent billing data and reimbursement integration such as that provided by single payer systems) to reflect the examples provided in Strategy. In addition, this strategy reflects three seemingly distinct strategies that should be discussed in more detail – 1) Coordinated public health, 2) Accessible healthcare for the underserved, 3) Nimble, decisive, effective leadership. Each of these needs to be described as supported by reference #41 which suggests implementing universal healthcare coverage (not in Action Steps), among other things. P11 lines 19-22: clinical care and programmatic strategies both alone cannot adequately compensate for a lifetime of accumulated disadvantage especially among indigenous communities, Blacks and the Latinx, nor will it address the factors that influence health inequities. It is recommended that the authors explicitly advance a number of social policies beyond the healthcare system in greater detail, such as universal food income and a reformed unemployment insurance: (https://www.nejm.org/doi/full/10.1056/NEJMp2021209). Please include faith-based and community organizations in the approach of how public health can engage the community. Please expand on how community health workers (mentioned on P11, line 19) can positively impact community engagement and culturally aligned interventions to mitigate COVID-19 infections Please expand on or include a strategy to reach the population who use drugs, including needle services Please include smoking cessation strategies to address communities with higher prevalence of smoking which increases risk of severe COVID-19.

	Please give particular attention and guidelines for equitable distribution of preventive measures to pregnant women and children in childcare and schools would also be helpful. P11, lines 27-29: The statement "Seeking community input…" needs a strong reference to support this claim of community uptake and information distribution. This should be relatively easy to find in the literature regarding Community-based Participatory interventions increasing engagement & dissemination, preferably a review or consensus statement on the subject. As discussed elsewhere, OSHA has developed standards which are not discussed in the Problem Statement (either supportively or critically). This impacts the relevant sections of the Evidence-based Strategies and Action Steps which need to acknowledge and either recommend improvements or updates, stronger enforcement, etc. (https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf)
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? cc. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. dd. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address	The Opposing Views (3) are limited to the large cost, risks to privacy/confidentiality, and the risk of misinterpretation by the public. It is critical that you characterize and then provide references (peer-reviewed not necessary) to support the Opposing Views themselves, so that users (advocates or APHA gov't relations staff) are fully informed about the counter-arguments they will face. In addition, the refutation of these opposing arguments need to be supported with sufficient evidence. Therefore, it is recommended that the following opposing views are added (regardless of their distastefulness or lack of strong evidence): • Politics has played a big role in the people's response to this pandemic. An opposing view of states' rights is particularly relevant • The perspective (with opinion cited) that people do not believe COVID is real or a serious risk. • The belief that a pandemic is once-in-a-century event, so costs and time frame are not justified, the faith-based and political beliefs that may exist among disparities groups that individual fate is not in our hands or that personal health choices are an individual responsibility. These beliefs

inequities, more expansive in reach etc.)? ee. Are alternative viewpoints, ethical, equitable and reasonable? ff. Were any opposing views missing?	present barriers to PH mitigation & prevention measures including vaccines and accessing care. One or more references is needed to support and better characterize (and criticize, as this is an opposing view) the estimated scale of investment needed to build an equitable system. This is refuted using reference #1 (APHA policy 20189) which is appropriate in this instance as that policy does make a case to justify the costs. Reference #49 (P12, line 18) makes more sense in supporting the subsequent sentence on lines 18-21, as it supports the refutation of this perspective. A reference supporting the Opposing View is still needed to support the initial statements from lines 15-18. Most notably, the third opposing view about misinterpretation is made very briefly, without supporting evidence (an example or review discussing issues with scientific communication perhaps) and the recommendation that public health practitioners stay involved with communication needs to be supported with best-practices cited.
Action Steps Are the **ACTION STEPS**: cc. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? dd. Focused on policy/principle, and not on specific legislation/regulation? ee. Supported by the evidence or rationale documented in the proposal? Are the action	The action steps are entirely directed toward governmental (legislative and administrative) bodies. Consider adding calls to action for individuals and community organizations, as well as health education, health promotion, community health workers, and other medical professionals. Action Steps # 1, 3, 4, & 5- We strongly recommend that these steps be made more specific and feasible by including specific agencies or responsible/accountable parties and details about the particular steps to take. There are multiple action steps which include vaccine program guidance. Each of these needs to be set up with discussion in the Evidence-Based Strategy section: 2 & 3 in particular. There are other Steps which are not supported by the Strategies section: #s 11 in particular. Please also consider making explicit the importance of free tests and testing, vaccine supply and the administration as discussed in earlier sections. Action item #1 involves multiple steps and could be broken apart. Consider defining “representation from underserved communities” and building this as a new action step or include as 1a. This reads as a distinct and separate action from funding/staffing/ educating/maintaining a public health infrastructure.

steps evidence-based, ethical, equitable and feasible? If not, please explain? ff. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Action step 2a, consider explicitly including reinfections and vaccine-breakthrough infections as specific subtypes of cases. Also please clarify what is meant by "health-related impacts". Is there an available standard definition from CDC (mental health? cognitive effects? standard symptom lists like anosmia?). This term is not mentioned in the Strategies section but is important for continued monitoring of existing inequities acknowledged in Problem Statement. Action Item #2b should clarify the prioritization of disaggregated sociodemographic data collection and sharing with higher levels of government up to the federal level. In addition, case investigations are the source of detailed data so it would be a stronger step to show that sociodemographic data is collected during the "rapid case and outbreak investigations" and "contact tracing" phases. Collecting social variables and demographics should be prioritized at each step. Action item 2c: It is recommended that the employer reporting recommendation be consolidated to including one federal agency for oversight – likely OSHA. Multiple reporting mechanisms are acceptable (i.e. to state agencies) if this is evidence-based, but recommendation should mirror other reporting systems already in place. Action item 4: It is recommended that this step be revised to recommend best-practice testing instead of "rapid tests", which are a problematic designation with variable, and higher, false results: FNR & FPR. Refer to the HHS COVID-19 Treatment Guidelines Panel recommendations section on Testing for SARS-CoV-2 Infection (https://www.covid19treatmentguidelines.nih.gov/overview/sars-cov-2-testing/) for accurate and up to date information. Lines 30-33: Please clarify who these evidence-based interventions should be directed – to everyone, or to low-income and communities of color specifically? Also, please clarify for how long these interventions should be made available – i.e., for the duration of the pandemic declaration or permanently? This is important information for understanding the scale and impact of the action and for gauging the evidence provided in this policy to support such a step. Consider separating the last clause (line 33) and giving "access to paid sick leave and supporting quarantine" its own action item. Action step 7: As discussed in previous sections, OSHA has developed standards which are not discussed in the Problem Statement (either supportively or critically). This impacts the relevant sections of the Evidence-based Strategies and Action Steps which need to acknowledge and either recommend improvements or updates, stronger enforcement, etc.

	(https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf) Action step 8: Please clarify whether this is intended to be a federal, state, or local responsibility for enforcement of whistleblower law. Action step 9: Please clarify (if correct) that this presumption should be legislated at the federal level to bring all states in line with the recommended strategy. Action step 11: The NIH, HRSA, CDC, are all providing large amounts of funding for this action. The Strategy section does not reference or support this Step or the benefits of conducting community-based / engaged research. This step should mention /acknowledge that activity and build on the characterization of research funding and supportive evidence provided in Strategies by calling for more, or more-narrowly focused research (if appropriate). Consider amending the step to "Fund and disseminate *even more* scientifically peer-reviewed…", etc.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	The times when the strength of cited evidence falls short are cited in sections above.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: cc. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? dd. Is the proposal consistent with	The proposal focused on but does not discuss IRHL, UDHR, CSDH. Review by IHRC and Ethics would be helpful.

the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? ee. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? ff. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	Major member comments not addressed above: **Problem statement:** There is no discussion of the impact of COVID-19 on individuals who use drugs. Between additional risks based on race, housing instability, compromised immune systems, treatment interruptions, and other factors, this subpopulation is also at great risk and suffers from the same marginalization and disenfranchisement as other identified groups. The problem statement does not discuss that people with substance use disorders (SUD), especially African Americans with SUD, are at higher risk of contracting COVID-19 and experiencing worse consequences from it.

	Mental health disorders are only briefly mentioned for the homeless and LGBTQ+ populations. It could be helpful to describe the issue for other vulnerable populations. For example: McKnight-Eily et al. (2021) found "Symptoms of current depression were reported 59% more frequently by Hispanic adults (40.3%) than by non-Hispanic White (White) persons (25.3%). Estimates of self-reported suicidal thoughts/ideation among Hispanic persons (22.9%) were four times those among non-Hispanic Black (Black) persons (5.2%) and White persons (5.3%) and approximately twice those of multiracial and non-Hispanic persons of other races/ethnicities (8.9%)".McKnight-Eily, L. R., Okoro, C. A., Strine, T. W., Verlenden, J., Hollis, N. D., Njai, R., Mitchell, E. W., Board,A., Puddy, R., & Thomas, C. (2021). Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic-United States, April and May 2020. MMWR. Morbidity and mortality weekly report,70(5), 162–166.https://doi.org/10.15585/mmwr.mm7005a3 The problem statement does not identify issues related to the increased prevalence of substance use disorders during the COVID-19 pandemic, both generally and specifically, in more vulnerable populations. References: (1) American Psychological Association. (2021, March 1). Substance use during the pandemic. https://www.apa.org/monitor/2021/03/substance-use-pandemic. (2) Czeisler, M.É., Lane, R. I., Wiley, J. F., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M.(2021). Follow-up Survey of US Adult Reports of Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic. JAMA Network Open, 4(2), e2037665-e2037665. (3) Czeisler, M. É., Lane, R. I., & Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., ... &Rajaratnam, S. M. (2020, June 24–30). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States. Morbidity and Mortality Weekly Report, 69,1049–1057. (4) National Institutes of Health. (2020, September). Substance use disorders linked to COVID-19 susceptibility.https://www.nih.gov/news-events/news-releases/substance-use-disorders-linked-covid-19-susceptibility. (5)NIDA. (2020, October 5). New Evidence on Substance Use Disorders and COVID-19 Susceptibility. https://www.drugabuse.gov/about-nida/noras-blog/2020/10/new-evidence-substance-use-disorders-covid-19-susceptibility Line 28 to 30 of page 4states as follows; "These health inequities are a result of institutional racism and economic injustice that continues to impact living conditions, working conditions, political voice, power and self-determination..."Since the relationship between racism and health inequities remain under-studied, and economic injustice and racism are not the only causes of health inequities, we may rephrase as " These health inequities are influenced by institutional racism, economic and social disparities as well as poverty, all of which continue to impact living

	conditions, working conditions, political voice, power and self-determination..." For section on immigrant population in line 23-29 on page 9, it is necessary to include that non-essential workers many of whom are undocumented immigrants are known to live in shared housing, rely on shared transportation and work in poorly ventilated work settings. Despite these risk of infection, undocumented workers are less likely to be vaccinated against COVID-19 due to fear of encountering immigration enforcement. Health Communication and the level of health literacy is a major intersectionality of SDOH not mentioned as a factor in the problem statement. Critical to inequity for disease or public health mitigation is health literacy which frames, methodology, messaging and frequency and even the type of messaging you give for target population understanding. Without it misinformation fuels disease spread and mistrust even further. Discuss disabled populations see: Andrews,E.E., Ayers, K.B., Brown,K.S., Dunn,D.S., &Pilarski,C.R. (2020,July23). No Body Is Expendable: Medical Rationing and Disability Justice During the COVID-19 Pandemic. American Psychologist. Advance online publication. http://dx.doi.org/10.1037/amp0000709 **Evidence-Based Strategies:** For an all-inclusive approach, the community should be engaged in the planning, implementation and monitoring of strategies and activities to address the problem. Recommend adding strategies for improving care for those with disabilities from the following reference: Maya Sabatello, Teresa Blankmeyer Burke, Katherine E. McDonald, Paul S. Appelbaum, "Disability, Ethics, and Health Care in the COVID-19 Pandemic", American Journal of Public Health 110, no. 10 (October 1, 2020): pp. 1523-1527. https://doi.org/10.2105/AJPH.2020.305837 Cultural competency should also include physical disability. Conducting implementation science research to further characterize and measure the effectiveness of these strategies, with a focus on their impact on vulnerable populations.

	It should be updated to reflect more information about vaccination, which is now an integral part of the response. To support this strategy, please provide evidence from clinical trials from Pflizer-BioNtech, Moderna, Janssen. **Opposing Views:** Include the opposing viewpoint that involves people not believing COVID is real? And the political issues some people have? There is not really mention in the Action Steps of what an individual can do to further this agenda. Opposing views should include the belief that a pandemic is once-in-a-century event, so costs and time frame are not justified, the faith-based and political beliefs that may exist among disparities groups that individual fate is not in our hands or that personal health choices are an individual responsibility. These beliefs present barriers to PH mitigation & prevention measures including vaccines and accessing care. The opposing views are not well refuted. The single alternative strategy considered-develop local and state response teams on health equity–is dismissed as being too expensive and requiring major change. While just a dozen states have implemented these, many have upped their health equity reporting and states do provide innovation laboratories. **Action Steps:** The action steps are vague and do not provide real solutions and just focus on overall "umbrella" solutions. The authors leave the reader to figure out what the best course of action forward would be. The steps need to be more specific and strongly worded.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	

Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

B3: Adopting a Single Payer Health System

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, requires minimal revision

JPC Assessment: Conditional

Vote: 9 yay; 0 nay; 1 abstaining

Criteria	Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.*
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy	

on this issue now). If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? y. Are there important facts that are missing from the problem statement? If so, describe them. z. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? aa. Identify any relevant ethical[xxv], equitable[xxvi], political or economic[xxvii] issues.	Change language to person first as in individuals with low income (p6, 15, 20, 21, 25, 26; p7, 24, 25, 29; p8, 4) Add additional discussion on mental health and substance abuse Add additional discussion on social determinants of health (current system does not address this) Emphasize racial, ethnic, and citizenship status disparities Note that the narratives in the summary and rationale also define the problem. Consider an additional source: "UHC in US Healthy Debate" by Zeiff et al 2020. Additional up-to-date sources would help the proposed policy statement. Discuss important legislation like the ACA or Parity legislation that forges equity between physical health, mental health and substance use treatment and insurance. Define "Two-tiered" in quotations or parentheses (VIII, C., Page 5, Line 22). This is such a dynamic and changing concept that it is surely difficult to stay current. However, the following are pretty old: # 12,24,28,29, 41. Consider updating. Define Universal Healthcare Coverage.

Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? y. Is/are the proposed strategy/strategies evidence-based? z. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. aa. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Clarify whether cost estimates include coverage for all persons living in the US Address anticipated legal challenges Consider adding more detail on logistics to employ proposed strategies. Update with new legislative implications of American Rescue Plan, CARA and CARES Address: • increased opportunities to address preventive measures. These measures would include the single-payer's interventions to prevent disease (i.e., chronic diseases diabetes) through the promotion of life-style changes, effective health policies and environmental factors (i.e., green spaces)that would lessen costs associated with treating the low socio-economic status segments of the population • the Single-Payer System has a greater opportunity to require value-based care by negotiating for and receiving value that is reflective of the actual value of such care • the Single-Payer System shall be better equipped to handle the coming chronic disease pandemic that is now certain to occur due to the reluctance of money individuals to obtain treatment for their chronic diseases during the COVID-19 pandemic • to inform public opinion, through the use of various communication tools, of the unfounded positions of those opposing a Single-Payer System
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? gg. Does it adequately refute the opposing/alternative	Add and address common opposing arguments such as: increase in taxes, increase in deficit, incentive for undocumented immigration; inability to meet demand; countries with SP are poor; and/or healthcare will be rationed.

viewpoints presented using evidence? If not, please explain. hh. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? ii. Are alternative viewpoints, ethical, equitable and reasonable? jj. Were any opposing views missing?	
Action Steps Are the **ACTION STEPS**: gg. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? hh. Focused on policy/principle, and not on specific legislation/regulation? ii. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? jj. Culturally responsive to the under-represented and underserved populations being	Include a "whole health" focus that includes physical, mental and substance use treatment. Strengthen the linkage between the action steps and evidence based strategies. Add an action step calling on Congress to support and pass a single payer bill or expand the ACA to cover all residents of the US. It would be helpful to educate Congress on the short-term and long-term benefits of a Single-Payer System' This not an action that APHA should be responsible for. APHA should continue to provide leadership in partnering with other advocacy collaborators.

addressed, if appropriate? If not, describe why not.	
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Update citations if more recent data is available 12,24,28,29, 33,38,41. The references should use the AMA 10th edition for presenting references. Please move the year of the reference after the name of the journal. Please give the web address for reference 27.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: gg. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? hh. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? ii. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? jj. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the	

International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	Clarify strategies by providing greater discussion of how they can be achieved in a US context Ensure subheadings clearly match the content. Improve conciseness. Add additional strategies. See "Universal Healthcare in the United States of America: A Health Debate," by Zieff, et al. 2020
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	Please collaborate with the authors of B6 so that the policy statements are complementary.
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Consider review with Ethics section.

B4: Addressing Coercion in Contraceptive Access to Promote Reproductive Health

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, requires minimal revision

JPC Assessment: Conditional

Vote: 10 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	The current title can be strengthened to be action directed. Consider the revised title, "Opposing Coercion and Criminalization in Contraceptive Access to Promote Reproductive Health"
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	Include policy statement number that is being archived at the end of 2021. The proposed policy statement updates current APHA policy statement #200122 which is set to be archived.
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy	The rationale for consideration is missing and must be included in the revised statement.

on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? bb. Are there important facts that are missing from the problem statement? If so, describe them. cc. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? dd. Identify any relevant ethical[xxviii], equitable[xxix], political or economic[xxx] issues.	The description of the problem uses good quality qualitative and quantitative evidence as well as reports and program and policy statements to describe the problem of contraceptive coercion in the U.S. (in particular). The conceptual description of the problem is excellent. However, you could do a better job making the connections between the problem of contraceptive coercion and health outcomes, particularly for people of color. Even if this particular direct evidence doesn't exist, recommend that the you more explicitly walk through this logic and naming the places where we need more evidence would be helpful. Correct grammatical errors and typos in this section. Ground how addressing coercion addresses health equity and health outcomes. Focus on commercial insurance. Quantify how common coercion is among affected populations. And who and how to reach those who need access to services. Update the description of contraceptive coercion. Limit use of acronyms without PPS; be consistent throughout Use people first language when citing evidence and in proposed policy statement. When referencing studies, reference those populations who were included in studies. The proposal omits the most recent reports of involuntary hysterectomies and should list LB that preceded D3 as relevant policy. There is one item bottom of p. 2 in need of clarification relating to the history of Norplant, the first LARC. True it was discontinued in 2002 but another product is available, so the topic is not moot. This should be indicated so the reader is not left with the impression that LARCs may no longer be a concern. Also, the later product, Implanon, a similar hormonal (norgestral) treatment is a 3-year rather than a 5-year implant. p. 4 top continues to discuss long-acting as first-line. Here is an opportunity to reflect the clinical pharmacologic concept that

	long-acting products should never be first-line because an adverse drug reaction could not be interrupted without considerable pain and cost to remove the embedded LARC. p. 2 mid-paragraph has a missing reference (ref) on eugenics. p. 3 bottom paragraph addresses a complex question on reducing teen pregnancy. True, there are underlying socioeconomic and educational issues, but the argument seems to give no credence to the individual case of balancing of early pregnancy, loss of opportunities for the young teen and the potential fetus to have greater quality of life. Add discussion of incarcerated populations detained in local jails, prisons, federal prisons, ICE and others who may lack agency On line 34 need to type out what CRACK stand for. This is done in the problem statement, but should be explained earlier then if used later in the proposal can be used as acronym
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? bb. Is/are the proposed strategy/strategies evidence-based? cc. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. dd. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Include CHES/MCHES and CHWs either within the healthcare worker section or as its own sections. As frontline public health workers, these credentialed professionals educate about contraceptive methods, connect their clients and communities to health and social resources. Among those resources could be proper access to contraceptive education. Recommend a closer look in terms of ensuring all areas have been exhausted. It may be less about creating new sections and more about fleshing out the existing. If the action steps could be more explicit about the types of healthcare professionals involved that would be a helpful addition

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? kk. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. ll. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? mm. Are alternative viewpoints, ethical, equitable and reasonable? nn. Were any opposing views missing?	Opposing views need additional elaboration. Additional opposing arguments include: population control, politicized counterpoints (e.g. why might a health dept not want to do this), ethical and financial considerations. Call for the need for research to refute politicized counterpoint on the proposed strategy. Discuss choice in access to preferred method of contraception. Alternative strategies in the healthcare setting for preventing adolescent pregnancy should also be provided. .
Action Steps Are the **ACTION STEPS**: kk. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? ll. Focused on policy/principle, and not on specific legislation/regulation? mm. Supported by the evidence or rationale documented in the proposal? Are	Action steps are very focused on the public sector; consider private sector work in commercial insurance as well that would be relevant and adding an action statement related to commercial insurance. Consider whether Action Step 6 is part of a different policy that requires its own problem statement, evidence-based solutions, etc. Some of the action steps that ethically make sense (e.g. #8) require significant amounts of money or may be politically infeasible (e.g. #3). Consider whether there is a way to acknowledge the questions regarding feasibility earlier in the proposal – perhaps in arguments in opposition (?). Discuss issues related to populations that lack agency. Opposing argument re: right to life Cross reference Policy Number 200122: Opposition to Coercion in Family Planning Decisions Involuntary hysterectomies to problem statement

the action steps evidence-based, ethical, equitable and feasible? If not, please explain? nn. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Consider a racial-based strategy or action to specifically bring action to racial disparities associated with LARC, such as in this article: • Holliday, C. N., McCauley, H. L., Silverman, J. G., Ricci, E., Decker, M. R., Tancredi, D. J., Burke, J. G., Documét, P., Borrero, S., & Miller, E. (2017). Racial/Ethnic Differences in Women's Experiences of Reproductive Coercion, Intimate Partner Violence, and Unintended Pregnancy. Journal of women's health (2002), 26(8), 828–835. https://doi.org/10.1089/jwh.2016.5996 • Nikolajski, C., Miller, E., McCauley, H. L., Akers, A., Schwarz, E. B., Freedman, L., Steinberg, J., Ibrahim, S., & Borrero, S. (2015). Race and reproductive coercion: a qualitative assessment. Women's health issues: official publication of the Jacobs Institute of Women's Health, 25(3), 216–223. https://doi.org/10.1016/j.whi.2014.12.004 Add citations for two sections on page 4 that are missing them. The first sentence is “Contraceptive use can improve health outcomes and reduce health and healthcare disparities, including reducing pregnancy related morbidity and mortality, improving birth outcomes, reducing the risk of developing certain reproductive cancers, preventing STIs, and treating medical conditions.” And the second area are the last two bullets in that paragraph under “contraception coercion can:”

Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: kk. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? ll. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? mm. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? nn. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	International health- Address the feasibility as it related to costs of making all methods free. Suggest addressing this in evidence-based solutions or opposing arguments. CHPPD – Add literature on how make changes in religious and faith-based organizations & training providers. Editing action step #3 to also include Dept of ed; and adding some additional literature on racial-inequities associated with LARC

	MCH Section- Address concerns re: adolescents (brain development, unintended pregnancy impacts, contraceptive failure rates) Women's Caucus- Include information about LARC among specific populations, e.g. people with HIV and adding more to the opposing arguments section. References implementation science as the tool to make these changes happen; possible to add this in evidence-based strategies. From individual in SRH section: Add alternative educational strategies to get information to people, suggests centering the LARC statement of principles more clearly, and including population control arguments in opposing views section
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

B5: Sexual and Gender Minority Demographic Data: Inclusion in Medical Records, National Surveys and Public Health Research

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 3b- Insufficient scientific reasoning, requires major revision.

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.*
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e.,	

why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? a. Are there important facts that are missing from the problem statement? If so, describe them. b. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? c. Identify any relevant ethical[xxxi], equitable[xxxii], political or economic[xxxiii] issues.	Be consistent with the groups included and be inclusive of the current groups that are recognized by this community (LGBTQAI?) Include examples of questions that have been validated and used in medical records and surveys Please include more information with references on the health disparities among the LGBTQI population and the non-LGBTQI population and consider addressing whether this problem disproportionately impacts LGBTQI individuals of different racial/ethnic groups and other intersecting social characteristics. Elements related to political, ethical, and economic issues are not included in any substantial way in this section. One example of political issues that could be consider for discussion pertains to challenges around inclusion of SOGI items that are based on value differences. Barriers to item inclusion often emerge, for example, in state data collections where opposition is sometimes expressed because inclusion is seen as equivalent to acknowledgement of populations that some do not wish to be recognized. Content in the opposing argument/evidence section touches on some elements that are related to this. However, that content is more focused on general broader opposition such as Sexual Orientation Change Efforts. Speaking directly to political opposition related to population acknowledgement identifies an additional set of environmental variables around which strategies should be developed to promote data-related inclusion. Ethical issues such as the consequences of continued exclusion are lightly addressed. These could be brought more, if doing so is possible within operative space constraints The statement addresses trauma and minority stress throughout life course which have long-lasting effects on individual health and wellbeing. The problem statement is aligned with the Mental Health Section's perspective. Bullying, suicide, opioid misuse, and homelessness addressed in the problem statement are all important topics in public mental health.

	Although the problem has been described, more evidence should be included to demonstrate how individuals will be protected when gender identity is identified in the two-step process so that it reduces misuse of the data and stigma. The implications of lack of data on health outcomes and health disparities have been appropriately explained. However, the implications of such lack of data for decision-making, issues of ethics, etc. have not been illuminated in the section. Are there issues involved in not collecting SGM data? Any political and sociocultural implications? I suggest that the authors should think of the problem beyond just health. Line 16-24: Policy states that assumptions are made about gender from sources that do not ask people how they identity. Cites multiple examples of data estimates from various sources but never explicitly states that these sources do not ask how a person identifies (e.g.VA data from medical record). In addition, the citations are dated. For example, a quick literature review provided multiple more recent articles on transgender veterans. Without up-to-date references, the authors' claims regarding sources and whether or not gender identity is established may not be evidence-based and accurate. P5-In the section on minority youth, states there are problems collecting data for minority youth. However, then provides multiple data points on this population without making a connection. Suggest clear statement at the end of the paragraph line 21 regarding what the problem is-eg data indicates lots of concerns re sexual minority youth SMY so need to make sure that there is adequate data collection on this population (Is this what the authors intended to imply?). Also, references appear to need updating on this topic. No articles cited from 2019 and 2020. Are any being overlooked? Unclear why you cite ref # 30 that has been retracted by the publisher for statistical issues. Seems inappropriate and should be removed. Re 22: Dragon CN, Guerino P, Ewald E, & Laffan A. 2017. Identifying Medicare Beneficiaries Accessing Transgender-Related Care in the Era of ICD-10.LGBT Health Special Issue on Older Adults. Available at: http://online.liebertpub.com/toc/lgbt/0/0. Link does not take reader to the special issue. This is an incomplete citation. Needs the complete reference and the correct link. I did not check all links. Please go back and recheck all references to ensure they are correct and appropriate.

	Address repetition of information (page 3 lines 29-34 and page 5 lines 6 – 9). Unclear why page 5 lines 6-29 and page 6 lines 1-5 are included – to show the impact of knowing the data? This seems separate from the issue of needing to uniformly collect the data. Page 6 line 33 is an incomplete sentence and seems to be repeated on page 7.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? a. Is/are the proposed strategy/strategies evidence-based? b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. c. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	To further strengthen the statement, please discuss more specific evidence-based strategies on the methodologies that could be used for collecting sexual and gender orientation. It is not clear to readers not intimately familiar with the research space what the methods used to ask questions related to sexual and gender identity are. One additional strategy that could be considered for inclusion is to address value-based barriers to and enablers for SOGI data collection. This could be vital given that such factor may speed or delay achievement of desired data-related goals. Also, please give examples of evidence-based validated questions that have been or could be used in data collection on gender identity and sexual orientation. Additional actions that would strengthen this section include: (1) add references given as footnotes to the reference list; (2) deleting strategies given under the section of "Champion Internal Policies and Practices to Normalize SGM Identities" and possibly adding them to the Action section (this however, would require sufficient support in the strategy section); and (3) clarify approaches for posing questions / collecting data confidentially in different settings and with different age groups. It has been pointed out that validated two-step questions already exist that could be incorporated in these surveys/medical record/research. However, it is not clear what the two steps are and the specific question. Further, it is not clear how these two-step questions were developed and validated. As such, it is critical to expand on how the questions were developed and if they are of broad use. In the last sub-section on normalize SGM identities: ○ It is not clear how including preferred pronouns in salutations and signatures could facilitate the collection of SGM data in surveys/medical

	records/research. No evidence was presented that such action facilitates or enhances the collection of SGM data. ○ APHA cannot be agent for proposals in policy statement; therefore, the section may be out of place in this policy statement. Specific strategies for how to address the gap – the third section "champion internal policies and practices" focuses on what APHA could do but could be expanded to state that communities, affiliates and others can implement those changes Include evidence-based actions for communities, local or state level work. Discuss how to incorporate SGM data into specific policies (e.g. federal policies) or data sources (e.g. census data, vital statistics, Medicaid, Medicare, and clinical records). Recommend adding specific strategies related to incorporating SGM data into specific policies and data sources. The authors also need to provide counterpoints for the presented opposing views. Consider generalized education and awareness programs for healthcare providers beyond those that may be developed solely for public health professionals or toolkits developed by the APHA. Do barriers exist among healthcare providers, such as primary care providers, that prohibit them from understanding LGBT+ needs and recognizing the importance of inclusion in research and data collection? Additional References: ○ What Sexual and Gender Minority People Want Researchers to Know About Sexual Orientation and Gender Identity Questions: A Qualitative Study. (2020). PubMed Central (PMC). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7497435/ ○ Vance SR Jr, Halpern-Felsher BL, Rosenthal SM. Health care providers' comfort with and barriers to care of transgender youth. J Adolesc Health. 2015;56(2):251-253. doi:10.1016/j.jadohealth.2014.11.002 ○ Dichter ME, Ogden SN, Scheffey KL. Provider Perspectives on the Application of Patient Sexual

	Orientation and Gender Identity in Clinical Care: A Qualitative Study. J Gen Intern Med. 2018;33(8):1359-1365. doi:10.1007/s11606-018-4489-4
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. b. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? c. Are alternative viewpoints, ethical, equitable and reasonable? d. Were any opposing views missing?	Add counters to opposing arguments described. This is key to add to subsequent versions. Such content allows for a full consideration of opposing arguments and possible counterarguments. For example, how have concerns about cost and survey real estate use been addressed in other efforts? What approaches have been used to safeguard identity-disclosure and enhance confidentiality preservation? How can ever shifting terminology changes and growing lexicons be accounted for? Please refute the oppositions that state that because response rates might be low, it would be too expensive. Consider other questions that have been added to national surveys previously that maybe expensive, but the benefit outweighs the cost. Add as opposing points: ○ Resources needed to support the proposed data collection ○ The potential for political etc. pressure by other minority groups to demand similar data collection in national surveys, medical records, and public health research. Address relevant policy and perspectives related to healthcare providers being able to voluntarily choose not to provide care to LGBT+ patients and explore whether or not these views intersect with the purpose of this statement.
Action Steps	The proposal should identify actors that APHA must engage in the advocacy and research domains described. In the current

Are the **ACTION STEPS**: a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? b. Focused on policy/principle, and not on specific legislation/regulation? c. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	version, the statements seem to only be framed for action just by APHA itself. This may be the goal. However, policy statements are mainly used by the organization to encourage action by other external actors. Statements related to the features ethics and equitability provided for rows on the strategies and actions also apply here. These focus on the nature of implementation. This is key given that many subgroups make up the category of SGM. Consideration of intersections with other social categories that have historically been a basis for various levels of social inclusion/exclusion is key also to encourage cultural relevance. Consider an action step that proposes school data collection given the major issues in school setting regarding SMG youth. Action steps lack any action at the medical facility level to encourage adoption of two-step gender identification incorporation. Much could be done to improve this without legislative or judicial action in a timelier fashion. Action items could be expanded to include actions affiliates could take to help push for these changes at the state and local level. Action steps call for advocacy and additional research. It would be difficult for UPHA to use the action steps to address this problem as they are limited to federal action & APHA action. In support of the proposed action steps, though we would recommend adding "and research funding agencies" after "Explicitly advocate for public health research" under the Advocacy section. Consider an action step for advocacy with medical facilities to include expanded gender on medical records. As medical records are foundational - and often the gold standard - for nonfatal public health surveillance, it is important that change in data collection occur at the primary source. Likewise, changes to the binary gender/sex field on the uniform death certificate would allow better information to be captured for mortality surveillance. In mortality surveillance, however, the proposed two-step methodology will need to be adapted since the individual is no longer able to self-identify. Recommend further work on that action steps so that they adopt the S.M.A.R.T. goals framework (Specific, Measurable, Achievable, Relevant and Time-based)

References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	The references require a bit of attention to formatting References seem somewhat dated. Recommend updating. For example, we did a quick lit review and found multiple more recent articles on transgender veterans.
Member Comments What are the major comments by APHA units with expertise on the issue?	There is the need to strengthen the underlying evidence of the statement and better align the action steps with the strategies. Address the opposing arguments, expand the evidence-based strategies and action steps to be inclusive of multiple levels of action. Suggest working with a PhD level researcher (from the Epi Section?) to review references as the statement lacks or improperly cites scientific evidence. Suggest that the problem statement be updated, including clear statements regarding why data is cited together with an updated evidence base. There are minor grammatical/contextual errors that need to be addressed. Information on cost-benefit/cost-effectiveness analysis as it pertains to feasibility of gender identity inclusion on surveys could have been presented in order to refute claims against but otherwise, the proposed policy statement looks good. What does correct gender mean? Note that could be understood as offensive depending on the reader. Suggest saying assigned gender at birth. "Line 2, page 4" Action steps need to be more concrete. The proposed action steps are quite generic. They lack agency i.e. there is no specific external agency tasked with the implementation of the actions and they are not clearly tied to the evidence-based strategies. The Actions Steps should emanate from the strategies, which is not the case in this policy statement.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**?	

Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization).	

B6: The Importance of Universal Healthcare in Improving our Nation's Response to Pandemics and Health Disparities

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3b- Insufficient scientific reasoning, requires major revision

JPC Assessment: Conditional

Vote: 10 yea; 0 nay; 1 abstaining

* Revision must include most recent evidence/context as of July 1, 2021

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Update the document to include more about the pandemic or update the title.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the	

relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now). If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? d. Are there important facts that are missing from the problem statement? If so, describe them. e. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? f. Identify any relevant ethical[xxxiv], equitable[xxxv], political or economic[xxxvi] issues.	Add citations to justify the problem. Discuss access and quality in more detail. Strengthen the problem statement by talking about communicable disease and COVID-19 as an example, not the overall focus of the policy. That will give it an extended shelf life. If focusing on COVID and preparedness, then the policy needs to have more clarity overall about what COVID demonstrates (e.g. interconnectedness of the health of all, problems with tying healthcare to employment, and the link between health and the economy). This could help to justify the need for UHC (and should be examples to highlight). Consider reframing to strengthen this section and the arguments for UHC. Address human rights in greater detail. P5,26-28 Consider the role for single-payer financing and payment for coverage. Additionally, add more info on the fragmented US system (% government, % employer-based, etc.). Using examples from other developed countries could be helpful to make the case (Germany, Canada) that UHC countries had better outcomes. It's important to also note the distinctness of the US system and political and economic concerns. Provide greater detail on the differences between U.S. and other countries' health systems; using more developed countries would strengthen the argument Page 4 lines 30-31: Strike the statement about this being a late breaker. Add a discussion of the interconnectedness of the health of all people.

	Address the problem of employment-based health insurance in a pandemic. Ensure that the term "access" is used consistently throughout the proposed statement. P7,1-2, Explain how Medicaid will be impacted and the effect on access. P7,15-22, Include more data comparing the health outcomes of those treated at lower income hospitals compared with better funded hospitals. Page 4 lines 30-31: Strike the statement about this being a late breaker. Add discussion about how to expand existing payor structures (ACA, Medicaid, Medicare) the statement stops short of suggestions on how to control costs and expand access simultaneously. The economic issues of healthcare costs and financing are largely avoided (e.g. how does universal coverage affect the risk pool). The issues of equity are added inconsistently and not supported with the multitude of evidence available. Expand issues of equity addressed and back the discussion up by evidence
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? d. Is/are the proposed strategy/strategies evidence-based? e. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. f. What other strategies, if any, should be considered? Should	Alternating between COVID-specific statements and those focused on long-term evidence from previous responses creates confusion about sources and durability of the overall argument (universal coverage for next pandemic vs. overall benefits to health outcomes, access and equity in general). Add more evidence and clarify the final sub-heading to the section IX. "Universal health care better supports the needs of vulnerable groups" will benefit this section. More clearly outline the various vulnerable groups that are being supported. Add alternative strategy to expand the ACA (although politically feasible?) Add discussion of past failures of UHC and bipartisan attempts, ex. Ted Kennedy introduced the HMO act and Nixon signed it. Add explanation for natural experiments as a source of evidence.

additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Add discussion about how the transition to UHC would be coordinated and implemented. Add additional explanation for economic analysis. • Estimates of how the expansion of coverage results in lowering the risk pool for the national patient mix; • Reducing administrative burden in a consolidated system (even if offering multiple financing strategies) to reduce the rising costs of the National Health Expenditure (overall cost to all payers involved) P8,29-30, provide evidence of useful strategies Clarify the link to the Taiwan system and sufficient hospital isolation rooms. It's important that the authors either provide context of the number of cases, the demand for tests, and the Taiwanese population, or remove this characterization as distracting. Clarify the link between Medicaid coverage and reduced racial disparities. P9,2, COVID-specific statement about coverage, with a current tense verb which should be changed to past tense (for accuracy in the future) P9, 21-22, Reference is insufficient; add more evidence. P9, 33-34, add citation to statement about Norway as evidence is implied. Clarify the 2nd sentence about Germany. Is there an increased ability to care for individuals with disabilities? Which vulnerable group is better supported and how is this different than SSDI/Medicaid coverage in the U.S.? P10, 16-17, clarify the statement about long-term care for those over 60 years of age. Explain why Medicare is not sufficient. Final paragraph, add evidence to support statement discussing access to mental health care. Reference #34 is not enough. Add discussion of lowering costs by expanding the risk pool.

	Please discuss political strategies for coordinating and implementing the transition to universal coverage (regardless of financing strategy) in more detail.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? e. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. f. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? g. Are alternative viewpoints, ethical, equitable and reasonable? h. Were any opposing views missing?	Provide additional information on the other countries with UHC (# developed) if available. Discuss the U.S. costs for our system now vs others should be important (we spend a much higher % of GDP on health care and don't see matching results) One opposing argument is the opportunity provided by universal coverage to previously underinsured/uninsured individuals to purchase healthcare will drive them to utilize more services (moral hazard). The counterpoint is nicely articulated here: Nyman, John A. "Is 'moral hazard' inefficient? The policy implications of a new theory." Health Affairs 23.5 (2004): 194-199. The first counterpoint under "UHC is more expensive": The numbers cited of $450 billion annually, $1.8 trillion over 10-years from SINGLE PAYER UHC (not necessarily all universal coverage strategies), & 17% GDP refers to the savings seen to the National Health Expenditure (including private and uninsured system costs and not just Medicare, Medicaid, & CHIP (CMMS governmental costs)). This is confusing because the prior paragraph discusses costs from CMMS programs including a cost of 5.2% of GDP in 2018. Obviously, it didn't jump from 5.2% to 17% in one year. When thinking about the opposing viewpoints in the scientific evidence some are missed. Much of the evidence is from single-payer systems and since the authors chose not to pick a model, this might need to be distinguished. • Is a Universal healthcare system as adopted in other countries appropriate for the United States? (e. g. given its size, unresolved immigration issues, people's temperament towards being taxed more to pay for this system, etc.) • Is healthcare a right? Some say no or limit this benefit for those who have "paid into" the healthcare system and/or workforce.

	• Political barriers, claims of socialism or government overreach • Market forces for innovation in health care will be dampened by universal coverage, negotiation of costs by governmental payer(s), and uniform/fixed price sheets Add expanding ACA as an alternative strategy. P12, 31-33, Cite the claim that ACA cuts rendered it unreliable. P12, 11-12, expand on the counterpoint of the review of 100 countries increasing access to care and population health; add a citation. P13, 7-13, expand on the claim that the CARES Act and Families First fell short in requiring assistance with COVID-19 treatment; add citation.
Action Steps Are the **ACTION STEPS**: e. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? f. Focused on policy/principle, and not on specific legislation/regulation? g. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? h. Culturally responsive to the under-represented and underserved populations being	Consider adding action steps for state/local level action (especially action for affiliates) Address the infrastructure that needs to be in place for success. Add recognition of UHC as a right. #2 Clarify what Congress is to fund and design Action step #3 urges congress and "states" to "use the COVID-19 pandemic as a catalyst" which should be reconsidered or reworded to provide operational details about what this would involve. #5 Clarify how every U.S. resident will recognize institutional racism in the healthcare system. Concerns re: lack of a recommendation for single-payer financing of the universal coverage described in this proposal, while the authors simultaneously use evidence restricted to countries implementing single-payer (or else SP-approximate /hybrid strategies). Consider referring to or harmonizing with B3. Strengthen language throughout. For example, action steps #4, 5, and 8 use soft action verbs such as "to examine", "to recognize" and "to build a system".

addressed, if appropriate? If not, describe why not.	Action step #5 involves two action verbs "to recognize" and "collaborate to build a system" without providing operational details about what this involves. Action step 5 because it is too broad. Further, how will you require all the listed parties, particularly every U.S. resident recognize institutional racism in the health care system? Provide evidence or rationale to support action steps 6 and 8. They appear out of nowhere. Step 8 is appropriate, but there is no discussion about the strengthening of public health infrastructure anywhere in the statement. #7 urges national health care leaders to design the transition and implementation strategy for the system they recommend Congress designs. This transition/ implementation must be paired and developed in tandem with the financing and reimbursement aspects of the core UHC strategy, not afterward by the people implementing the plan designed by elected leaders. The transition/implementation must also be funded by Congress. Consider the infrastructure to support implementation for it to have the best shot available. Off-setting costs, cost neutral, and other economic drivers may be beneficial to add. Workforce and regulatory solutions should be added. If possible, discuss the nexus of disparities, climate change, healthcare, and public health in action steps, to create robust resources to solve multiple challenges. Concerns re: lack of a recommendation for single-payer financing of the universal coverage described in this proposal, while the authors simultaneously use evidence restricted to countries implementing single-payer (or else SP-approximate /hybrid strategies). **Consider referring to or harmonizing with B3.**
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Correct references to include all dates, info on specific journals if online, publishers Since COVID-related, please update all pandemic references with those prior to July 1, 2021. Page 5 line 25: The statement indicates the statistic represents the job loss as of January 2021, however, the references indicate the source was accessed in September 2020. Update and also change in the references

	Page 6 lines 19-20: Needs a reference for Virginia statistics.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: a. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? b. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? c. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments	Working with other universal healthcare policy group (B3) to make a more robust, thorough case. General assertions could be improved with specific data or explanations.

What are the major comments by APHA units with expertise on the issue?	Consider the framing of the policy. While the title and some of the document reference, the value of universal healthcare to the response to pandemics and health disparities, the document itself more describes the overall value of and need for universal health care. The document either could more clearly narrow the focus to pandemic preparedness and to helping to deal with COVID-19 and future pandemics, or discuss universal health care overall, and then use this pandemic as an example of the need, equity implications, and value to helping us be better prepared for future pandemics. The policy could also have a longer "shelf-life" if you select the 2nd option.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	Please work with authors of B3 Adopt a Single Payer System
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Consult with the Ethics Section. The Section review contained extensive suggestions.

B7: An Equitable Response to the Ongoing Opioid Crisis

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 3b- Insufficient scientific reasoning, requires major revision

JPC Assessment: Conditional

Vote: 11 yay; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	See comments below about the term "equitable" (i.e., a suggestion to define it.)
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	

Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? g. Are there important facts that are missing from the problem statement? If so, describe them. h. Document any disproportionate impact on underserved	Consider rewriting summary statement after the body of the policy statement is revised. The policy statement focuses on secondary and tertiary prevention. Authors should consider including some information on the importance of primary prevention. No need to repeat statistics once they are provided in one Section. PS, EBS, AS: abbreviations for Problem Statement, Evidence-Based Strategies, and Action Steps. **<u>Formatting</u>** Correct the Roman numeral numbering of the Sections to conform to Author Guidelines. If a Section is skipped (e.g., Alternative Strategies) still include the header and appropriate Roman numeral, with N/A notation. P. 5, lines 24-34 and P. 6, lines 1-7. Delete from the Problem Statement (PS) Section. (These are potential topics for Strategies and/or Action Steps.) Consider using sub-headers to organize the Problem Statement.

populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? i. Identify any relevant ethical[xxxvii], equitable[xxxviii], political or economic[xxxix] issues.	**Organization of the Problem Statement** Page 3, lines 30-34 and Page 4, lines 1-22 is largely data about the problem of opioid use disorders and overdoses, but not about the authors proposed topic of an "equitable response" to the opioid crisis. Consolidate the data on the OUD and overdoses. Explain/Define "equitable response." PS should focus on the inequities and the reasons for them. (For example, provide more information about why certain populations experience inequities in treatment/care.) **Affected Populations** Recommendation to include LGBTQI+, incarcerated persons, and post-release incarcerated males as populations that receive an unequal response, in order to more accurately reflect the social landscape of today's risk for SUD. Also consider including parents involved in child welfare services (who are disproportionately non-white) as another marginalized population. P.5, lines 19-20. What are these barriers that rural residents experience? With 20% of the US living in rural settings, these barriers should be detailed. Page 6: The authors mention assessment of readiness and communities needs in rural and tribal settings. Is this not appropriate/necessary for suburban and urban settings, too? **Topics Related to Inequities:** Discuss inequities as a consequence of criminalization, stigma, and mental health. Also consider impact of financial resources, housing instability, lack of transportation and access to health care on "equitable response to the opioid crisis" and systems-level interventions (e.g., criminal justice reform; laws regarding who can prescribe buprenorphine and bridge dose.) *Criminalization and Stigma* Discuss the continued criminalization of people who use some drugs is a barrier to reducing opioid-related harm. For example, the possession and use of drugs, the possession and distribution of syringes is deemed a criminal offense in the vast majority of places. Consider including the role of excessively criminalizing Black Americans instead of extending access to treatment. The "War on Drugs" is rooted in racism and to a lesser extent, classism. There is excess criminalization among minorities vs white population. See this publication about stigma as a key hindrance to US opioid response: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6957118/

	Consider adding more to explain that opioid overdose deaths currently are caused largely by synthetic fentanyls. This shift is driven by criminalization of some drugs and reduction in the prescription opioid supply, without a corresponding coordinated effort to increase access to MOUD, pain treatment, etc. A safer supply of opioids would dramatically reduce these deaths, but is made impossible by the continuing criminalization of people who use some drugs and people with substance use disorders. See: Today's fentanyl crisis: Prohibition's Iron Law, revisited (2017), Int. J Drug Policy. https://www.sciencedirect.com/science/article/abs/pii/S0955395917301548 See: "Tackling the overdose crisis: The role of safe supply" (2020). Int. J Drug Policy. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7252037/ Possession of some drugs, possession of syringes, possession of non-prescribed buprenorphine, etc are all criminalized which is a significant contributor to stigma. As long as OUDs are criminalized, people will be stigmatized. Under current law, in most states, the possession and distribution of syringes for use in injecting illegal drugs is a crime. Should those laws be changed? What stigma do these laws perpetuate? What role does racism play in the application of these laws? See: Paraphernalia Laws, Criminalizing Possession and Distribution of Items Used to Consume Illicit Drugs, and Injection-Related Harm (2019). *Am J Public Health* https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2019.305268 This article also outlines how structural violence and stigma have paralyzed the OUD response: https://journalofethics.ama-assn.org/article/how-structural-violence-prohibition-and-stigma-have-paralyzed-north-american-responses-opioid/2020-08 ("The best interventions proposed and practiced in the medical community will always be limited within the confines of a system in which drugs are illegal and the people using them must turn to sources that are entirely unregulated and often toxic.") Address in greater detail the link between stigma, strict legal consequences, and systemic racism. (It is insufficient to write: "the challenge is in assuring that all levels of stigma are addressed." (see p.11)

	Mental Health and Trauma Mental health disorders should merit more attention. 7.7 million adults live with co-occurring mental health and substance use disorders (https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/comorbidity-substance-use-other-mental-disorders). Untreated mental health disorders can exacerbate OUD and vice versa. The following study about prescription opioid use among adults with mental health disorders states found that 16% of Americans who have mental health disorders receive over half of all opioids prescribed in the United States. https://www.jabfm.org/content/30/4/407 Studies have shown that mental health often coexists with individuals with non-medical use of prescription drugs are more likely to misuse another class of prescription drugs, illicit drugs and substance initiation before age 13. Tetrault, J. M., & Butner, J. L. (2015). Non-Medical Prescription Opioid Use and Prescription Opioid Use Disorder: A Review. *The Yale Journal of Bio Med*, 88(3), 227–233. *Training/education of health professionals* There are systemic shortcomings in addiction medicine training which are another obstacle for responding effectively to OUD. The following article states: "A recent survey found that only 1 in 4 healthcare providers in Massachusetts received addiction training as part of their medical education. Among surveyed internal medicine and emergency medicine providers, less than half believed that opioid use disorder is treatable at all. The lack of training combined with the stigma attached to addiction is a troublesome combination Action Steps providers seek to steer patients away from costly for-profit programs, which have shown to be little to no help, and toward evidence-based medical care." https://www.bmc.org/healthcity/policy-and-industry/until-addiction-medicine-training-made-universal-filling-gap Consider this: "Less than 20% of primary care physicians considered themselves “very prepared to identify alcohol or drug dependence.” This contrasts with more than 80% feeling very comfortable diagnosing hypertension and diabetes." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741399/ *Barriers to Care* Authors should consider each of the following topics related to barriers to care:

	a) elaborating on the difference or impact of access to MOUD /OAT for minorities in rural vs urban social environments. Also on topic of MOUD: Legal and policy changes urgently needed to increase access to opioid agonist therapy in the United States (2019). Int. J of Drug Policy. https://www.sciencedirect.com/science/article/abs/pii/S0955395919301847 b) discussing disparities in pharmacotherapy, especially between buprenorphine and methadone. (Methadone carries higher chance of overdose and requires daily treatment appointments for monitoring, compared to opposed to take-home pills or a long-lasting buprenorphine injection). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855417/ c) adding information concerning state laws that create barriers and reduce utilization policies by public and private payers which restrict access to MOUD. d) adding policies by insurance companies that limit series of treatments/in-patient stays if the individual is ready for recovery. e) discussing zoning restrictions for opioid treatment programs as an access barrier: https://www.healthaffairs.org/do/10.1377/hblog20190920.981503/full/ *Role of health care providers* Pharmacists (and technicians) have a role to play in addressing the problem. They are educated to screen for diversion, monitor for potentially problematic use of prescription opioids, and educate patients about opioid-related risks. https://accpjournals.onlinelibrary.wiley.com/doi/abs/10 .1002/jac5.1171 Education on SUDs should be part of these curriculums and this is not always the case. Continuing education is also needed, but many pharmacy, dental, athletic training, and nursing students graduate with no training or experience in this area. **References** Consider this additional reference: Hedegaard et al. (2020). Drug overdose deaths in the United States, 1999-2018. NCHS Data Brief, no. 365 Hyattsville, MD: National Center for Health Statistics Add evidence/ references for the following: Page 3, line 30-31 (70% of drug overdose deaths involving an opioid) Page 4, lines: 1-2, 7-8, 8-10, 12, 12-13, 14-15, 16-17, and 30-31 Page 5, lines: 13-14, 14-15, and 15-16

Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? g. Is/are the proposed strategy/strategies evidence-based? h. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. i. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	A large portion of the information in this Evidence-Based Strategies (EBS) Section is a continuation of the Problem Statement (PS). (P. 6, lines 19-29). Page 7, Lines 22-27 mentions general strategies, but this section would be greatly enhanced with specifics about the strategy. The EBS Section is meant for a discussion of specific programs and practices that are proven effective. In the description for each strategy, describe the target audience(s) for the proven intervention (or a population for which it might be appropriate.) This will help readers know any special considerations that need to be made for specific populations. Refine subheaders so each one addresses a specific strategy. "Pregnant and breastfeeding women" and "Interprofessional coalitions" are topics, not an EBS. On the other hand, "Safe Consumption Sites" and the explanation is an example of an EBS. Almost all other topics in this Section do not provide data to show the program or practice is an effective strategy. P. 6, beginning at line 30 (re: SBIRT). It is unclear what the strategy is. Is the "brief intervention" mentioned an example of a strategy that uses SBIRT? Page 6, lines: 11-12, and 12-13: (If this information remains in the document, provide a reference.) Page 7, lines: 3-4, and 31-32: (If this information remains in the document, provide a reference.) Page 7, lines 10-13: Provide the evidence to support the Am. College of OB/G recommendation (if this information remains in the document.) P. 7, lines 21-30. What EBS exist to improving access to MOUD that addressing regulatory, reimbursement, training, and/or infrastructure barriers? If Strategies do exist, then include them as an Action Step. P. 7, line 3-4 Provide evidence that needle service programs are effectiveness. In what localities/states are they available. (In the Opposing Arguments Section—authors can describe the laws that prohibit or create obstacles for these programs.) P. 8, lines 7-8 (on Stigma): provide data/describe the evidence that these strategies are effective. P. 8, Provide evidence that PDMPs are an effective strategy for reducing fatal and non-fatal overdoses and/or lead to treatment. P. 8, lines: 15-16, 16-17 and 31-32: (If this information remains in the document, provide a reference.)

	p. 18. Considering adding the issue of multistate variability in frequency and accuracy of PDMP data reporting in addressing opioid diversion. Finley, E.P., Garcia, A., Rosen, K. et al. Evaluating the impact of prescription drug monitoring program implementation: a scoping review. BMC Health Serv Res 17, 420 (2017). https://doi.org/10.1186/s12913-017-2354-5 Page 9, Provide specific examples of what should and shouldn't be done with PDMP data. Consider the following evidence that denying opioids is a reason for the relationship between PDMPs and heroin overdose: • Prescription drug monitoring programs operational characteristics and fatal heroin poisoning. (2019) *Int. J Drug Policy.* https://www.sciencedirect.com/science/article/abs/pii/S0955395919302749 • Perceived Unintended Consequences of Prescription Drug Monitoring Programs (2018). *Substance Use & Misuse*. https://www.tandfonline.com/doi/abs/10.1080/10826084.2018.1491052 • Must-access prescription drug monitoring programs and the opioid overdose epidemic: The unintended consequences. (2021) *J of Health Economics.* https://www.sciencedirect.com/science/article/abs/pii/S0167629620310547 P. 9, Line 1: explain "data collection in real-time." Provide evidence that it is an effective strategy. **<u>Considerations for Other Strategies</u>** (1) Implementing Compassion Fatigue training for lay worker employees (2) Conducting Naloxone Training https://www.tandfonline.com/doi/abs/10.1080/1533256X.2019.1640018 (3) What/How can strategies be applied in prisons and jails, and for reentry populations? (4) Increasing and marketing medication disposal sites at the community level. (5) Incorporating naloxone administration training into workplace training, especially for service providers who work in public settings.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**?	Most of the items in this section are obstacles or challenges to implementation, not opposing views. The purpose of this section is to describe briefly the opposing views for the EBS discussed in the previous section. Topics to consider are: What reasons are given for objecting to using some of these strategies? (e.g., time-consuming? cost-prohibitive? Not proven to be effective?) For

i. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. j. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address	example, p. 10, lines 1-3 (needle exchange). What reasons do opponents of needle exchange programs give for opposing this strategy? (Do they say "it encourages drug use?"; "It brings crime to the community?") Refute the argument with evidence. Think about each EBS included in the proposed policy and identify any key opposing views. Briefly describe the opposing view, and then refute/rebut it. There may not necessarily be an opposing view for every EBS. A possible opposing view about PDMP. There are reasonable and ethical concerns about the "chilling" effect that PDMP have had on providers' prescribing ability, leading to under treatment of pain and in turn, leading to illicit opioid seeking behavior and increase in mortality. P. 9, lines: 16-17 and 29-30 (If this information remains in the document, provide a reference.) p. 11, line 9 (Fentanyl test strips (FTS)) Needs a reference to support the "false sense of security" statement.) "FTS are actually quite reactive to many fentanyls, and harm reduction programs counsel participants that a negative result does not necessarily mean that fentanyl or another substance is not present in the drugs. " See: Selectivity and sensitivity of urine fentanyl test strips to detect fentanyl analogues in illicit drugs. Int J Drug Policy (2021). https://www.sciencedirect.com/science/article/pii/S0955395920304035

inequities, more expansive in reach etc.)? k. Are alternative viewpoints, ethical, equitable and reasonable? l. Were any opposing views missing?	
Action Steps Are the **ACTION STEPS**: i. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? j. Focused on policy/principle, and not on specific	The list of Action Steps (AS) is so long that topics included are not presented thoroughly in the PS or EBS Sections. All proposed AS must be described previously in the document. For example, the authors mention Medicaid expansion; culturally appropriate and trauma informed prevention programs; opioid prescription guidelines; OUD treatment quality standards; Good Samaritan laws; improvements to electronic health records, however, these are not mentioned in PS or EBS. [Recognizing the 10 page limit, the authors should include topics in the EBS and Action Steps (AS) that are the most important.] The targets for action (i.e., federal, state, tribal, local) are too general. Specific actors should be named based on their authority or expertise. For example: P. 12, Lines 10-11: "Ensuring prioritization and reimbursement for nonopioid chronic pain management to support adherence to opioid prescribing parameters;" [What agency would do this?]

legislation/regulation? k. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? l. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	P. 12, Line 8-9: "Providing opioid prescription guidelines including informed patient consent and responsible opioid use, and dose limitations;" [What agency would do this?] P. 12, Lines 29-31: "Continuing medical education requirements for all primary care providers including coursework related to chronic pain management and OUD for medical, dental, nursing, and other health professions students" [What agency would do this, or is it an accrediting body or professional association?] Depending on what AS are included in the next draft of the proposed policy, make sure that a specific actor(s) is affixed to every AS. Authors should consult with the Council of Affiliates to discuss state/local actions that may already be in place or potential action.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	References should not be auto-numbered. Correct formatting based on Author Guidelines.
Social justice and human rights metrics Does the proposal **primarily** focus on an	

issue of human rights and social justice? If no, proceed no further. If yes, see below: e. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? f. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? g. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? h. Is the proposal consistent with guidance (if any) from APHA	

constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	Included in appropriate sections above
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Strongly encouraged to collaborate with Pharmacy Section and Council of Affiliates.

B8: Structural Racism is a Public Health Crisis: Impact on the Black/African American Community

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3b- Insufficient scientific reasoning, requires major revision

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.*
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e.,	The Rationale section is very brief, and the core message of the Rationale section is actually summarized on page 5, lines 10-13. Please consider moving that statement: "The consequences of structural… actionable solutions" to the Rationale section.

why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? j. Are there important facts that are missing from the problem statement? If so, describe them. k. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? l. Identify any relevant ethical[xl], equitable[xli], political or economic[xlii] issues.	The strengths of this proposed policy are the breadth and depth of the discussion and consistent use of definitions and terms for racism across sectors. There are ethical/philosophical, political and economic issues identified that could be expanded upon. Authors are encouraged to add bioethical, economic, and other considerations as described. Consider adding discussion of the following to this section: Political: • Specific "Jim Crow" laws, • Additional description of segregation, the so-called "3/5 compromise", • Recency of the Civil Rights movement; Economics: • Redlining minority neighborhoods by banks for business and home loans; • Employment disparities which limit health and economic mobility in Black/AA communities, families, and individuals. p. 6 line 22 uses statistical jargon that is not universal. 'Net of potential confounders'. Is that equivalent to 'adjusted for potential confounders?' Same issue on p. 8 line 31. Add "and vaccination." to p.6, line 17 and cite recent and historic reasons. Reword: "Criminal Justice" to "criminal legal system" (not 'just' yet). Reword: "have borne the brunt of" to "are overrepresented and disadvantaged" page 7., line 33 and add: something like "due to structural racism in the criminal legal system where white privileged and income inequality create a system of injustice and a present-day extension of slavery." See APHA LB30-05 and 18-20185 for additional resources and information and include in list of existing APHA statements.

	P4, line 29 At this point, Latinx persons and Native American/Indigenous Persons have the highest COVID-death rates. It is true that Black/AA community has elevated (compared to Whites or compared to national averages) risks of transmission and death. Please revise this statement and provide appropriate reference. P6. Lines 9-10 Re: Tuskegee, while the denial of effective treatment was one racist practice, more fundamental was the belief in different biological races that enabled this research and its multiple racist practices at all. page 6 line 10 "Tuskegee Syphilis Study" should be amended to clarify the full name of the study as "The United States Public Health Service Study of Untreated Syphilis in the Negro Male at Tuskegee Institute" commonly referenced as "The Tuskegee Syphilis Study". Page 7 line 27: Reference #10 (an infographic) is a very insufficient source of evidence for this statement about environmental justices from economic and political practices. The source data used to inform the infographic would be preferable if it was pertinent. However, the source describes "school to prison" pipeline statistics through racially disproportionate enforcement outcomes but does not address the claim that it is attached to in the policy statement about environment, policy, or banking practices. The clause that is added after reference 10 is a more appropriate statement for the strategy section but is not described there. Strongly suggest cutting this statement of abolishing unfair economic and banking practices from the problem statement and add a thorough discussion of eliminating these extant practices in the Strategy section. Page 5 lines 10-13: Suggest moving this text about the purpose and scope of the policy to the Rationale section. This could include the previous sentence as well (lines 8-10). Reviewers encourage the authors to address the following issues in addition to those found in the Problem Statement: ▪ The recent work on Black bioethics as well as on whiteness/white supremacy in the field of bioethics should be noted. ▪ For the Economics (page 8, line17) section: please include information about structural racism within the U.S. tax code and its negative impact on African

	Americans/ Black communities. Dorothy Brown has done extensive research & advocacy on this. Her book "The Whiteness of Wealth: How the Tax System Impoverishes Black Americans—and How We Can Fix It" may also prove to be a great resource on this topic. ▪ The political context (without getting into specific legislation) of the current progress on systemic racism (which begins with describing the community's response to the traumatic images of police brutality) could be appended, by describing the current federal administration's 'equity in all policies' approach, via executive order to review all agency or department policies for inequitable impacts. ▪ Please consider providing more detailed evidence regarding the burden of racism on black women in particular. Black women hold the undue burden of racism because they are the center or often the leads and perhaps heads of households concerning the factors presented in this policy statement. Their burden does not end or begin with maternal health and birth inequities. Finally, please move the statement from page 5 lines 10-13: "The consequences of structural… actionable solutions" to the Rationale section where it is more appropriate.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? j. Is/are the proposed strategy/strategies evidence-based? k. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. l. What other strategies, if any, should be considered? Should	While suggesting more research be conducted is one important strategy, the section lacks description of policy strategies (although specific legislation should be omitted), programs and community efforts that are in sync with addressing structural racism and the array of topical categories that are discussed in the Problem Statement. The following ordered Action Steps are not discussed in the Strategy section and should be fully described and supported with scientific references in this section: bullet point #s 2, 4-11, 13, 15. Please encourage and support with evidence that substance use cessation services be used to replace criminal justice (e.g., incarceration) and that unequitable drug policies be amended and/or repealed. Also, a recent policy statement that was endorsed by several major organizations (including APHA) recommends tobacco control policies be decriminalized to ensure that tobacco control policies do not further add to systemic racism by the enforcement of commercial tobacco

additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	control. https://sph.cuny.edu/wp-content/uploads/2020/10/Tobacco-Control-Enforcement-for-Racial-Equity_FINAL_20201007.pdf Please add strategies that address other systemic (highest level) strategies to address the "systems" of structural racism (ex. Economics). These additional approaches can and should more fully support the many and wide-ranging Action Steps. Please include discussion of the sustainability of all strategies described, particularly organizational culture changes. Are there any policy incentives for the organization to sustain these strategies? The authors should also include best practices to provide adoption incentives for the organizations with new training requirements, in order to sustain these strategies. In addition, there is insufficient evidence to support the strategies in this section. For example: • The current strategies of public health education and professional training initiatives should be supported with references demonstrating/ providing evidence of successful efforts for such trainings and educational campaigns. • CBPR and better measures of racism are certainly key strategies for addressing structural racism. These strategies could be strengthened by tapping the extensive and recent CBPR literature as well as epi literature on measurement of racism. • Also missing is a discussion of developing standardized measures of trustworthiness. To increase trust in historically marginalized communities moving past a focus on measures of the causes of mistrust and also develop tools to measure trustworthiness of institutions conducting research and/or interventions among these populations. Community-based participatory research is a very helpful strategy but must incorporate other methods of inclusion and fostering trust as well. • The abstract states that "instituting anti-racism public health education campaigns to change attitudes with ongoing program evaluation… is crucial" but does not explicitly recommend that this extends to individuals of all ages. Amend to include mention of the need for anti-racist public health education to young people as part of primary and secondary education, as is mentioned in the

	action steps: "Supporting public awareness of racism by encouraging reexamination of history curricula for K–12 education." ▪ Reference 47 is a sizeable book and it is used to support multiple strategies described. Please reference the chapter, or better yet, page # for each of the citations in this section so that advocates and other users of the policy can identify and draw from the source. ▪ Ref 23 is appropriate for its use supporting implementation and evaluation of interventions. This point should be elaborated on to share the strategic recommendations from Bailey et al. ▪ The last sentence recommends training efforts to use anti-racism principles in multiple areas ("decision making, policy implementation, and interventions") but the citation is a study of evidence for disparities in birth outcomes by race. That paper's recommendations likely cite evidence of such efforts, but it is not clear, and this reference seems insufficient. Was this perhaps intended to be ref #23? • p.9 line 23: Critical race theory should be explained briefly. The proposed strategy is evidence based. In fact, the primary proposed strategy focuses on conducting community based participatory research and practice — in order to gather and document the "evidence" of persistent structural racism and how this inequity results in poor health.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? m. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.	We suggest the authors breaking these 2-3 opposing views apart to headline a paragraph each, each denoted as a new Argument. Then, the argument should be described and supported with references (not-necessarily peer-reviewed, but opinion or editorial references, since the authors point out that the root of many counterarguments are seeded by White supremacy). Then each of these arguments needs to be refuted thoroughly, with supporting evidence – adopting the problems as outlined in the Problem Statement. These may be distasteful, but it is worth noting that APHA advocates and government relations staff will meet several arguments, not mentioned in this section, in trying to enact the recommendations in this policy. Consider if there are any ethical arguments against ending structural racism. Perhaps revise first

n. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? o. Are alternative viewpoints, ethical, equitable and reasonable? p. Were any opposing views missing?	sentence to "There are no ethical arguments against ending structural racism, however there are those who contend…". Consider looking into: ▪ Opposition to abolitionist arguments? ▪ Opposition to reparation considerations? Missing opposing views, to consider for inclusion: • Costs of federally funding this field of research is too great • Costs of training all health and research professionals in anti-racism is too great • Some people believe diversity / inclusion training efforts are divisive. This should be referenced with opinion columns (such as, but not necessarily: https://www.forbes.com/sites/janicegassam/2020/09/05/trump-bans-diversity-training-claiming-its-divisive-anti-american-propaganda/?sh=35ee301f65ce) • There are many legal and constitutional barriers (e.g., state, not federal, oversight and regulation of healthcare regulations/reimbursements & education policy) in place that will make racism education or research infeasible • Legislation to research, monitor, and address systemic racism may be difficult to pass (even in 2021) – e.g., the bill mandating lynching as a federal hate crime was proposed in 2018 and still hasn't been voted on in the Senate. • Legislation and funding federal or state agencies to conduct public health research to look at racism may be politically difficult to implement as well • Overhauling and teaching African American/Black history might be difficult to implement due to centuries of overshadowing Black/AA accomplishments and / or because cultural competency and racial discussions are still difficult to have for people, limiting adoption at various levels. Counter argue the opposing arguments with facts by demonstrating that each argument lacks credibility. Refute each and every opposing view in the section. Specifically, the following statements lack sufficient refutation: • Ending structural racism and supporting racial equality. • At the end, the SES-race link is mentioned. Please include the references from- and connect this opposing view and its refutation- back to the earlier discussion, well-addressed on pp 8-9.

	We recommend using the quality references in the problem statement regarding maternal and infant mortality disparities (when adjusted for SES, education, income, etc.) to refute some of the relevant opposing views that systemic disparities are based on SES and not race (e.g., page 14, lines 23-34, refs #43, 44, 45, 46). Add citations to studies in maternal mortality and infant mortality that control for educational level, income and other SES indicators and still show statistically significant differences for Black women as compared to white women. These articles are cited in the problem statement and should also be referenced here to further refute the opposing views to the problem statement and strategies. Examples include page 14 lines 23-34 [43] [44] [45][46] Consider including the following to support evidence and refutation for denial of racism: Nelson, J. C., Adams, G., & Salter, P. S. (2013). The Marley hypothesis: Denial of racism reflects ignorance of history. Psychological science, 24(2), 213-218
Action Steps Are the **ACTION STEPS**: m. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? n. Focused on policy/principle, and not on specific legislation/regulation? o. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? p. Culturally responsive to the under-represented and underserved populations being	Many of the Action Steps do not map back to any supporting text in earlier sections. Because the evidence-based strategies section is not well developed, this mapping is not possible. We suggest using the Action Steps as a guide to further develop the text above this section and add a focus on Steps that can also help address the effects of structural racism on mental health and well-being. The following ordered Steps are not discussed at all, and should be fully described and supported with scientific references in the Evidence-Based Strategies section: #s 2, 4-11, 13, 15 #1 includes elements of a strategy to increase public health research in racism that is not described in the Strategy section. It would be better to set up the idea of a National Center for Anti-Racism there and then just reference it in the call to action here. Also, APHA asks that authors avoid referencing specific legislation (i.e., the Anti-Racism in Public Health Act) because this is a temporary construction and the policy should hold up for at least 20 years. Consider if the name of the Act changed in a year or two (sadly this must assume it doesn't pass) and how that would confuse users of the policy. First and critically, please describe the important, evidence-based points of the policy in the STRATEGY section, but don't mention legislation by name. Then you can call for such policy in the Action steps.

addressed, if appropriate? If not, describe why not.	Bullet point #3 looks very similar to #1, so we recommend either combining them or making the distinction clearer overall. Bullet point #15: In order to strengthen the action steps and tie them to the evidence provided, reviewers suggest the author please identify and mention the specific health and health research fields where the minorities are less frequently included. In addition: ■ It may help to structure the action steps by federal, state, regional/territorial, and local policies, and to include all agencies or other accountable parties for each step. This is primarily an issue in the second half of the list where steps do not even mention the agencies/ organizations called upon to take action. ■ Consider including possible mechanisms for effective implementation, monitoring, assessment, and assigning/documenting accountability of the successful implementation. ■ Address the need for active Anti-racism practices / collaboratives in communities and organizations. Recommend the authors should strongly consider for inclusion: • Increasing the allocation to HRSA Centers of Excellences (COE) for pipeline programs in the medical professions to Historically Black Colleges & Universities which has remain level since the original $12M allocation. Also increase the scope of the definition to include pipeline programs for public health professions under HRSA. • Specifically mention the need for the proposed legislation setting anti-racist policy (in action steps calling for legislative or administrative actions) to use the information from new assessment strategies to improve the action items' implementation and success. • Add step to the remove false and medical misinformation from medical texts, ex) Blacks being more susceptible to pain, etc. P. 11 line 9 has a typo, review and correct
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Reorder the references throughout the entire document. The first references are #s 27 & 29 and the issue continues throughout the proposed policy. Update citations if more recent data is available. The following citations are more than 10 years old (3,4,12,15,16,17,18,22,27,28,29,39,46,49)

	The other times when the strength of cited evidence falls short are cited in sections above.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: a. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? b. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? c. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	The proposal **primarily** focuses on an issue of human rights and social justice, but IHRL, UDHR and WHO CSDH are not discussed. Please address.
Member comments: What are the major comments by APHA units with expertise	Major member comments: **Problem Statement:** Evidence is thinner on the beliefs/ values/ ideological aspects of structural racism (White supremacy) that undergird racist

on the issue? Please summary recommendations from these Units/members in the 2nd column.	practices. Missing is serious attention to White supremacy as the ideology of structural racism (see for example second bullet below). P4, line 29 At this point, don't Latinx persons have the highest COVID-death rate? Missing topics: •You should incorporate how inequitable enforcement of substance use policies may further cause structural racism. •Black women hold undue burden of racism because they are at the center or often the leads/heads of households concerning the SES factors presented in this policy statement. Their burden does not end or begin with birth inequities. **Evidence-Based Strategies:** This section is not developed. While suggesting more research be conducted is one important strategy, the section lacks description of policies, programs and community efforts that are in sync with addressing structural racism and the array of topical categories that are discussed in the Problem Statement. What are incentives for the organizations to sustain these strategies? These strategies could be strengthened by tapping the extensive and recent CBPR literature as well as epi literature on measurement of racism. Also, are their other systemic strategies to address the "systems" of structural racism? …Few strategies are evidence-based at this point but could this section more fully support the many and wide-ranging Action Steps? Also missing is a discussion of developing standardized measures of trustworthiness. To increase trust in historically marginalized communities we must move past just focusing on measures to quantify and/or measure the levels of the causes of mistrust and also develop tools to measure trustworthiness of institutions that are to be deemed trusted to conduct research and/or interventions among these populations. Please also consider including accountability measures or teams in the legislation Congress would pass and in the new Anti-Racism committees for the CDC would be extremely helpful in addition to all the other recommendations/strategies. It would fit the criterion because the data/evaluation methods could be utilized from the federal, state, or local agencies to measure if

	the policies/strategies are still perpetrating racism or becoming anti-racist. Additionally, consider adding: - The abstract states that "instituting anti-racism public health education campaigns to change attitudes with ongoing program evaluation... is crucial" but does not explicitly recommend this extends to individuals of all ages. This section could also include mention of the need for anti-racist public health education to young people as part of primary and secondary education, as is mentioned in the action steps: "Supporting public awareness of racism by encouraging re-examination of history curricula for K–12 education." - Encourage substance use cessation services be used to replace criminal justice (e.g., incarceration) and that unequitable drug policies be amended and/or repealed. - Also, a recent policy statement that was endorsed by several major organizations (including APHA) recommends tobacco control policies be decriminalized to ensure that tobacco control policies do not further add to systemic racism by the enforcement of commercial tobacco control. https://sph.cuny.edu/wp-content/uploads/2020/10/Tobacco-Control-Enforcement-for-Racial-Equity_FINAL_20201007.pdf **Opposing Views:** The opposing views that are mentioned need more explanation and references. This section (with only one cite) is framed as if racism/white supremacy is the opposing view. Yet the problem statement is "Structural racism is a public health crisis," so I would expect the opposing view to be that structural racism is not a public health crisis." As noted above, I understand White supremacy to be the ideological roots of structural racism, and thus part of the problem, (and thus would be addressed in the problem statement) vs an opposing or alternate view of the problem. At the end, the SES-race link is mentioned. Consider citing back to this discussion, well-addressed on pp 8-9. Additional Evidence for Refutation: Use the references in the problem statement regarding maternal and infant mortality to refute the relevant opposing views (e.g., page 14, lines 23-34, refs #43, 44, 45, 46). Also: Nelson, J. C., Adams, G., & Salter, P. S. (2013). The Marley hypothesis: Denial of racism reflects ignorance of history. Psychological science, 24(2), 213-218

	Action Steps: Many action steps do not map back to any supporting text. Because the evidence-based strategies section is not well developed, this mapping is not possible. We suggest using the Action Steps as a guide to further develop the text and add a focus on Steps that can also help address the effects of structural racism on mental health and well-being. Missing: Suggest adding ethics analysis and education/reflection for example, p11, line 4, include research in ethics; p11, line 20, expand to "history and other curricula; p11, line 30–add here (or elsewhere) are cognition and development of ethics. The recent work on Black bioethics as well as on whiteness/white supremacy in bioethics should be noted–perhaps better in the problem statement and strategies sections.
a) Which (if any) APHA Units/members gave this proposal a negative review? Please summary recommendations from these Units/members in the 2nd column.	
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

B9: The Role of the Health Department in Activities Related to Abortion

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 2- Sufficient scientific reasoning

JPC Assessment: Conditional

Vote: 9 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	The title of the policy statement may be too vague, as it signals no clear cue to action for the promotion of health accessibility and equity. Consider adding an action verb into the title, such as "Improving the Role of Health Departments Related to Abortion."
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now). If the proposed policy statement	

updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? m. Are there important facts that are missing from the problem statement? If so, describe them. n. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? o. Identify any relevant ethical[xliii], equitable[xliv], political or economic[xlv] issues.	Provide more specifics about particular racial disparities – Black/Brown, Latinx Add issues related to the incarcerated who have no healthcare payer, no care requirements, and who may lack access beyond what is addressed here. Also consider adding and the use of funds for Title X grantees, more detail regarding "other preventive services," in addition to access to contraception, sexually transmitted infection treatment. Add a statement that explicitly ties abortion access to health equity, justice, or equality for marginalized populations. Two citations which speak to location and race-based trends for abortion accessibility, and how the lack of access perpetuates health disparities, are as follows: ▪ Sutton A, Lichter DT, Sassler S. Rural–Urban Disparities in Pregnancy Intentions, Births, and Abortions Among US Adolescent and Young Women, 1995–2017. American Journal of Public Health. 2019;109(12):1762-1769. doi:10.2105/AJPH.2019.305318) ▪ Dehlendorf C, Harris LH, Weitz TA. Disparities in Abortion Rates: A Public Health Approach. American Journal of Public Health. 2013;103(10):1772-1779. doi:10.2105/AJPH.2013.301339) You include research to support the claim that there are "no long-term negative physical or mental health effects of having an abortion" (p. 4) but consider adding on negative mental health effects of abortion. Though it is only a fraction, it would make the audience/reader more receptive to this policy statement if the opposing data were acknowledged. (See Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med. 2018;6:2050312118807624. Published 2018 Oct 29. doi:10.1177/2050312118807624)

	States with conservative political climates as indicated do often require public health officials to implement regulatory practices that restrict/oppose access to abortion. Providing specific details regarding what those practices might look like would strengthen this policy. For instance, public health workers often waste valuable time and financial resources following up on FOIA requests asking for the number of abortions paid for by Medicaid and answering questions regarding miscarriages vs terminations at various gestations. These are resources in underfunded, low infrastructure public health departments that could be better spent elsewhere. Acknowledge that workers in many state and local public health agencies have little autonomy these days, and although COVID19 showed the strength of public health workers, it also showed how they could be personally harmed, both financially (e.g., complete job loss, having to move) and physically (e.g., threats to themselves and family members) by following through with scientifically-backed policies. Narrow down to whether health departments are engaged in activities related to abortion or are they supporting activities that are not evidence-based.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? m. Is/are the proposed strategy/strategies evidence-based? n. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. o. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide	Add evidence on how the strategies have actually been implemented in health departments and the outcome. Include strategies to address disparities in minority populations. It is noted in the workforce development section that this is an area of needed professional development, and likewise the policy addresses some of the challenges facing public health leaders. Consider addressing the fact that many conservative states are also at-will employment states. Therefore, navigating this topic may cause fear regarding not only the funding as noted but also job security. How would workforce development support these workers in navigating such a complex scenario? Within the policy and funding please mention of monitoring impact of hospital merger. P11 states: "*basing policies and public health practices on the best scientific evidence regardless of political climate is a core public health value. Political constraints on how public health officials have been able to respond to the COVID-19 pandemic have made it clear how essential it is for public health officials to be able to clearly communicate and base decisions on scientific evidence regardless of politics."*

data or references that should be considered.	While the sentiment of this statement is appreciated, this is not a complete view of the reality of the situation, especially with the COVID-19 comparison. COVID-19 resulted in an exodus of public health civil servants due to political pressure, racism, or even death threats. Address the ability of health departments in heavily conservative states to do this kind of work without personal threats and potential job loss ("Workers in many state and local public health agencies have little autonomy these days, and although C19 showed the strength of public health workers, it also showed how they could be personally harmed both financially (e.g., complete job loss, having to move) and physically (e.g., threats to themselves and family members) by following through with scientifically-backed policies"). The strategies should elaborate on what actions are appropriate in states with heavily conservative lawmakers in power.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? q. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. r. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? s. Are alternative viewpoints, ethical,	Recommend adding & refuting the opposing argument of skepticism of government action (as seen for COVID vaccination). It also omits issues related to the incarcerated who have no healthcare payer and no care requirements and who may lack access beyond what is addressed here. Recommend adding privacy concerns related to skepticism of government as a provider. Add as a counter to the opposing view re: funding, this policy is that it may decrease wasted funds spent on practices that do not help public health departments meet their missions, such as excessive regulatory reporting. Consider referencing the influence of employment at will practices in states.

equitable and reasonable? t. Were any opposing views missing?	
Action Steps Are the **ACTION STEPS**: q. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? r. Focused on policy/principle, and not on specific legislation/regulation? s. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? t. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Recommend incorporating only action steps related to health departments; Eliminate #1. All action steps begin with "APHA calls on …., " Change #6 from "APHA recommends" to match other language. Add an action step that speaks more directly to the "external partners" or "partnerships between health and academic centers" (page 10) which were mentioned as evidence-based knowledge translation strategies, or a step that clearly defines what constitutes as "scientific-evidence". Consider strengthening calls to action by adding a specific call to the CDC to include as part of essential public health service in its model and to make sure incarcerated women are covered by public health agencies since correctional facilities have no national oversight. Consider whether the Action Step "APHA calls on federal, state, and local policymakers to base abortion-related policies on the best available scientific evidence, respect for self-determination and ensuring equitable access to health care" is feasible in the current legislative environment. Add an action step related to few schools of public health include training about abortion in their curriculum discussed in the problem statement. Additional evidence should be presented regarding exactly what health departments are currently doing regarding abortion care. This would facilitate a better understanding about whether the action steps are appropriate and implementable.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-	See Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med.

reviewed? Are there no more than 50 references?	2018;6:2050312118807624. Published 2018 Oct 29. doi:10.1177/2050312118807624) Consider two citations which speak to location and race-based trends for abortion accessibility, and how the lack of access perpetuates health disparities, are as follows: • Sutton A, Lichter DT, Sassler S. Rural–Urban Disparities in Pregnancy Intentions, Births, and Abortions Among US Adolescent and Young Women, 1995–2017. American Journal of Public Health. 2019;109(12):1762-1769. doi:10.2105/AJPH.2019.305318) • Dehlendorf C, Harris LH, Weitz TA. Disparities in Abortion Rates: A Public Health Approach. American Journal of Public Health. 2013;103(10):1772-1779. doi:10.2105/AJPH.2013.301339)
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: i. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? j. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? k. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]?	

l. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	Additional evidence should be presented regarding exactly what health departments are currently doing regarding abortion care. This would facilitate a better understanding about whether the action steps are appropriate and implementable. In the paragraph where the you mention Title X grantees and the use of funds, they mention access to contraception, sexually transmitted infections and “other preventive service”. Suggest elaborating on this and specifically mention what kind of services state depts or others should provide to make the paper more specific. That paragraph also concludes in talking about how state and local depts have engaged with abortion as part of title X activities. It would be nice to elaborate on how this has impacted the issue and the conclusion it draws. It seems to end a little abruptly. Review the earlier parts of the policy statement to make sure you've covered all view points and not just your own view--state the facts concisely and clearly, no need to lengthen every sentence. Make sure you have revised any gendered language that may block your audience from focusing on the important parts. Vary your language, so that repetitive openings (e.g., "Learning Communities" begins the first 3 sentences in paragraph 2 of page 9), and also to keep language flowing. Perhaps creating an acronym for "activities related to abortion" would help declutter some of the sentences. Many of the sources were from the same authors repeatedly, consider replacing with more varied resources to ensure avoidance of biases.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	This proposal is related to PPS B1 Ensuring Support for and Access to Self-Managed Abortion. While related, the policies have a significant difference in focus and combining them does not seem workable.

Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	An additional review provided in collaboration with the Health Administration Section could strengthen the proposal by illuminating issues in management/administration of local and state health departments that would impact the likelihood of success of the PPS and its action steps.

C1: Environmental Noise Pollution Control

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, require minimal revision

JPC Assessment: Conditional

Vote: 7 yea; 4 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.*
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	
Relationship to existing APHA policy statements Is there an existingAPHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	P. 3, line 17-26: Delete the mention of the "American Academy of Nursing on Policy" position statement on harmful effects of noise. It is mentioned elsewhere in the proposed policy statement.
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e.,	You offer this proposal to "update to replace" the 2013 policy statement "Noise Pollution Control" (#20135). This current APHA policy statement addresses both occupational and non-occupational noise and includes many of the same sources of noise (e.g., highways, construction activities, urban congestion, power generation) described in the proposed update. The authors' proposal to adopt a narrow definition of noise, however, will excludes the most at-risk population----workers. Many hazardous outdoor noise sources are generated at worksites---the places where the exposures are highest. Controlling noise exposure in work environments will, by extension, reduce exposures in neighboring environments (e.g., near homes,

why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	schools, parks, etc.) APHA can advocate more effectively on noise exposure impacts with a policy statement that includes non-occupational and occupational noise. Consult with and collaborate with the Occupational Health and Safety Section to revise the proposed policy.
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? p. Are there important facts that are missing from the problem statement? If so, describe them. q. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? r. Identify any relevant ethical[xlvi], equitable[xlvii], political or economic[xlviii] issues.	At p. 4. Line 31-32, as well as at p 5, lines 1-2, you use the same definition of noise. The reference they use, however, are different for each one. In addition, for that definition, consider using this WHO document for the reference (which will be easier for readers to access than the references the authors provide.) https://www.euro.who.int/__data/assets/pdf_file/0008/136466/e94888.pdf (at p. 99) To complement the definition, consider including information on the association between different noise levels and health effects (e.g., ~30-45 dBA sleep disruption). Perhaps selecting 2-3 of the strongest examples of evidence from this document WHO document: https://www.euro.who.int/__data/assets/pdf_file/0008/383921/noise-guidelines-eng.pdf Two areas of evidence could be strengthened. First, you have proposed a policy that excludes some sources of noise (occupational, health care activity, entertainment and sports, appliances, personal listening devices and children's toys.) For example, Page 5 lines 10-11…"The health of more than 100 million Americans is estimated to be at risk," and Page7 lines 1-2…."more than half of all Americans continue to be exposed to harmful levels of noise." Do those estimates include noise exposures that the authors propose excluding from the policy? [This may become a moot point if the authors revert back to more inclusion sources of noise in the PS.] The Problem Statement (PS) only briefly mentions disproportionate impact on low-income and minority populations. (See: P5 lines 30-31 and Page 7 Lines 1 and 2.) Consider adding more information about the structural factors as to why certain communities are impacted disproportionately by noise issues. Recommend including an additional international reference, such as: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7114011

	Consider including information on the economic impact of noise-related adverse health impacts. p. 6, lines 13-14: Does enforcement of the Noise Control Act and the Quiet Communities Act depend on having the Office of Noise Abatement and Control? Could responsibility be delegated by the Administrator to another office within EPA? (In other words, could Congress provide funding to EPA for noise control initiatives without have ONAC?) P 7Line 25: - Recommendation to delete the descriptor "high quality". Recommendation to identifying data gaps that could be addressed in Evidence-Based Strategy and Action Steps. The structural factors resulting in these disproportionate impacts are not adequately addressed and need to be better described in the problem statement. CHPPD commented that the socioeconomic disparities were not dealt with adequately and recommended a couple of references that are more focused on-air pollution but may be useful given their focus on disparities. Consider linking racism and institutional racism to noise pollution, such as described in these articles: https://discardstudies.com/2017/11/06/urban-noise-pollution-is-worst-in-poor-and-minority-neighborhoods-and-segregated-cities/ https://news.berkeley.edu/2017/07/25/noise-pollution-loudest-in-black-neighborhoods-segregated-cities/ https://www.pbs.org/newshour/nation/urban-noise-pollution-worst-poor-minority-neighborhoods-segregated-cities Proposal excludes a disproportionately affected population, specifically, workers. In many cases, workers have the most significant exposure to noise. Moreover, immigrants and people of color are over-represented in jobs with higher risk of injury, including jobs with excessive noise exposure (roofing; masonry; tree trimming; framing during residential home construction.) The prevalence of noise-induced hearing loss is greatest among workers (including on U.S. military bases.) By extension, the cardiovascular and other systemic adverse health effects are more prevalent—although under-recognized as being related to noise and/or diagnosed as work-related. Highly suggest revising to address the full scope of noise (as is the case in the 2013 policy statement).

	Additional evidence for the authors to consider with respect to occupational noise exposure: U. Bolm-Audorff, J. Hegewald, et al. Occupational Noise and Hypertension Risk: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health. 2020 Aug 28;17(17):6281. doi: 10.3390/ijerph17176281. E. Kerns, E.A., Masterson, et al. Cardiovascular conditions, hearing difficulty, and occupational noise exposure within US industries and occupations. Am J Ind Med. 2018 Jun;61(6):477-491. doi: 10.1002/ajim.22833. N.K., Sekhon, E.A. Masterson, et al. Prevalence of hearing loss among noise-exposed workers within the services sector, 2006-2015. Int J Audiol. 2020 Dec;59(12):948-961. doi: 10.1080/14992027.2020.1780485. H.P. Eriksson, M. Soderberg, et al. Cardiovascular mortality in a Swedish cohort of female industrial workers exposed to noise and shift work. Int Arch Occup Environ Health. 2021 Feb;94(2):285-293. doi: 10.1007/s00420-020-01574-x. J. Selander, L. Rylander, et al. Full-time exposure to occupational noise during pregnancy was associated with reduced birth weight in a nationwide cohort study of Swedish women Sci Total Environ. 2019 Feb 15;651(Pt 1):1137-1143. doi: 10.1016/j.scitotenv.2018.09.212. The role of local/county governments in noise control, such as with local ordinances; or policies at state level regarding state-funded road construction projects that include contract language related to noise abatement during the project are not addressed. These roles should be discussed and appropriate state/local level action added Clarify whether the Noise Control Act/Quiet Communities Act prohibit states or localities from adopting their own noise control standards.

Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? p. Is/are the proposed strategy/strategies evidence-based? q. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. **r.** What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	The Evidence-Based Strategies section (EBS) does not provide evidence to demonstrate the strategies are effective. (Very few references in this Section.) Inconsistency: You suggest in places your intent to focus on transportation related noise and frame the policy statement as related to fossil fuels. However, the Evidence-Based Strategies and Action Steps address other noise sources and non-transportation interventions. The strategies largely focus on starting with the federal government and take a regulatory approach. Little evidence is provided that this approach will make a difference. Reference is made to European standards, without evidence of policy effectiveness. The actions can be taken across the community to national spectrum, though no best practice or exemplars are noted. If you intend on developing the issue of disproportionate impact on low-income and/or communities of color, they should include EBS to address the problem. For example, are there policy issues regarding land use, zoning, etc., that affect minority communities (that need to be changed)? Page 8, line 28-30, is a recommendation not a Strategy. A strategy would be providing an example of an agency that has the expertise to in "evaluating research data and setting national noise production and exposure standards." Is this a task for the National Institute for Standards and Technology? Page 8, Line 28, "federal government must take lead in …adequately funding state and local noise control and enforcement efforts." What is the model for the federal government to do this? Does EPA fund state and local agencies for other environmental enforcement activities? P. 9, lines 2-7. Consider rephrase this (or reconsider whether it belongs.) It looks as the "National Prevention, Health Promotion, and Public Health Council" (which created/or involved with the U.S. National Prevention Strategy (USNPS)) has not had a meeting since 2016. Do the authors have evidence that the USNPS was effective with respect to addressing noise exposure? If not, provide evidence that the USNPS was effective for a comparable issue. p. 9, line 9-10: (Health Impact Assessments.) You mention HIA, but don't describe an EBS. Provide an example of an HIA being used in an effective way to address noise hazard(s). Did the

	result of the HIA trigger an intervention? Are there examples of federal, state, local highway projects that require/required noise hazards in a HIA? Other projects linked to the noise sources mentioned in the Problem Statement (PS)? p. 9, line 10-15. Is this topic linked with lines 9-10 on HIA? p. 9, lines 10-15: This reads like a recommendation, not an EBS. No evidence provided to demonstrate these are appropriate strategies. p. 9, line 11: Who would do the asking?? p. 9, line 10-15: regarding "developing metrics and methods in combination with digital technology" for comprehensive noise exposure assessments. Elaborate on what this digital technology is. Provide an example to demonstrate an evidence base for pursuing it. p. 9, line 16: "programs to reduce noise can drive economic growth". Provide evidence. p. 9, Line 17: "Renewable energy products tend to be quieter" is vague. Provide evidence linked to noise sources mentioned in the Problem Statement. p. 9, Line 22-24: "locating schools far from significant noise." Is there a best practice(s) for how this has been implemented in a school district? Provide examples/evidence about sound insulation around schools and quiet pavement around schools. What has been the impact? Link this to the Action Steps. p. 9, Line 25: "may also be implemented and should be recognized by the federal government as a noise reduction strategy" is not an EBS. With respect to the phrase "should be recognized," is linked to a reference of a Federal Register notice for a final rule adopted by DOT/Federal Highway Administration. The rule mandates noise controls for highway construction projects. This suggests that the federal government *already* recognizes these strategies. If the strategies are in place because of federal action, the authors need to explain why this action hasn't been effective or explain the gaps in implementation. P. 9 Line 26-30: Not an EBS. In addition, describe the laws/agencies that would mandate reductions in noise from air, rail, vehicle, and from machinery, HVAC, power tools, etc.

	P. 9 Line 29: "…analogous to the European programs for consumer goods"- Provide further explanation and reference. P. 9, lines 29-30---the "Buy Quiet" program is a project of the National Institute for Occupational Safety and Health. It is designed to set up voluntary partnerships with power tool equipment manufacturers (and employers) to encourage employers to purchase machinery and tools that have engineering controls to reduce noise. Because this is an outreach/cooperative program, it doesn't seem an appropriate example to fit with the proposed strategy for the federal government to "mandate reductions" in noise levels. [Note: In the 2013 policy statement there are additional strategies, such as programs to encourage manufacturers and employers to implement "quiet and affordable solutions and use noise reduction as an agent of competitive advantage in the marketplace." This is largely what NIOSH's "Buy Quiet" outreach program is about. Cite evidence that it has been effective.] P. 9, line 30: provide a reference for the assertion that these efforts will "increase market demand for quieter products." p. 10, line 1: "limit the intrusion of outdoor…." Do authors mean "outdoor noise"? Consider adding an EBS and AS to address noise from emergency vehicles (police, fire, ambulances) which are frequent and annoying in urban settings. Consider adding EBS and AS to address noise generated by wind turbines.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? u. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.	Opposing arguments are not well-developed. The text should refute the opposing arguments with data/evidence. Please rewrite this section after they revise the Evidence-Based Strategies. Statement refers to the 40-year gap in federal leadership (absence of the Office of Noise Abatement and Control.) Consider providing evidence elsewhere in the document that ONAC was effective. p. 10, Line 7: Do all local public health authorities "have the authority to address noise hazards"? Confirm that control of noise has been ceded to local government. City and counties have noise ordinances that are not necessarily the responsibility of public health agencies in those locations.

v. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? w. Are alternative viewpoints, ethical, equitable and reasonable? x. Were any opposing views missing?	p. 10, line14: FAA study only relates to airports. Consider adding more to refute the opposing position. p. 10, Line 18-19. "…involves likely the costs" is vague. Explain some of the cost issues. (E.g., cost of funding ONAC, cost to industries and/or businesses for XYZ. Cost to consumers?) Then rebut the opposition, such as with language about externalities.
Action Steps Are the **ACTION STEPS**: u. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? v. Focused on policy/principle, and not on specific legislation/regulation? w. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? x. Culturally responsive to the under-represented	Ensure all Action Steps relate to topics addressed in the Evidence-Based Strategies (EBS). Most important strategies are to establish national leadership, implement health impact assessments, suggest specific ways to impact infrastructure and product development related to reducing noise pollution—potentially public/private partnerships also involvement of local and state jurisdictions. AS#1: mentions standards for "major sources of environmental noise." Recommend it say "transportation noise" as that is what the body of the document addresses. [E.g., Page 7, line 26 mentions "road traffic noise; Page 8, line 10 refers to a study of "aircraft noise"; Page 8, line 12 refers to "transportation noise"] AS #2: Clarify what is meant by "Congress to empower." Are you calling for Congress to give these agencies additional authority? AS #3: Funding a national outreach program for government and NGOs is not well thought out. Is this something different than funding for ONAC (AS #1). If not, who would lead this initiative? AS #4: What law(s) should be amended? Or what agency(ies) should be the target(s) of the actions proposed (i.e., accelerate

and underserved populations being addressed, if appropriate? If not, describe why not.	development and adoption for quiet, clean energy products; what programs need to be "extended beyond transportation…"? AS #5&6 are state/local initiatives, but the underlying theme in the PS and EBS is for federal responsibility. Consider other AS that state/local organizations and governments can take. AS #5&6: Confirm that NACCHO and ASTHO have the capacity to engage in the recommended activities. Do they have the expertise and resources to do the tasks the authors are proposing? AS#7: Assume responsibility from another agency that currently has this authority? The need for better data and role of CDC and NIH is assisting with state/local activities is not mentioned in the body of the document. AS #11-13 are not in the EBS. (Either add to EBS or delete as AS.) You mention briefly in the P.S. the disproportionate impact on minority/low-income/underserved communities. Add EBS or AS to address this disproportionate impact. AS# 11: The topic of HIAs is not well developed in the body of the document (e.g., in Evidence-based Strategies.) As written here, it is unclear if the HIAs are conducted by certain federal agencies to support decision-making (which ones?). Or is it that HIAs required by federal agencies of entities seeking a permit or other decision by the agency? For a contract with the federal government? In the body of the document, please provide specific examples of how the use of HIAs in this context have worked (or failed to work.) AS# 8: mentions the National Environmental Protection Act, but it is not referred to elsewhere in the document. Provide examples of how NEPA analyses were effective in compelling noise abatement controls or analyses that NEPA is an underutilized tool. AS#9: There is little to no discussion in the PS or EBS on the role of states/municipalities. The authors' proposal suggests the appropriate role is for the federal government. Upon revision of the document, if AS#9 remains, clarify what is meant by "…for future proposals"? AS #10: Consider whether the "National Prevention, Health Promotion, and Public Health Council" is active and/or being

	reconstituted in the current administration. (If so, is there a mechanism for topics to be added to its agenda?) AS# 11: Delete the names of the specific professional organizations. AS #13: "The government" to develop noise measurement tools…. (What agency? Is there a suggestion for another agency to have this responsibility (that is, if the Office of Noise Abatement and Control (ONAC) is not funded?) Are some of the Action Steps moot if the ONAC is not funded?
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Ref. 45 is not written properly. It is a Federal Register notice. Please revise.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: m. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? n. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? o. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]?	

p. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue? P	Include in the appropriate sections above
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Consult and coordinate with the Occupational Health and Safety Section, as well as others who can advise on feasibility issues.

C2: Ensuring Equity in Transportation and Land Use Decisions

Science Board Assessment: 2- Sufficient evidence; 2- Sufficient scientific reasoning

JPC Assessment: Conditional

Vote: 11 yea; 0 nay; 0 abstaining

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	The proposed policy is focused on metropolitan areas. Consider narrowing the title to emphasize metropolitan areas. Rather than rewriting to include rural areas, which will have different considerations and recommended actions, narrowing the focus of the title would be more straightforward. Consider "Ensuring Equity in Transportation and Land Use Decisions to promote health and wellbeing in metropolitan areas."
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	The proposed policy statement also replaces, "APHA Policy Statement 20044: Creating Policies on Land Use and Transportation Systems that Promote Public Health," which is even older (2004). Please add.
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the	

relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? s. Are there important facts that are missing from the problem statement? If so, describe them. t. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? u. Identify any relevant ethical[xlix], equitable[l], political or economic[li] issues.	Review spacing and formatting to comply with author guidelines. Add a statement about the SDOH or a socioecological model at the start to frame it and the discussion, would help to point out the link between these categories, like transportation and land use on health, which is clear in the first policy proposal and also make the categories clear. One model to consider: https://health.gov/healthypeople/objectives-and-data/social-determinants-health Mention in the first heading for the Problem Statement the impact on health of inequities in these 2 areas. Discussing equity and employing an equity lens, which is critical, but making it clear the need to adapt these 2 areas in a more equitable way to improve health and outcomes would be helpful. Add additional data about the costs and benefits of transportation and land use planning (e.g., saved morbidity and mortality, costs, community benefits) and inequities to help to show what successes may occur with improvements. There are only a few examples of the data about disparities between populations or costs and other impacts which helps to strengthen the cases. In many cases, this information might be included in the citations and resources mentioned so should not be difficult to find. While the impact on equity is mentioned, in many cases the example are of racism and specifically black or white differences. If possible, identify examples to share around Latino, AI/AN, APIA, LGBTQ+, immigrants, rural populations, and those with disabilities could help to make your arguments stronger. With the first sentence, qualify the list of things that are more easily accessed due to equitable transportation and land use planning with something, as this is not an exhaustive list (e.g. doesn't include housing as an example). Add a concluding transition statement to the problem statement before beginning with strategies to address all of the described problems in the following section.

	In the 3rd sentence of the 2nd paragraph, it seems a word is missing, between "should the racial." Maybe consider or evaluate? Last sentence of this 2nd paragraph - add citation. There are a number of pretty sweeping statements (majority of transportation is sought to serve downtown and people working 9-5, or "decades of white flight and redlining" or urban centers grown and displace disadvantaged inner-city residents.) While the statements might be true, it would help to have a source or to provide statistics or data about these points. Many of these things also fit to me under employment or something besides "health-promoting" resources. It would help to make it clear how the examples tie to health (for example, people don't go to doctor's visits or the ER when there are transportation issues...or can't make the window of time for appointments). "people with vulnerabilities - define the term. What types of vulnerabilities (disabilities, poverty...)? Explain terms "urban form," "Spatial mismatches" and "modal mismatches". Define VMT and GHQ the first time they are used. Problem statement identifies 5 key health outcomes including social cohesion and mental health. The outcome is not well-developed with strong evidence and should be expanded. Add citation about how disparities are traced to governmental decisions about inequitable access to environments and econ opportunities. Physical activity is a good example of a place where the arguments seem to really focus on urban and suburban populations. For this area, discussing issues in rural communities and for people with disabilities would be valuable. Need for things like joint use agreements, opening up spaces? Accessible streets/transportation for those who need it. Transportation? Citation needed for the 5 Ds. The environmental explanation was really detailed. Consider streamlining to allow for more space for other arguments or sections while still covering the key issues.

	No major focus really on people with disabilities. Discussion of accessibility in equity in all decisions might mean that, but it could be more explicit and perhaps point out data or health consequences.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? s. Is/are the proposed strategy/strategies evidence-based? t. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. u. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	These two resources are (1) strategies rated as 'Scientifically Supported' within the *County Health Rankings & Roadmaps* [41] and (2) strategies supported as 'Recommended' (due to **sufficient evidence**) through relevant *Community Guide* systematic reviews." Do you mean insufficient evidence? Strategies are from the County Health Rankings and Roadmaps and Community Guide. These are great resources, but there are many others, please expand. The CHR&R model often consolidates recommendations from other places and also uses Community Guide recommendations too. Address how each strategy is equitable or how related to the five key health outcomes identified in the problem statement. Consider incorporating CHWs who can help with collection of important feedback and suggestions from the community to ensure community needs are addressed in transportation and LU plans. Discussion of using equity in all decisions is good but consider discussing some of the other related (or preliminary tools that these can build on, e.g. Environmental Impact Assessments, then Health Impact Assessments and maybe now Health Equity Impact.) An example of where it has been used successfully could be helpful. To accompany the example of traffic and safely, Complete Streets is great, but it might be helpful to add in Vision Zero too since it's pretty specifically based on ending traffic fatalities: Here's a network focusing on it: https://visionzeronetwork.org/category/families-for-safe-streets/ Citations needed from resources and statements like COVID-19 has shown that efforts must include … Suggest explicitly mentioning gentrification at this time and earlier in the policy.

	Consider discussing zoning or giving incentives for better development, access, types of transportation more. Provide examples of success. Are there states and communities doing it right? So far just ideas we "should" do certain things. Articulate that the transportation options should also apply environmentally friendly/carbon reduction/green energies. https://www.urban.org/sites/default/files/publication/102557/leveraging-the-built-environment-for-health-equity.pdf Add a couple evidence-based strategies/research from RWJF and SmartGrowth • https://www.rwjf.org/en/library/infographics/infographic--better-transportation-options---healthier-lives.html • https://smartgrowthamerica.org/wp-content/uploads/2019/12/The-State-of-Transportation-and-Health-Equity_FINAL-PUBLIC.pdf Add strategies for the community, local or state level work.
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? y. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. z. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? aa. Are alternative viewpoints, ethical, equitable and reasonable? bb. Were any opposing views missing?	Consider expanding your discussion of alternative strategies. If going to note white flight and redlining, please add a citation. Particularly since the point being made is being conjoined to emerging gentrification concerns - the transition is a bit awkward. (top of page 6 of PDF) Consider addressing these additional arguments: • Applying a framework like this will cost more money to systems, particularly among those that are already under-resourced. Further, it will reduce efficiency of implementing needed transportation reforms. • Competing priorities • Too expensive and complicated. • Not feasible for some things, like adding sidewalks in some places. • How to ensure safety? • Criticisms of community engagement processes, asserting that community members may be

	overburdened by too many engagement requests and that authentic engagement processes add time and other resource burdens. You mention that healthy communities can have unintended consequences, such as de facto segregation. The problem statement and action steps should try to address how equitable decision-making would work to prevent that from happening in future land use development. Address inequities with regards to transportation and land use are a result of individually controlled behaviors, responsibilities, and choices rather than stemming from system-level issues and influences.
Action Steps Are the **ACTION STEPS**: y. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? z. Focused on policy/principle, and not on specific legislation/regulation? aa. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? bb. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Ensure Actions Steps are specific and designate the actor. Consider moving Action Steps #3 to #1 beginning with federal agencies and then making each subsequent step more detailed in 1a. Is long and fairly dense. It also is a little repetitive (see participatory). Please make more of a specific action step. Consider discussing land use and zoning policies to a greater extent. Are there specific suggestions and steps which state, territorial, local, and tribal populations are interested in? Consider explicitly calling out that transportation and planning agencies should seek out people with disabilities, not just lump them in with others in Step 1B. The reason is that in the problem statement and summary it is listed that these individuals have been historically left out of the conversation and decision-making process.

References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	The references are peer-reviewed and connected to the text. However, some are from a while back if it's possible to update them. Include more literature from the past 1-3 years.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: q. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? r. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? s. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? t. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	

Member comments What are the major comments by APHA units with expertise on the issue?	Problem statement, strategies, and actions steps are well thought out. The problem statement could use a concluding transition statement before beginning with strategies to address all of the described problems in the following section. Add consideration for rural transportation Make action steps more actionable to local and state health departments Expand alternative strategies section. Social cohesion and mental health problem statement needs a more well-defined outcome. Strategies are evidence-based but proposal does not address how each strategy is they equitable of how they are related to the five key health outcomes identified in the problem statement – please revise statement to reflect this. Redraft the opposing arguments section to identify alternative points of view and address why these views are not valid. Action steps could be strengthened by adding who could perform the action steps and what policy change is expected from actions. Most references are 5 years or older – may want to consider incorporating more recent literature. Consider pursuing sponsorships from other sections, caucuses, and outside organizations to build more consensus . Articulate that the transportation options should also apply environmentally friendly/carbon reduction/green energies: https://www.urban.org/sites/default/files/publication/102557/leveraging-the-built-environment-for-health-equity.pdf

Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

D1: Advancing Public Health Interventions to Address the Harms of the Carceral System

Science Board Assessment: 3b- Insufficient evidence, requires a lot of additional evidence; 3b- Insufficient scientific reasoning, requires major revision

JPC Assessment: Negative

Vote: 10 yea; 1 nay; 0 abstaining

* Revision must include most recent evidence/context as of July 1, 2021

Criteria	**Write a summary statement and include recommendations to the author. *Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Revisit the title after the final round of edits
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	

Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	P3, line 31, insert "strategies to reduce the harms of the carceral systems at all levels."
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? a. Are there important facts that are missing from the problem statement? If so, describe them. b. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.?	The framing of the statements requires adjustment for tone to make them more balanced and functional. The statement does not do the best job of engaging the full extent of ethics, equity, political, and economic issues that the focal problem entails. One of the most important of these is that there isn't consideration of divides around the concept of restorative justice. It also does not fully grapple with ethical considerations around who should or shouldn't be released in relation to the severity of documented offenses. The political frames activated by discussions of incarceration are not accounted for as forces that also shape incarceration trends. Lastly, the statement does not address the economic and profit-based drivers of prison, jail, and detention patterns and trends that make deconstruction of carceral systems challenging. Such elements should receive some consideration to set up sufficient preparation for strategy development and a layout of concrete actions—including specific actors requiring particular forms of engagement to promote goal achievement. Add information on 1) availability/quality of rehabilitative services, 2) impact on recidivism and lives after incarceration, and 3) stability/cohesion in families and

c. Identify any relevant ethical[lii], equitable[liii], political or economic[liv] issues.	communities to which persons released from incarceration return. Include discussion of ending cash bail and electronic monitoring due to mention in strategies. P4, 25, cite the information that supports the significantly older prison population. Sources cited #4 & #5 should be replaced with more current sources. Eliminate arguments on climate change and immigrant detention. Focus on types of incarceration and failures for the individual and society. Consider explicitly defining carceral systems and institutions. Simplify language. P3, 39, consider editing to provide more focus. Provide comprehensive number of people in all carceral systems and breakdown by type. P6, 17, replace "substance abuse" with more comprehensive "mental health needs."
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? a. Is/are the proposed strategy/strategies evidence-based?	Consider another word for abolition as it does not add to the argument in support of the proposed statement. Provide evidence/support for all strategies: • Ex) strategy 1 could be strengthened by including any available evaluation content linking health improvements or changes in other key outcomes to the specifically noted kinds of interventions. It is noted that transformative justice approaches have yet to be subjective to formal evaluation, although some evidence of the potential effectiveness of

b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. c. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	restorative justice approaches is integrated. The latter could also be supplemented with additional treatment beyond those such as satisfaction, sense of fairness, and recidivism—which are important but may only make up a part of outcomes that would be key to describe given the policy's aspirations. One noted disconnect is that the strategies presented do not cover all aspects noted in the extensive problem statement section. While the proposal initiates a very critical push for doing away with systems that are dysfunctional, the four strategies presented have ethical, equity, and feasibility weaknesses that require attention for the proposal to achieve its potential. The strategies, even if understandable, may not be considered reasonable. More evidence regarding decarceration practices that do not involve electronic monitoring and more treatment of what such practices could include would strengthen the section. The proposal opposes use of monitoring strategies but does not offer viable implementations that do not involve electronic monitoring. In addition, what other measures could be proposed if risk assessments are abandoned? This question is posed because possible shifts away from the current carceral system are more likely to occur in stages or progressive shifts versus having full abolition occur. How could transitional decisions to reduce prison populations occur in a manner that balances the ethical, equity, and political realities present? In addition, if the various additional manifestations of the carceral system noted in the problem statement are to be tackled, it may be key to think through what strategies would be needed for those. For example, to address the manifestations in school settings address immigration and community context considerations (e.g., pieces speaking to the need for public health and trauma informed approach to problem resolution to shift away from the pattern of addressing problems using criminal justice measures).
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? a. Does it adequately	The proposal includes an extensive list of opposing arguments but does not sufficiently refute the opposing arguments and does not sufficiently consider alternative viewpoints or concerns. • Ex) The policy does not address concerns of persons who experienced victimization. Doing this would be key because some justice involved persons may have perpetrated serious offenses. The impacts of

refute the opposing/alternative viewpoints presented using evidence? If not, please explain. b. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? c. Are alternative viewpoints, ethical, equitable and reasonable? d. Were any opposing views missing?	the proposed strategies and later to follow actions on those who have experienced victimization require thoughtful contemplation. The proposal does not acknowledge that the severity of offenses present can vary greatly. This requires more nuanced implementation planning. Not just to ensure that releases of those whose offenses are most severe do not lead to additional harms. But to also properly account for levels and degrees of services that might be necessary to fully and relevantly help persons with different levels of need. Not all the provided responses to the noted opposing arguments actually directly address the noted arguments. • Ex) the response to the opposing argument that incarceration increases public safety states that "…one study found increased incarceration rates accounted for only 6-12 percent of subsequent reduction in property crime in the 1990s and accounted for less than 1 percent of the decline in property crime this century." However, a property crime entails situations where a victim's property is stolen or destroyed, without the use of threat of force against the victim. Property crimes include burglary and theft as well as vandalism and arson. How do these specific crimes relate to the author's notion of safety? This isn't clear in part because the notion of safety itself isn't really defined operationally. The statement addresses the public focus on "violent charges" and its tie to the perception that incarceration increases public safety. However, the response does not speak to whether incarceration of persons who commit violent crimes affects "safety". Instead it challenges the scope of what is considered violent. While there is indeed a threshold for categorization of behavior as violence that is far too wide in many states, the focus on the valence of the definition shifts attention away from the true opposing argument that incarceration increases public safety. Much of the rebuttal addresses circumstances following the occurrence of offenses. Provide sufficient support for how using a more SDOH focused approach actually increases safety.

	Consider including a discussion about the potential for restorative justice to increase safety, especially in domestic violence. Consider adding as an opposing argument the lack of resources and funding for community based mental health services. Consider adding as an opposing argument is that status quo is sufficient. Clarify argument #5 refutation. Consider whether a public health approach especially in light of the current pandemics (COVID-19 and racial injustice) may be more feasible than suggested despite the limited focus on preventative measures. Compress and tighten all arguments, remove tangents, reduce, summarize, and cite examples. Consider additional source, https://www.courtinnovation.org/programs/red-hook-community-justice-center, to demonstrate why accountability is better realized at the community level.
Action Steps Are the **ACTION STEPS**: a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? b. Focused on policy/principle, and not on specific legislation/regulation? c. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? d. Culturally responsive to the under-represented	The action steps are only partially supported by the evidence in the proposal and have challenges related to ethics, equity, and feasibility. The section contains content not addressed in the evidence section. It does not consider aspects such as requirements for emergency funds access noted as a key piece to support objective fulfillment. Examples of additional actions not addressed in the evidence section include: (1) Re-allocate funding from the construction of new jails, detention centers, and prisons to the societal determinants of health, including affordable, quality, and accessible housing, healthcare, employment, education, and transportation; (2) Immediately expunge and pardon all criminal records across the country; and (3) Restore voting rights for all formerly or currently incarcerated people to ensure their basic democratic right to participate in elections. The challenge is that a universal frame characterizes the action section. Specific statements related to the diversity of the many populations covered and differences in the social drivers' marginalization are lacking. Emphasize early childhood intervention, especially in marginalized communities.

and underserved populations being addressed, if appropriate? If not, describe why not.	Consider mentioning the ALICE initiative of the United Way, (Asset-limited, Income-constrained, Employed). Provide evidence for Action Step #4. Consider linking Actions Steps #1 and #2. Provide a clear rationale for Action Step #4.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	The references require substantial revisions. References must be reduced to meet criteria outlined in Author Guidelines (50 max). Suggests for references are included in sections above.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: a. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? b. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? c. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/s	

ocial_determinants/the commission/en/]? d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	Problem Statement: The recommendation could be expanded to include prevention and treatment for substance use disorders. (These are given appropriate mention in the action steps.) Consider review of some of the work of the Policy Research Associates (https://www.prainc.com/); while their Sequential Intercept work has not extended to abolition, it does consider community-based diversion & intervention approaches. The very small number of people who, despite being immersed in the beneficent social environments proposed (to which people will necessarily also have variable exposure), will nonetheless exhibit behavior that is dangerous for society. You could strengthen the persuasiveness of the argument for general abolition by considered what might be necessary to ensure public safety in the presence of this small group. Consider providing more detail on the prevalence of mental health disorders for individuals in prison and jails, as well as a comparison between the cost of the carceral system versus treatment in the community. [Al-Rousan et al. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. BMC Public Health, 17(1), 342–342.] Consider providing a comparison between the cost of the carceral system for individuals with substance use disorders related offenses versus the cost of community/outpatient substance use disorder treatment. [1)Zajac et al. (2019). Estimated costs to the Pennsylvania criminal justice system resulting from the opioid crisis. The American Journal of Managed Care, 25(13 Suppl), S250–S255; 2) Zarkin et al. (2015). Lifetime benefits and costs of diverting substance-abusing offenders from state prison. Crime & Delinquency, 61(6), 829–850.]

	Add the following ethical, political and economic issues (1) the need to continue with some modified detention system pending a successful rollout of the prevention strategies; (2) the cost of maintaining two systems pending the success of the prevention strategies; (3) the ethics behind the choice of who stays in detention facilities versus who is released; and (4) the level or percentage of crimes committed by individuals either released from detention facilities, or who never were placed in one as a preventive strategy, that is acceptable to the community. In strategies you discuss ending cash-bail, electronic monitoring, etc. Discuss the problems with these in the problem statement. Page 5 line 13 calls out CPS as an interconnected system of state racial social control. While this is cited, it is not explained. Many people would think CPS is helping children. When discussing impacts of parental incarceration on children, suggest mentioning it as a form of Adverse Childhood Experiences (ACEs) which have a series of poor psychological and health outcomes. Also outlining long-term impact of all these harms: cyclic nature of incarceration and generational curses within families to emphasize why these matters . Recidivism rates should be included. There is evidence that recidivism rates are high, meaning that carceral system does not fulfill its basic function, which is improving public safety. p.7 Line 2: … consider "and sent today to for-profit treatment centers that lack evidence and serve as assessable alternatives to incarceration for people who can afford to pay" (I.e., white privilege); lines 22-26 – while sentiment is appreciated; specific harms are unclear. Strategies: Reviewers recommend providing comprehensive number of people in all carceral systems and breakdown by type. Use known data (see PPI) and remove weaker "estimates suggesting." p. 8 consider addressing the high rates of incarceration in prison after parole with no new charges (technical parole violations are 40% of admission charges in NYS prisons). Some concerns: • Is 'abolition' an appropriate keyword? There are many other issues here to support and this reads like a hot-

	button issue. Whereas the summary softens the use of the term by saying 'moving toward abolition' and explains the concept in the paper, as a keyword, it is not nuanced. Decarceration achieves a similar goal without the potential misunderstanding. • At a minimum, the term abolition needs to be carefully defined in operational, policy terms. • The term 'houselessness' is referenced by a paper with 'homelessness' in the title. Simplification rather than new jargon might be useful. • p. 7 line 4. A paragraph that might be removed as 'houselessness' was already presented--whereas immigration and detention follows and is critical to the problem statement. This is indicative of the editing down needed to focus the section. • The section is supportive, and the perspective is reflected in the scope. It is the scale and the unfocused nature of the section that is more concerning. Robust list could be compressed / reduced to address page length with less descriptions of the analyses and a more focused description of the types of strategies and what aspect of the problem they address. It might be useful to limit each of these 4 EBS sub-sections to a concise statement on the strategy—more vivid, easier to absorb. The long intro to this section might not be needed at all. The 4 strategies are excellent: 1. Community investment; 2. Transformative justice; 3. Decarceration; 4. Community-based mental healthcare. #4 mentions poor counseling access/availability but is silent on high psychotropic medication use among incarcerated persons that may be merely for social control and not therapeutic. Overall, the Strategies are reasonable but the basis for several is still not substantiated by research. For instance, you call for investing in transformative justice, but concede that "further research is needed to evaluate programs explicitly identified as transformative justice." It is premature to propose an investment/commitment to a system that it is not yet proven. You also call for the decriminalization of substance use and sex work. Outright decriminalization will not be effective for the community being impacted. All decriminalization does is make wealthy entrepreneurs wealthier by opening new markets for them – look at the cannabis industry. The preventive strategy from a public health perspective should be to get the individual out of sex work or to cease the use of illegal substances.

	Further research is needed to gauge society's responses to the thought of not having a handle on the current location of an individual found to have recently committed a violent crime against another person (i.e., rape of a women). The law requires, and society does not seem to be against, the registration/notice requirements for a convicted sex offender in a community. If sex offenders are required to register, where is the equity when a recently convicted "armed robber" can travel throughout his/her community without supervision at an electronic level. Clarify the statement -- it is not clear enough: "In fact, state governments that have pursued public health priorities, such as policies and public investments designed to bolster the social safety net (e.g., SNAP programs, Medicaid, primary and secondary education, unemployment insurance)…." What I think is meant is "to bolster existing social safety-net programs, such as SNAP, Medicaid, and unemployment insurance, as well as bolster primary and secondary education." Community-based mental health care is, of course, preferable, but beginning care in the institution is not a bad idea even if reducing the number of incarcerated people is an overall aim. Changing public policy to allow Medicaid dollars to be used for care of the incarcerated or detained would bring in federal dollars to help existing partnerships between community mental health care providers and law enforcement, courts, and corrections. The topic should at least be mentioned here. Also promote CIT, Crisis Intervention Training or Crisis Intervention Team. A concurrent strategy to reform the governmental public housing system could make it easier for individuals and families to receive safe, affordable housing, making generational positive changes. Educational efforts perhaps directed at children in schools to eliminate redlining, improve graduation rate and decrease incarcerations in high-risk communities, and yes, supporting the youth especially those with incarcerated parents can prevent continuation of cycle. Increasing access to stable, well-paying employment; increasing access to affordable education; intervening through labor laws so that employers cannot discriminate against applicants who have criminal records; urging cities and states to remove criminal record information after a certain amount of years rather than

	forcing people to have the burden of going through a pardon to erase their records; restorative justice practices on college campuses and in work places and community spaces; mental health first responders Page 10, line 14 - should be "fewer people," not "less people" Opposing or alternative Views: Under opposing argument 2, you state need for accountability, but do not provide methods. Rather you continue to state which punishment doesn't work. Consider describing home decarceration, which requires community investment in MH and Substance use treatment (see Oklahoma City, OK). Provide examples of successful neighborhood courts (See Red Hook https://www.courtinnovation.org/programs/red-hook-community-justice-center) to demonstrates why accountability is better realized on a community level. Consider addressing the large numbers held awaiting a hearing in facilities and economic consequences – can't work, pay rent, support family, no access to public health insurance – (address like parents in military? Interim measures? Need National standards). Also note how bail reform/recent decarceration efforts due to COVID19 have shown no substantial increase in crime or safety (Chesa Boudin etal) Even PA DOC Superintendent recently said re Decarceration, "If not now, when?" People serving sentences for murder convictions are least likely to commit new crime. Maybe tie-in to Norway example? p.15, line 5 add: "and access to healthcare across all systems." p.12 line 12 consider adding (i.e. early childhood education). Under Alternatives consider adding Single Payer Payment to reduce inequities and provide access to MH SU for all. Consider including prevention strategies, i.e., social workers instead of police, probation and parole. Most of the stated opposing views are what we have heard and expect from people holding onto the belief that prisons "help" change the incarcerated for the better. A number of these views are easily refuted by the authors. Although referenced in Opposing Argument #1, the opposition view not addressed is that "incarceration is truly necessary for

	the forcible felony committing criminal (i.e., murderers, armed robbers, rapists, serial forcible felony offenders, etc.)." This opposing view must be addressed by the authors. Your response to Opposing Argument #6 that the requirement for electronic monitoring is punitive is based on an individual's inability to obtain employment/housing/services because of the employer's, lessor's, or service provider's reluctance to deal with an individual wearing an ankle monitor or being monitored by other electronic means. This can be remedied easily by making such reluctance a discriminatory employment or housing practice subjecting the employer, lessor, or service provider to fines and civil liability. Consider for Opposing Argument 1, showing that restorative justice can increase safety even in very unsafe situations, such as domestic violence. Action Steps: The overall policy and its collection of action steps is a truly visionary call for massive social and cultural change. The action steps are carefully focused on the end result, but they do not include what could be crucial intermediate action steps to improve the feasibility of those proposed for governments and agencies. Policy can get only just so far ahead of the polity. For much of the population, the seeming propriety and necessity of punishment are firmly grounded in religious beliefs, implicit and explicit moral commitments, individualistic ideology, and, for many – whether acknowledged or unacknowledged – racist convictions. This is in addition to the strenuous resistance to be expected from powerful private-sector interests that reap enormous profit from operating prisons and spend some of it to ensure favorable policy, or from localities where prisons have existential relevance to their economic survival. To realize the monumental shift that this policy proposes, policymakers will need the kind of help that might follow from significant efforts directed at winning hearts and minds over to alternative ground. There is an action step focusing on effectiveness of alternative community programs; there could also be action steps for R&D focusing on education, attitude change and other change processes, etc. Steps should address for profit contracts at federal / state and local workforce. Consider adding steps that place emphasis on early childhood, especially in marginalized communities, family formation, family preservation, and support for families. The ALICE initiative of

	United Ways seems to have informative data and ideas for directions to take. (ALICE = Asset-Limited, Income-Constrained, Employed) . Step #4, however, which may strike many readers as the most radical, is not well addressed in the Problem Statement nor in the Strategies, so its rationale is unclear. Provide evidence. Multiple action steps are provided for action at the federal state, tribal, territorial and municipal governments and agencies. The action steps are all reasonable and I support all of them and the policy could be used to support the action steps to work towards addressing the carceral systems and institutions. Additional action steps aren't needed. Many of the action steps build on each other or could be done in conjunction with one another, but they're all going to take time and resources. Action Steps #1 and #2 must be linked. It is important that prisoners not be released into the streets without any supports or housing. Not all are feasible to happen in the proposed timeline considering that defunding has hardly been accepted by a vast majority of society. It is important to add some intermediary steps that do not compromise the action steps listed. Some of the action steps were not mentioned as much throughout the policy so maybe incorporating some of those ideas so that it is not a surprise (#4). General This is a broad policy recommendation with action steps that are aspirational. A more targeted approach with reasonable action steps should be put forth. The policy statement does not have a mitigation plan for foreseeable harms. Suggest seeking more updated citations such as 4, 5, 109.
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that	

they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	The Medical Care section provided extensive constructive critique and review. Engagement of this section could be recommended. Consider Dr. Anne Spaulding, MD at Emory University as a possible reviewer- aspauld@emory.edu. She could provide insights into the feasibility of the proposed actions and the merit of the opposing arguments

D2: Preparing the US Public School System for the Next Public Health Emergency: Lessons Learned from COVID-19

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, requires minor revision

JPC Assessment: Conditional

Vote: 10 yea; 1 nay; 0 abstaining

* Revision must include most recent evidence/context as of July 1, 2021

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Consider revising to D2: Preparing US Public School Systems for Pandemics and Public Health Crises: Lessons Learned from COVID-19 to better fit evidence presented
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	Add "APHA Policy Statement 201415 Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health."
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the	

author adequately describes the relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? d. Are there important facts that are missing from the problem statement? If so, describe them. e. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? f. Identify any relevant ethical[lv], equitable[lvi], political or economic[lvii] issues.	Check for more current data on evidence of spending across our nation's schools. Discuss the risk that children/youth who live in abusive home environments that are now subject to potential abuse for 7 days a week, 24 hours a day with remote learning. Check for recent studies on the negative impact of remote learning. Remove politics (democrat vs republican). Address the possibility that remote learning or the stress of the current learning environment may lead to resorting to tobacco use, alcohol use/overuse or drug use/overuse. Discuss other types of public health emergencies or disasters that public health and education agencies must work to prepare for. Line 7, pg. 2: define 'disadvantaged communities' Lines 32-33, pg. 6. Add citation to: "Although federal funding was made available to assist schools during the pandemic, this was not sufficient to cover all the additional demands for resources in educational environments." Remove statement on page 4, which is misleading, "most schools were also unprepared for a health emergency, as no state requires its schools to have a school nurse or to have infection prevention and control plans" (Phone and email communications, National Association of School Nurses, July 2020). On page 5 lines 21-30 remove statement, "without national surveillance of K-12 students and staff, policy makers are unable to make fully informed decisions regarding risk of in-person learning versus remote learning models." The AAP statement was clarified (and all statements are reviewed and updated at least

	every 30 days to take into account the changing information about COVID-19. Since there are not a one size fits all approach to opening schools and the community spread was always a factor and so the AAP added language to make this clearer and to be supportive of state and local public health guidance. Remove statement on page 8 lines 10-11 as it is not accurate in NC, “local public health agencies did not receive additional support in COVID-related appropriations to help schools with pandemic plans.” Please revise. Address needs of the workforce, both support and instructional. Page 2, Line 11, you wrote: *"A healthy and prepared environment is essential to ensuring success for all learning and working in our K-12 schools."* Address the risk for potential community spread. Page 2, Line 32 – Page 3, Lines 1-2: *"The care of children attending childcare or early education programs is organizationally and physically different than schools."* Address childcare and early education programs take place in school buildings. Page 3, Lines 7-17. Revise for clarity: “there is considerable overlap between K-12 and Institutes of Higher Education (IHEs), the differences are sufficient for a separate set of policies for the two levels of the public education system and that this statement only addresses K-12.” Page 3, Lines 10-12. *"College students are considered adults; as such, they are responsible for activities of daily living in ways that are fundamentally different than children in K-12 settings."* Consider removing. College students may be adults, but we know that cognitive develop is not complete until close to 25 years of age – so most students in 2 – 4-year colleges are still cognitively developed young adults. As important, APHA engages in public health and as such we seek to promote public health planning and prevention measures and not rely on individual behaviors---when we struggled to impose social distancing, mask wearing, and engineering and administrative measures to prevent transmission and exposure, and testing, contact tracing, and additional surveillance measures, as well as a vaccination program. Throughout, please replace the word "teacher" with the word "educator." There is a range of occupational categories in educational facilities – teachers, aids, housekeeping/janitorial,

	maintenance, security, administrative, nurses, food services, social workers, bus drivers. Those who are not teachers are educational support personnel and integrated into the overall effort to educate children. Page 4, Line 22: *"…as no state requires its schools to have a school nurse or to have infection prevention and control plans."* Massachusetts requires each school district to have one or more physicians/nurses for the schools https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXII/Chapter71/section53 Massachusetts is likely not the only state with such a requirement. Obviously, a standard of 'at least one' per district is woefully inadequate, but it is a requirement for a medical professional to be part of the school system. (9) Page 5, Line 16: *"This readiness…"* Change to "The degree of educator readiness…" Page 5, Line 31 to Page 6, Line 3: This paragraph minimizes the infection rates and disease prevalence among worker populations aged 20-49 years. That is the age range for a high proportion of workers in school buildings. This paper says the mid-2020 surge was mostly due to adults 20-49 years and 65% of infection was in this population. https://science.sciencemag.org/content/early/2021/02/01/science.abe8372 The primary reasons for remote teaching during the COVID 19 pandemic are to protect the many adults who work in a school building and prevent community spread (add to P2, L 11). Page 6, Line 18: Change "Other organizations" to the National Education Association and the American Federation of Teachers. Or "Other organizations, including the National Education Association and the American Federation of Teachers"… Page 7, Line 2: Add effective and well-maintained ventilation systems. For better flow, we recommend reversing the placement of two paragraphs. On page 7, the paragraph from lines 15-23 and the paragraph from lines 24-33. Just change the order of them. Sometimes you use COVID-19 pandemic and sometimes they use SARS-CoV-2 pandemic. Please standardize. Address why private schools are not included. Seems like including them would be more comprehensive.

	Address the impact of new variants of the virus. In Lines 6 to 14 of page 7 which focuses on schools transitioning to online options, it is important to identify the impact of schools staying closed or reopening on children with disabilities. These children often require individualized education program, and as such experience greater impact from the pandemic if they opt for virtual training. Consider one of the non-pharmaceutical strategy i.e., physical and social distancing guideline of maintaining 6 feet distance, it is difficult to accommodate all students in class if all were to opt for in-person classes. P2, 6, clarify sentence and ensure that it is complete. P3, 12, IHE's also require guidelines for sporting events. P5, 13, review the 40% statistic about students lacking Internet access to ensure it's used in the appropriate context.
Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? d. Is/are the proposed strategy/strategies evidence-based? e. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. f. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide	The national surveillance system for schools that was mentioned in the problem statement should added as a strategy to help inform public health and school leaders in real time. Draw on more examples from public health preparedness evidence-based practices that can be applied to the education system. Address how the use of electronic education has been used to increase health awareness (e.g., Stanford's Tobacco Prevention Toolkit and Stanford's Cannabis Awareness and Prevention Toolkit) among students attending public schools. Consider encouraging substance use cessation services be used to replace ESDs for students who violate purchase, use, and possession laws both in a K-12 setting and in the broader society. More information, including citations, can be found at the following link that provides a fact sheet about PUP laws: • https://www.changelabsolutions.org/product/pup-smoke#:~:text=Do%20laws%20that%20prohibit%20youth,smoking%20rates%20and%20improve%20health%3F&text=Instead%20of%20holding%20Big%20Tobacco,may%20be%20addicted%20to%20tobacco.

data or references that should be considered.	https://sph.cuny.edu/wp-content/uploads/2020/10/Tobacco-Control-Enforcement-for-Racial-Equity_FINAL_20201007.pdf Consider adding increased teacher/staff and support especially those with families. Insufficient evidence is provided to support the strategies, draw on non-COVID examples to expand. Expand the strategies beyond the federal level, as most decision making around schools is at the state/local level. Consider adding the need to do research in racially and ethnically diverse populations. Page 8, Lines 23-24: In the list of agencies, mention specifically the National Institute for Occupational Safety and Health (which is part of CDC), include EPA, and include the Department of Commerce because they oversee telecommunications/WiFi infrastructure (they should be involved to ensure universal broadband access that is needed for emergency notification and communication and remote learning).
Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? e. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. f. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective,	If scientific evidence exists on outbreaks in public school settings, it would be good to include here. There remains a lot of open questions on the true risks to students and teachers both from an "in-person" perspective related to virus transmission and from a "remote-only" perspective in relation to the potential drawbacks mentioned in this section. These gaps in knowledge/research make it difficult to have a true opposing view and the ability to refute it. What is known is that more research is needed, as the authors state. Additional opposing view for consideration: • Against the significant resource allocation to implement the strategies. This could easily be refuted based on the investment that is needed in our students as they are the future. • Local control of school boards and school decisions in contrast to the suggested federal approach. Provide more clarity to the opposing views specifically on federal guidelines. Provide evidence for all opposing views discussed.

better equipped to address inequities, more expansive in reach etc.)? g. Are alternative viewpoints, ethical, equitable and reasonable? h. Were any opposing views missing?	Consider alternate strategies- One might be to just re-open schools without testing or precautions and assume herd immunity will prevail. Add vaccine hesitancy and requirements for COVID-19 vaccination as factors for return of students and staff to school.
Action Steps Are the **ACTION STEPS**: e. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)? f. Focused on policy/principle, and not on specific legislation/regulation? g. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? h. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	Consider structuring the action steps by federal, state, regional/territorial, and local policies, programs, and approaches. Consider the addition of implementing evidence-based training and communication strategies developed by public health preparedness to support readiness for a variety of future public health emergencies, not just those related to infectious disease. Add steps for state/local action. Discuss how funding should be allocated and with equity in mind. Consider feasibility of increasing federal funding to upgrade ventilation and structural changes in schools. Consider revising Step 9 to address the choice of states to use funding for surveillance and research. Address the mental health of students and teachers during virtual and remote learning. Page 11, Line 29: Change "outbreak" to "public health emergency." Page 12, Line 9: Clarify the action step to support the links to educational effectiveness of distance-learning with student and instructor health. Add an Action Step: The U.S. Occupational Safety and Health Administration (OSHA) must develop an emergency temporary standard/or mandated guidelines for education sector workers if

	there is no other standard for protecting these workers during a public health emergency.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	If retained, please site the primary source for reference 1: Cornman, S.Q., Zhou, L., Howell, M.R., and Young, J. (2017). Revenues and Expenditures for Public Elementary and Secondary Education: School Year 2014–15 (Fiscal Year 2015): First Look (NCES 2018-301). U.S. Department of Education. Washington, DC: National Center for Education Statistics. Retrieved [date] from http://nces.ed.gov/pubsearch.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: e. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue? f. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? g. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? h. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human	

rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	The problem statement should consider what other types of public health emergencies or disasters public health and education agencies must work to prepare for. Consider adding in proposed strategies: drawing in more examples from public health preparedness evidence-based practices that can be applied to the education system. Consider how these findings can be applied to other important health crises among this population, particularly ATOD use. There are a few grammar issues in the earlier section – check thoroughly. Clarify aims. Research issues related to K12 and pandemics. Overall, be succinct. Add discussion about vaccination of children and subsequent changes. Eliminate opinions
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	

D3: A Call to Investigate and Prevent Further Violations of Sexual and Reproductive Health and Rights in Immigration Detention Centers

Science Board Assessment: 3a- Insufficient evidence, requires minimal additional evidence; 3a- Insufficient scientific reasoning, requires minor revision

JPC Assessment: Conditional

Vote: 9 yea; 0 nay; 0 abstaining

* Revision must include most recent evidence/context as of July 1, 2021

Criteria	Write a summary statement and include recommendations to the author. ***Please note that these recommendations may be shared with the author verbatim.***
Title Does the **TITLE** accurately reflect the problem statement, recommendations, and/or action steps?	Consider updating the title to be actionable, e.g., Preventing Violations of Sexual and Reproductive Health Rights in Immigration Detention Centers. A call to investigate and prevent further violations can be further described in the problem statement and subsequent action steps.
Relationship to existing APHA policy statements Is there an existing APHA policy statement that covers this issue? What is the **RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?** (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	
Rationale for consideration Does the proposed policy statement address a **POLICY GAP or requested UPDATE** identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author adequately describes the	This section is missing. Add this section in your revised statement.

relevance and necessity of the proposed policy statement (i.e., why APHA should adopt a policy on this issue now).If the proposed policy statement updates an existing statement, is the rationale for the update well supported?	
Problem Statement Does the **PROBLEM STATEMENT** adequately describe the extent of the problem? g. Are there important facts that are missing from the problem statement? If so, describe them. h. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.? i. Identify any relevant ethical[lviii], equitable[lix], political or economic[lx] issues.	Add peer reviewed references to the problem statement. References are not consistently provided. See p2, lines 36-37; p3, lines 1-3; p3, lines 11-13; p4 line 1; p4, line 4; p4, line 23-26, p4, lines 34-37 as examples. Include specific and consistent language when referring to governmental agencies and individuals described in data reports, policies, etc. On p4, lines 4-8, the authors reference, “A 2016 ICE policy included a presumption of release for pregnant people...” The policy is titled, “ICE policy on Identification and Monitoring of Pregnant Detainees.” In reference 14, government data describes pregnant women and detainees. The problem statement reads long and primarily focuses on sexual and reproductive health-related rights. Focus the problem statement only on discussions of these rights for a more concise statement.

Evidence-based Strategies to Address the Problem Does the proposal describe what **STRATEGY/STRATEGIES** is/are being **PROPOSED TO ADDRESS** the problem? g. Is/are the proposed strategy/strategies evidence-based? h. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not. i. What other strategies, if any, should be considered? Should additional evidence for the proposed or other strategies be included? If so, please provide data or references that should be considered.	Very few strategies are included. The strategies that are included should be expanded. This paragraph should be moved to the problem statement: "Yet, ICE has failed to consistently enforce these standards across facilities and failed to penalize facilities that violate standards. Moreover, ICE regularly issues waivers that allow facilities to violate standards without consequence.[45] Numerous government inspections of ICE facilities have documented "egregious violations" of ICE's own performance standards, including inadequate medical care, moldy food and bathrooms, and lack of hygiene items.[46] Many of the largest ICE detention facilities are run by private contractors, and OIG reports have shown that ICE does not sufficiently enforce performance standards with these contractors.[45]" These proposed strategies need a source: "More broadly, a growing body of scholarship advocates for re envisioning the immigration system altogether so that detention is reduced or eliminated wherever possible. Potential strategies include reducing the number of detainees in custody by identifying low-flight-risk, vulnerable groups who are eligible for parole; keeping families together by offering parole to guardians with children; and establishing community-led partnerships that focus on alternatives to detention." What evidence is there to support their effectiveness? In the problem statement, you noted, "...several UN agencies, including UN Women, the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, and others, collaborated on an interagency statement recognizing that nonconsensual sterilization violates human rights to health, information, privacy, reproduction, and freedom from discrimination." Do those organizations have suggested strategies to address the issue? If so, add them to the evidence-based strategies section. Evidenced based strategies should tie to the problem statement. Address policies/practice standards currently describe ethical treatment of pregnant detainees as evidence-based strategies.

Opposing Arguments/Evidence Does the proposal include **OPPOSING OR ALTERNATIVE VIEW POINTS**? i. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain. j. Is the proposed approach justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)? k. Are alternative viewpoints, ethical, equitable and reasonable? l. Were any opposing views missing?	Relevant peer reviewed citations are missing. As an example, Lines 1-3 are missing citations. An opposing argument about the legality of detaining individuals are missing from the opposing arguments section. Additionally, the section focuses only on the US-Mexico border and should address detainees at all border locations.
Action Steps Are the **ACTION STEPS**: i. Externally-directed (i.e., directs an external entity, NOT	All Actions steps are not specific to direct specific actors on actions. For example: • Action step 1: Indicate who is supposed to take the action suggested in the first action step, "Calls for investigative and precautionary measures to be taken to prevent future violations of sexual and

APHA, to promote or implement a specific strategy)? j. Focused on policy/principle, and not on specific legislation/regulation? k. Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain? l. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.	reproductive health and rights in immigration detention centers." • Action step 4: "Calls on ICE and/or the local government agency that is responsible for procuring ICE detention operators to immediately update all intergovernmental service agreements" Identify which local government agency/actor. Action step 8: Specify examples or standards of appropriate community-based alternatives to detention.
References Are the **REFERENCES** connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Consider peer-reviewed sources as primary evidence whenever possible. Several of the reference cited are gray literature opinion pieces and unpublished reports.
Social justice and human rights metrics Does the proposal **primarily** focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: i. Does International Human Rights Law [http://www.asil.org/erg/?page=ihr] support this issue?	

j. Is the proposal consistent with the Universal Declaration of Human Rights [http://www.un.org/en/documents/udhr/]? k. Is the proposal consistent with the WHO Commission on Social Determinants of Health (CSDH) [http://www.who.int/social_determinants/thecommission/en/]? l. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the International Human rights Committee and the Ethics Section?	
Member comments What are the major comments by APHA units with expertise on the issue?	The policy statement (problem statement, evidence-based strategies, and action steps) needs more explicit discussion of the effects on mental health and well-being. Trauma is discussed, but it is not clear about the other effects on mental health. Another opposing view that was not included is that the purpose of immigrant detention is to punish those who entered into the U.S. illegally or are living in the U.S. legally as a deterrent for further illegal immigration. Such policy was explicitly implemented during the Trump administration. The argument can be refuted by providing an understanding of the purpose of detention for the government to conduct health, identity, and security checks. Under international law, a person should not be detained simply to determine his or her refugee claim because as you elaborate clearly, this may violate the sexual and reproductive health of detainees. The opposing views are currently insufficient and not supported by evidence from the other side. While it may be distasteful, it is important to provide strong, thought out opposing arguments to the proposed strategies.

	There is no supporting evidence (whether peer-reviewed or not) and whether we want to believe it or not, there are reports out there that back the opposing perspective. Cite conservative, pro-nationalist, anti-immigrant think tanks like the Heritage Foundation, American Enterprise Institute, etc. to support that these events are rare and that detention is the only method to "protect the border." The problem statement begins with information on the growth of private detention facilities and provides that this has led to numerous human rights concerns, without a clear indication as to whether this privatization caused the violations or is associated with an increase in reports of violations. The language should be changed or additional evidence provided to clearly establish this fact. The "reproductive justice" information is interesting, but it is not adequately or clearly tied to this particular problem in the statement. An additional sentence linking the concepts would be helpful. A summary of all of the alleged abuses in one sentence: (1) delayed abortion (2) inadequate consents (3) forced hysterotomies (4) inadequate or delayed medical treatment would assist the reader to comprehend the extent of the problem. Instead of stating there is no evidence that pregnant people are a flight risk, say there is evidence that they are not a flight risk because the author presents that evidence. Another opposing view is that the purpose of immigrant detention is to punish those who entered into the US illegally or are living in the US illegally as a deterrent for further illegal immigration. Such policy was explicitly implemented during the Trump administration. The argument can be refuted by providing an understanding of the purpose of detention for the government to conduct health, identity, and security checks. Under international law, a person should not be detained simply to determine his or her refugee claim because as the author elaborates clearly, this may violate the sexual and reproductive health of detainees. Action Steps: The additional steps that are needed for this strategy could be engagement on the part of the UN Commission on Human Rights to address this call to investigate and prevent further violations of sexual and reproductive human rights in immigration detention centers.

	Problem Statement: It could be made clearer that the policy statement is going to focus primarily on Latino immigrants (or expand it to focus on all immigrants), and more explicit discussion of the effects on mental health and well-being would strengthen the arguments. Trauma is discussed, but it is not clear about the other effects on mental health. Strategies: Discussing strategies that target the trauma, mental health and well-being of persons who have had their sexual and reproductive rights violated is recommended. Problem Statement: There is some question as to whether witnesses to these alleged incidents are being deported and therefore complicating attempts to investigate these abuses. It might be appropriate to include a line on that issue as well. [https://oversight.house.gov/news/press-releases/oversight-and-homeland-security-committees-demand-ice-cease-deportations-of].
Relationship to current proposals Does this proposal **RELATE TO OTHER CURRENT PROPOSALS**? Would you recommend that they be combined into one proposal?	
Additional review Does this proposal require **ADDITIONAL REVIEW** from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):	Consult with the Law Section and/or members with Immigration Law Expertise. Member(s) of the sexual and reproductive health (SRH) section with expertise in trauma informed cause would also strengthen the proposal.