

American Public Health Association Joint Policy  
Committee 2022 Spring Proposed Policy Statement  
Review

April 28-29, 2022 via Zoom

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## Attendees

### **Action Board Representatives**

Celeste Monforton, Chair  
Eleanor Fleming  
Shirley Orr  
Cindy Sousa

### **Science Board Representatives**

Danielle Campbell, Chair  
Apryl Brown  
Sarah Roberts  
Kevin Sykes

### **Education Board Representatives**

Elaine Archie Booker, Chair  
Anthony Santella  
Kusuma Schofield  
James Wohlleb

### **APHA Staff**

Courtney Taylor  
Donald Hoppert  
Susan Polan

Twelve (12) members of the Joint Policy Committee completed reviews of the proposed policy statements for 2022. Over the course of the meeting there were times when 1-2 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 11:40AM ET on April 28, 2022 by co-chair, Celeste Monforton. All members introduced themselves and APHA liaison, Courtney Taylor reviewed the house rules. The entirety of April 28th 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 was adjourned at 3:00 p.m. by co-chair Elaine Archie-Booker.

The meeting was called back to order on April 29, 2022 at 12:35 PM ET by co-chair, Elaine Archie-Booker. The majority of April 29th was spent 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 the author guidelines particularly with regards to setting a limit on the number of citations and length of the proposed policy statements accepted in the August revisions; updated guidance for authors resubmitting adopted late-breakers into the full proposed policy statement review the following year; plans to host webinars on how to use adopted policy statements and develop proposed policy statements; and recommendations to the Governing Council regarding early archiving of policy statements related to COVID-19 following the tabling of a motion on the topic at the October 2021 Governing Council session. The meeting was adjourned at 4:30PM ET by co-chair, Danielle Campbell.

**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
<a href="#">A1: Public Health as a Bridge to Peace in Israel, the West Bank and Gaza</a>	Negative (10 yes, 1 no, 0 abstentions)
<a href="#">A2: Justice in Global Access to COVID-19 Vaccination</a>	Conditional (11 yes, 0 no, 0 abstentions)
<a href="#">A3: A Call to Cancel International Debt for Global South Nations and Increase Public Financing of Health Systems</a>	Conditional (11 yes, 0 no, 0 abstentions)
<a href="#">A4: Support Decent Work for All as a Sustainable Health Strategy for Improving Population Health and Well-being</a>	Negative (8 yes, 2 no, 0 abstentions)
<a href="#">B1: The Overlooked Public Healthcare Crisis of Healthcare Waste: A Call for Oversight Protection and Tracking</a>	Conditional (10 yes, 0 no, 0 abstentions)
<a href="#">B2: Public Health Opportunities to Address the Health Effects of Gas Stoves</a>	Negative (10 yes, 0 no, 1 abstention)
<a href="#">B3: Ending the Practice of Conversion Therapy Among LGBTQ+ Populations</a>	Conditional (11 yes, 0 no, 0 abstentions)
<a href="#">B4: Ensuring Women's Inclusion in HIV-Related Clinical Research</a>	Negative (8 yes, 2 no, 1 abstention)
<a href="#">C1: A Strategy to Address Racism and Violence as Public Health Priorities: Community Health Workers Advancing Racial Equity and Violence Prevention</a>	Negative (11 yes, 0 no, 0 abstentions)
<a href="#">C2: Address Threats to Public Health Practice</a>	Conditional (11 yes, 0 no, 0 abstentions)
<a href="#">C3: A Public Health Approach to Gun Violence Prevention</a>	Negative (10 yes, 2 no, 0 abstentions)
<a href="#">C4: A Public Health Approach to Firearms Prevention Policy</a>	Negative (11 yes, 1 no, 0 abstentions)
<a href="#">C5: A More Equitable Approach to the Enforcement of Commercial Tobacco Control</a>	Negative (12 yes, 0 no, 0 abstentions)
<a href="#">C6: The Misuse of Preemptive Laws and the Impact on Public Health</a>	Negative (9 yes, 1 no, 0 abstentions)
<a href="#">C7: Advancing Health Equity Through Inclusive Democracy and Access to Early Voting</a>	Negative (9 yes, 0 no, 1 abstention)
<a href="#">D1: Defining Public Health Leadership to Achieve Health Equity: Merging Collective, Adaptive and Emergent Models</a>	Conditional (10 yes, 2 no, 0 abstentions)
<a href="#">D2: Ensuring Access to Affordable Medications</a>	Conditional (10 yes, 0 no, 2 abstentions)

<a href="#">D3: Falls Prevention in Adults Aged 65 and older</a>	Negative (12 yes, 0 no, 0 abstentions)
<a href="#">D4: Expanding Medicaid Coverage for Birthing People to One-Year Postpartum</a>	Conditional (7 yes, 5 no, 0 abstentions)

## A1: Public Health as a Bridge to Peace in Israel, the West Bank and Gaza

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations , and/or action steps?	<p>The title is confusing, and needs to be clarified, as it separates entities (the West Bank and Gaza are normally referred to as one entity – Palestine, or Occupied Palestinian Territory). Additionally, the title is reversed--- peace certainly improves public health but no scientific data or even history is presented that improved public health leads to peace. The title states that public health will lead to peace, but the text says peace will help public health and medical resources to be better used. This needs to be fixed.</p> <p>“Peace” needs to be defined as it is not just the absence of conflict. Please, in the title and elsewhere, clarify the ways that justice and peace relate, and include in the title and throughout an explanation about the facets of this particular issue that go beyond armed fighting and include other aspects of oppression and more invisible violence.</p> <p>Consider editing the title (and policy) to more broadly refer to</p>	

	<p>conflict in general or to highlight a particular public health strategy that has proven to be a pathway to peace in conflict settings.</p>	
<p><b>Relationship to existing APHA policy statements</b></p> <p>Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)</p>	<p>The reference to “many policy statements” is somewhat oblique and needs to be clarified, and your linking to existing policy statements is quite weak. There are many policy statements dealing with war and conflict that you have not identify. Of particular importance is 20095 The Role of Public Health Practitioners, Academics and Advocates in Relation to Armed Conflict and War, which has points very similar to the ones in this proposal, but better articulated and argued.</p> <p>The statement also does not update science of these existing statements and would need to be edited to do so: 20095 – Role of Public Health Practitioners, Academics, and Advocates in Relation to Armed Conflict and War  201910 – A Call to End Violent Attacks on Health Workers and Health Facilities in War and Armed Conflict Settings  20208 – about Yemen (determine if it is relevant)</p>	



<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>This proposed policy does not fit any gap and you do not adequately describe the relevance and necessity. Furthermore, the assertion of the timeliness of the resolution rests on assumptions of “relative quiet” that are not correct. (See below for comments from Sections on this). A better justification for why the U.S. should invest more in peacebuilding for this region is needed. How do current strategies fall short, and what additional policies need to be added?</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the</p>	<p>The problem statement does not adequately describe the extent of the problem, relies on dated and uneven assertions, and does not provide adequate justification for the role of public health as a broker of peace.</p>	

<p>extent of the problem?</p> <p>a. Are there important facts that are missing from the problem statement ? If so, describe them.</p> <p>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.?</p>	<p>a.1. Description of the problem lacks context. It does not provide a research-based historical account of the problem, leaving out discussions of the 50+ years of annexation, occupation, and settler-colonial project-making. In fact, <a href="#">in March 2022, the Special Rapporteur for human rights in the Palestinian territory</a> “concluded the political system of entrenched rule in the occupied Palestinian territory satisfied the prevailing evidentiary standard for the existence of apartheid. First, an institutionalized regime of systematic racial oppression and discrimination has been established. Second, this system of alien rule had been established with the intent to maintain the domination of one racial-national-ethnic group over another. And third, the imposition of this system of institutionalized discrimination with the intent of permanent domination had been built upon the regular practice of inhuman(e) acts.” You characterize the last year as a time of “relative peace,” disregarding the settler violence and home demolitions across the West Bank and East Jerusalem, imprisonment of Palestinians by Israel, and deaths of Palestinians who were unable to access healthcare. (Please consult latest numbers from the United Nations: <a href="https://www.ochaopt.org">https://www.ochaopt.org</a>)</p> <p>a.2. Turning particularly with regards to the effects of the situation on health infrastructure</p>	
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c. Identify any relevant ethical <sup>1</sup> , equitable <sup>2</sup> , political or economic <sup>3</sup> issues.	for Palestinians, more work needs to be done to emphasize Palestinian perspective.  To understand the state of the situation in Palestine, and the view of many Palestinian scholars, along with scholars who have worked extensively in the region, please read and use:  <i>The Gaza Strip: The Political Economy of De-development</i> , 3rd ed., by Sara Roy.	
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<sup>1</sup> **Public health ethics** can be subdivided into a field of study and a field of practice.

As a field of study, public health ethics seeks to understand and clarify principles and values which guide public health actions. Principles and values provide a framework for decision making and a means of justifying decisions. Because public health actions are often undertaken by governments and are directed at the population level, the principles and values which guide public health can differ from those which guide actions in biology and clinical medicine (bioethics and medical ethics) which are more patient or individual-centered.

As a field of practice, public health ethics is the application of relevant principles and values to public health decision making. In applying an ethics framework, public health ethics inquiry carries out three core functions, namely 1) identifying and clarifying the ethical dilemma posed, 2) analyzing it in terms of alternative courses of action and their consequences, and 3) resolving the dilemma by deciding which course of action best incorporates and balances the guiding principles and values.

CDC. Advancing excellence and integrity of CDC science. Public health ethics. Available at: <http://www.cdc.gov/od/science/integrity/phethics/>. Accessed March 18, 2014.

<sup>2</sup> **Health equity** is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

CDC. Chronic disease prevention and health promotion. Health equity. Available at: <http://www.cdc.gov/chronicdisease/healthequity/>. Accessed March 18, 2014.

<sup>3</sup> **Economics** is the study of decisions—the incentives that lead to them, and the consequences from them—as they relate to production, distribution, and consumption of goods and services when resources are limited and have alternative uses. CDC uses economics to identify, measure, value, and compare the costs and consequences of alternative prevention strategies.

CDC. State, tribal, local and territorial health public health professionals gateway. Public health economics and tools. Available at: <http://www.cdc.gov/stltpublichealth/pheconomics/>. Accessed March 18, 2014.

	<p>Washington, DC: Institute for Palestine Studies, 2016</p> <p>Becker, A., Al Ju'beh, K., &amp; Watt, G. (2009). Keys to health: justice, sovereignty, and self-determination. <i>The Lancet</i>, 373(9668), 985-987.</p> <p>Hammoudeh, W., Kienzler, H., Meagher, K., &amp; Giacaman, R. (2020). Social and political determinants of health in the occupied Palestine territory (oPt) during the COVID-19 pandemic: who is responsible?. <i>BMJ Global Health</i>, 5(9), e003683.</p> <p>And access the 2021 APHA special session, <a href="#">Sovereignty as a core determinant of health: The imperative for both social connection and independence</a></p> <p>b.1. The statement does not attend to the asymmetrical effects of the conflict on health; has a pretense of problem between equals, rather than uncovering through data the disparities in effects of the conflict. The statement does not adequately describe the health concerns that impact all of Palestine, including the ways these are related to the Israeli occupation. Relatedly, key perspectives are not centered in the action steps and that the action steps are a top-down approach to a conflict that is more nuanced than encouraging cooperation. For more information on this, please read and cite:</p>	
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	<p>Rosenthal, F. S. (2021). A comparison of health indicators and social determinants of health between Israel and the Occupied Palestinian Territories. <i>Global Public Health</i>, 16(3), 431-447.</p> <p>As well as the many databases from agencies like UN-OCHA.</p> <p>b.2. With regards to the claims to collaboration around COVID in particular, the statement leaves out the <a href="#">Israeli bombing of Gaza's only COVID testing facility in May 2021</a>, as well other critiques about the inequities inherent in the testing, treatment, and vaccination in the region from <a href="#">the BBC</a> and <a href="#">doctors in the region</a> and other pieces of evidence (see Devi, S. (2021). COVID-19 surge threatens health in the Gaza strip. <i>The Lancet</i>, 397(10286), 1698. Please address.</p> <p>c. The problem statement gives little attention to issues related to ethics, equity, or economics. Again, please read and cite: <i>The Gaza Strip: The Political Economy of De-development</i>, 3rd ed., by Sara Roy. Washington, DC: Institute for Palestine Studies, 2016. Edit to address ethical, equity and economic concerns</p> <p>From member comments (noted with quotations), the following concerns are apparent:</p> <p>Members found the proposed resolution to leave out the viewpoint and work of Palestinian</p>	
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	<p>health professionals, instead weaving a narrative about collaboration without telling the entire story about the nature of the conflict (CHPPD; PHEHP); poorly cited (IH Section; Reviewers' own research. See citations below); and contains factual errors (IH) – in particular, members noted that the characterization of this moment as “relative peace” is incorrect, as “meaningful peace negotiations have not restarted since the last major conflict in 2021.” (CHPPD)</p> <p>Regarding claims of collaboration in general, In <a href="#">2018, Human Rights Watch</a> noted that "Israeli authorities approved permits for medical appointments for only 54 percent of those who applied in 2017, the lowest rate since the World Health Organization (WHO) began collecting figures in 2008. WHO reported that 54 Palestinians, 46 of whom had cancer, died in 2017 following denial or delay of their permits." In May 2021, Israeli human rights organization <a href="#">B'Tselem noted that since the beginning of the pandemic</a> "Israel allowed almost no Palestinians out of Gaza for medical treatment." In the very WHO report the you cite in the piece, the WHO notes "According to a WHO review for Gaza patients, the percentage of permit applications by patients denied or delayed has increased from 10.2% in 2011 to 17.4% in 2014 (and</p>	
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	<p>19.5% for the first 2 months in 2015)." (IH Section)</p> <p>Regarding claims of collaboration around COVID vaccines in particular, the IH Section notes: "One of our members has written about this very issue (<a href="#">The Washington Post</a>). Israel consistently denied any legal or moral responsibility for providing Palestinians vaccines. In February 2021 <a href="#">Israel delayed a shipment of vaccines</a> from the West Bank to the Gaza Strip." (IH Section)</p> <p>Other sections note that it was written without much attention to the conditions in Palestine, rather focused on Israel. Furthermore, sections noted "you essentially claim that any breakdown of communications or activities around public health were almost entirely the fault of Palestinians or the Palestinian Authority." (PHEHP)</p> <p>Members note that to call the current situation "relative peace" is to ignore the ongoing <a href="#">demolitions</a> of Palestinian homes, a <a href="#">50% poverty rate</a> and nearly 70% food insecurity rate in the Gaza Strip due to the ongoing blockade, the <a href="#">hundreds of Palestinians held in administrative detention in Israeli jails</a> without charge or often even being informed about their apparent crime, and <a href="#">the rise in settler violence</a> perpetrated against Palestinians in the West Bank, among many other violations. (IH Section)</p>	
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	<p>Description of the problem “gives no context of the problem” and rests on “dated statistics” (Mental Health and IH Sections); in particular, it (1) ignores the role of international law and the provisions laid out by the Geneva Convention, which stipulates that the occupying power indeed has a responsibility for providing healthcare to the occupied. (IH section, reviewer’s own expertise and research); (2) ignores the context of direct assaults on Palestinian healthcare infrastructure, such as Israel’s bombing of Gaza’s only COVID testing site in May 2021.</p> <p>The problem statement does not adhere to principles of “social justice and equity [nor does it] provide a fair account of the underlying situations [or] provide a way forward that can lead to genuine health benefits for marginalized populations.” (IH Section) The lens of the alternative viewpoints seems more centered on dissuading anti-Israeli sentiment as opposed to understanding the perspectives of those who opposed collaboration; lacking perspective from populations that would be most impacted.</p> <p>There are clear political issues that are addressed in the policy statement. A weakness is that the statement does not appear to describe the conflict objectively. As written, the statement does not reflect the Palestinian viewpoint.</p>	
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	<p>Please take a step back from the actors that are involved in the conflict and focus on the humanitarian issues that are present in all areas in this conflict zone. That would remove the sense that this is a “politically” loaded proposed policy. Reference to other conflict situations where public health was a broker for peace would also help</p> <p>The description of the problem does not include the best available scientific evidence:</p> <ul style="list-style-type: none"> <li>• The evidence included in the problem statement is either outdated, not comprehensive, or there are statements made that are not supported by evidence. No evidence is presented that public health is the bridge to peace. This evidence should be demonstrated.</li> <li>• Remove or reconcile the statement says “times of peace allows gov’ts to expend resources on public health” with the current title noting public health leads to peace.</li> <li>• Add reference for line 89</li> <li>• Provide context for the paragraph starting on line 94 that simply lists data from Gaza/West Bank</li> <li>• Paragraph beginning line 102 says there was cooperation during COVID but complete information re: vaccine distribution is</li> </ul>	
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	<p>not included. Please include.</p> <ul style="list-style-type: none"> <li>● Paragraph beginning line 111 – explain the relevancy of this line to the statement</li> <li>● Paragraph beginning line 111 – revise this biased statement</li> <li>● Paragraph beginning line 140 – revise this biased statements and provide additional information to relate to health through peace, not vice-versa</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed strategy/st strategies evidence-based?</p> <p>b. Is/are the proposed strategy/st strategies, ethical, equitable and reasonable ? If not,</p>	<p>The statement includes a great deal of historical evidence to highlight past collaboration in the region. The only recent examples that are included pertain to COVID-19 and Avian flu. These don't seem to be strategies to address the problem, however. These all seem to be case-by-case collaborations that do not explain how sustained peace could be possible.</p> <p>The proposed strategies are not evidence-based. There does not seem to be the support necessary to truly see how sustained public health efforts lead to peace. You should provide scientific evidence to show that public health has led to peace in other conflicts.</p> <ul style="list-style-type: none"> <li>● paragraph beginning line 207 – relevance? Did it lead to peace?</li> <li>● Paragraph beginning line 220 –Ref 38 does not say what policy statement say it does</li> </ul>	

<p>describe why not.</p> <p>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 .</p>	<ul style="list-style-type: none"> <li>● Line 241 – unscientific language (“abundant”)</li> <li>● Line 250 – bias mentioning consanguinity when this is not relevant to the policy</li> <li>● Line 250 – selected data – 2005-2006 only</li> <li>● Line 258 - Ref 1 suggests that Israel/Palestine operate as one epidemiologic unit, not that they do/did</li> <li>● Line 264 – this is an example of lack of peace leading to disease but again, this is not what the title of policy denotes</li> <li>● Line 272, ref 44 –the statement in the policy proposal does not accurately reflect what ref 44 (gray literature) reports</li> <li>● Relevance of paragraph beginning line 284 unclear</li> </ul> <p>While it seems clear that there is a role for peace through health, the strategy as presented is either ill-conceived or deliberately misconstrues some of the basic principles of peace through health, including that one must understand the historical and political contexts of violence and peace, and that sovereignty and respect for human rights must be present for peace to really exist. There are concern that at best, the strategy as presented is “vague” (Council of Affiliates, CHPPD) and at worst, the statement either “misinterprets” (IH) or “misrepresents” (Medical Care) the</p>	
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	<p>principles behind peace through health.</p> <p>There is a lack of evidence presented in the strategies. Page 7: The proposed strategy does not seem justified: it is poorly articulated and not well-supported – for example, on line 201, you claim the “cooperative efforts” were responsible for improvements in maternal child health in the West Bank between 1968-1996, saying nothing of the considerable efforts among Palestinians to organize, train, and support their own healthcare workers. Indeed, at this time, many Palestinian health organizations formed across Palestine from locally formed and controlled popular health committees. These groups then, and still view healthcare in Palestine as emergent from their grassroots organizing and very much tied to political principles of independence and the development of Palestinian infrastructure on its own terms. For example, The Institute of Community and Public Health at Birzeit University, established in 1978, trains scholars and supports critical, engaged scholarship on health and social medicine as a part of a larger strategy to counter decades of repression. This organization should be named, along with its insistence on the idea that a solid health system can only put built alongside political freedom. They do not deny the role of cooperation, but also do</p>	
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	<p>not embrace it as the main ingredient for health in Palestine.</p> <p>Review and consider referencing:  Jean-Klein, I. (2003). Into Committees, out of the House?: Familiar Forms in the Organization of Palestinian Committee Activism during the First Intifada. <i>American Ethnologist</i>, 30(4), 556–577.  <a href="http://www.jstor.org/stable/3805249">http://www.jstor.org/stable/3805249</a></p> <p>Giacaman, R. (2018). Reframing public health in wartime: From the biomedical model to the “wounds inside”. <i>Journal of Palestine Studies</i>, 47(2), 9-27.</p> <p>Members point out that the strategy as presented is “hyperbolic / extending beyond the available evidence of what impact peace could have on Palestinian quality of care” (Medical Care) and that “There are a string of claim statements at the bottom of page 5, following ref 30, which do not have any citations in support. These are each strong statements of the effect that peace would have on the Palestinian healthcare system – including definitive grammar like “will be” and “would benefit” without any supporting evidence.” (Medical Care); there is a lack of specificity in the strategy presented (PHEHP); and that action steps are top-down and without nuance or evidence of key perspectives being considered.</p>	
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	<p>You leave out important elements of the “peace through health” framework, (International Health Section). Revisit as concerns were expressed by a member whose work was cited:</p> <p>Arya, N. (2004). Peace through Health I: development and use of a working model. <i>Medicine, Conflict and Survival</i>, 20(3), 242-257.</p> <p>Arya, N., &amp; Santa Barbara, J. (Eds.). (2008). <i>Peace through health: how health professionals can work for a less violent world</i>. Kumarian Press.</p> <p>From IH section: “The proposed resolution is based on a model of peace through health that has been largely discarded in the region. In recent years, efforts to improve health for Palestinians and the peace through health concept has focused on empowering communities and health programs and funding them so that they can meet people’s needs. By contrast, the model this policy proposes (with some variations) is essentially that Israeli health professionals offer support, training, etc to Palestinian health professionals. That approach has been largely rejected as paternalistic and not responsive to local needs.”</p> <p>Proposed strategies do not honor the asymmetrical nature of the relationships between Israel and Palestine, thereby circumventing larger issues of ethics and equity in addressing the important issue of</p>	
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	<p>public health in the region. More work needs to be done to emphasize the Palestinian perspective; More evidence is needed to support how mutually beneficial and meaningful a strategy hinged on collaboration would be. Proposed strategy lacks an equity framework, including perspectives from diverse populations involved – there are “concerns that key perspectives are not centered in the action steps, and the action steps are a top-down approach to a conflict that is more nuanced than encouraging cooperation.” It is unclear if the proposed action steps would fully address the problem” (CHPPD); “Strategy is for Palestinians and Israelis to cooperate on efforts to improve health. Evidence shows that this has been done extensively in the past and they want it to occur again. It seems like this depends on political and conflict situations and it is not clear how public health has a lead role in making this happen.” (PHEHP)</p> <p>The statement present a limited set of points and does not look at root causes.</p> <p>Consider strategies related to basic respect for safety, human rights, and sovereignty that are precursors for collaboration. Consult:</p> <p>Becker, A., Al Ju'beh, K., &amp; Watt, G. (2009). Keys to health: justice, sovereignty, and self-</p>	
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	<p>determination. <i>The Lancet</i>, 373(9668), 985-987; Hammoudeh, W., Kienzler, H., Meagher, K., &amp; Giacaman, R. (2020). Social and political determinants of health in the occupied Palestine territory (oPt) during the COVID-19 pandemic: who is responsible?. <i>BMJ Global Health</i>, 5(9), e003683; Asi, Y. M., Tanous, O., Wispelwey, B., &amp; AlKhaldi, M. (2021). Are there ‘two sides’ to attacks on healthcare? Evidence from Palestine. <i>European Journal of Public Health</i>, 31(5), 927-928; and Smith, R. J. (2015). Healthcare under siege: Geopolitics of medical service provision in the Gaza Strip. <i>Social Science &amp; Medicine</i>, 146, 332-340.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS?</b></p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p>	<p>Presentation of opposing viewpoint was inadequate. There are ethical, equitable and reasonable alternative view points; however, these were not described here. Please cite any original sources to develop their analysis, instead relying on critiques published by others.</p> <p>Members noted this proposed policy “misrepresented advocacy efforts are rooted in a desire to bring about peace” (Medical Care). Another section noted, “When refuting opposing/alternative views in this proposal, you need to cite evidence in to support statements. Lines 307-313 simply state that statements released by academic departments were inflammatory against Israel. This is</p>	



<p>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.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<p>not evidentiary support. This is a statement of opinion.” (PHEHP)</p> <p>The statement does not make a case for the effectiveness of this approach, nor does it adequately describe the nature of these collaborations in the past and what may have happened with them. Members note that this section is not grounded in evidence, but rather is reactive, drawing too much on negative publications and actions. Opposing views are very one-sided and not really clear oppositions to the strategies proposed. Likewise, others note “This section has problematic roots in several places, making pro-Israeli arguments or defending the country from accusations about its role in the decades of harm done to Palestinian health and public health systems.” (Medical Care). Please edit to provide additional evidence and address opposition to the strategies included in the statement.</p> <p>The opposing arguments presented are wholly insufficient. Please add opposing arguments from the large body of published works by Palestinian (and some Israeli and international) scholars about the need for sovereignty, a ceasing of the Israeli blockade of Gaza and an end to Israeli control of Palestinian movement (including the training of healthcare workers, who for instance, need permits from Israel to travel abroad for training). (see citations provided)</p>	
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	<p>BDS is a strategy being used in an effort to change behavior/policy. It is not an Opposing View and should not be presented as such.</p> <p>Paragraph beginning line 314 is not an opposing argument and does not explain why it was factually inaccurate. Please remove.</p> <p>Consider adding alternate strategies (notably, these center on supporting independence, rather than assigning more dependence as the answer) such as: “Improving the ability of the Palestinian healthcare system to independently through training, referrals and exchanges; Improve quality and advanced care by strengthening consulting between the Israeli and Palestinian systems and collaborative research; Increase resiliency and capability of the Palestinian healthcare system by collaboration with the more highly developed Israeli system and by sharing of clinical and epidemiological data.”</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <p>a. Externally-directed (i.e., directs an external</p>	<p>Action steps are not evidence based or feasible.</p> <p>The Nita M. Lowey Middle East Partnership for Health Act is not mentioned in the PS or EBS. What about the law needs to be strengthened. We note that the grant program authorized by the bill is underway, with proposals</p>	

<p>entity, NOT APHA, to promote or implement a specific strategy)?</p> <p>b. Focused on policy/principle, and not on specific legislation/regulation?</p> <p>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?</p> <p>d. Culturally responsive to the under-represented and underserved</p>	<p>not due until Sept 2022. The advisory committee mandated by the law has only had one meeting. What evidence is already available that the law needs to be improved?</p> <p>The proposed policy statement is based on a model of peace through health that has been largely discarded in the region, thus calling into question the efficacy of the action steps. It is understood public health collaborations can certainly help serve as a bridge to peace, the text of this statement does not build the case for these action steps. What is perhaps most concerning is that members who are experts (and indeed cited) in the statement have written comments asserting that their work is misconstrued, and that the citations and framework for this argument are archaic and not responsive to the now vast body of literature asserting the importance of freedom and self-determination as precursors for meaningful collaboration.</p> <p>This draft lacks a perspective from the populations that are most affected by the conflict, and an “equity-centered approach is lacking from the action steps, and more evidence is needed to support how mutually beneficial and meaningful a strategy hinged on collaboration would be.” The action steps as written may be viewed as paternalistic and do not</p>	
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<p>populations being addressed, if appropriate? If not, describe why not.</p>	<p>address the root cause of the problem.</p> <p>Action steps are heavily reliant on government and NGO actions, yet these organizations are not actively called out throughout the policy statement. Is this the public health collaboration the you believe would pave the way to peace? If so, that should be clear in the policy statement.</p> <p>Steps 1, 2, 4, 5, and 6 refer to health through peace but not vice versa.</p> <p>Step 4 is not ethical and equitable</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>References are not up to date. Many are not peer-reviewed.</p> <p>There is a lack of diverse representation within the references – specifically, although this proposed resolution claims to present an ethos and strategy of collaboration, there are very few references from the large body of work that exists among Palestinian health professionals and scholars. Please review the additional reference suggested in this assessment.</p>	
<p><b>Social justice and human rights metrics</b></p> <p>Does the proposal <b>primarily</b> focus on an issue of human rights and social justice? If no, proceed no</p>	<p>Please edit to adequately engage with the provisions laid out by international human rights law, the Universal Declaration of Human Rights, the WHO CSDH, or ethical and human rights guidance from APHA.</p> <p>This proposed policy statement does not engage with international</p>	

<p>further. If yes, see below:</p> <p>a. Does <a href="http://www.asil.org/erg/?page=ihr">Internatio nal Human Rights Law</a> [http://www.asil.org/erg/?page=ihr] support this issue?</p> <p>b. Is the proposal consistent with the <a href="http://www.un.org/en/documents/udhr/">Universal Declaratio n of Human Rights</a> [http://www.un.org/en/documents/udhr/]?</p> <p>c. Is the proposal consistent with the <a href="http://www.who.int/social_determinants/thecommission/en/">WHO Commissio n on Social Determina nts of Health</a> (CSDH) [http://www.who.int/social_determinants/thecommission/en/]?</p>	<p>human rights law – specifically, it ignores that there are provisions laid out by the Geneva Convention, which stipulate that the occupying power indeed has a responsibility for providing healthcare to the occupied.</p> <p>The 4th Geneva Convention, which outline the responsibilities of an Occupying Power, makes clear in Article 47 that "Protected persons who are in occupied territory shall not be deprived, in any case or in any manner whatsoever, of the benefits of the present Convention by any change introduced, as the result of the occupation of a territory, into the institutions or government of the said territory, nor by any agreement concluded between the authorities of the occupied territories and the Occupying Power, nor by any annexation by the latter of the whole or part of the occupied territory."</p> <p>Put simply, International Law already lays out one framework for supporting health in the region. With regards to the Universal Declaration of Human Rights, this proposal does not engage whatsoever with the question of ongoing problems with human rights violations in the region.</p> <p>On this point, please review read the latest report by Michelle Bachelet, United Nations High Commissioner for Human Rights on the implementation of Human Rights Council resolutions S-9/1</p>	
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<p>d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the <a href="#">International Human Rights Committee</a> and the <a href="#">Ethics Section</a>?</p>	<p>and S-12/1 on the occupied Palestinian territory, published and reported on in March 2022.</p> <p>Engage with health professionals and scholars with diverse viewpoints with regards to this issue. Many members and sections specifically commented on the ways that this proposed resolution lacked equity and consideration of populations that are most impacted by the ongoing repression and violence in the region.</p>	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>The International Health Section has a Palestine Health Justice Working Group and they should be consulted.</p>	

## A2: Justice in Global Access to COVID-19 Vaccination

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the title accurately reflect the evidence provided?	The title may not be sufficiently aligned with the evidence discussed in the proposal. For example, the title includes the word 'justice', but nowhere else in the proposal is justice discussed. Consider reevaluating what it means to contextualize justice related to a movement about vaccine equity.	
<b>Relationship to existing policy statements</b>  Is there an existing APHA policy statement that covers this issue? (Please identify related existing policy statement by number.) If yes, does this proposal update the science of the older policy statement?	<p>APHA Policy Statement 201512: Ensuring that Trade Agreements Promote Public Health</p> <p>APHA Policy Statement 200121: Threats to Global Health and Equity: The General Agreement on Trade in Service (GATS), and the Free Trade Area of the Americas (FTAA)</p> <p>APHA Policy Statement 20218: Call for Urgent Actions to Address Health Inequities in the U.S. Coronavirus Disease 2019 Pandemic and Response</p>	

	The content of the proposal appears to build upon and extend content from previous ancestral policy statements connecting them with current concerns	
Is there an archived APHA policy statement that covers this issue? (Please identify related archived policy statement by number). If yes, does this proposal update the archived policy statement?		
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>Summary overstates the benefits of preventing COVID-19 infection. New knowledge on BA.1 and BA.2 indicates that they are still highly effective, especially at reducing severe illness and hospitalization, but do not meet the &gt;90% effective at reducing infection. Although the development for highly effective medical products began in 2020, the timeline within the context of this policy really starts with distribution.</p> <p>It could be valuable to consider ways to make the proposed policy statement more evergreen, and more relevant to a wider set of disease concerns.</p> <p>As noted in the Guidelines for Authors, do not name particular administrations, that is delete the word "Biden" and "Trump." You could say "the U.S. Government."</p>	
<p><b>PROBLEM STATEMENT</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p>	The section could benefit from clarifications of content in a small number of places. Notes to support this appear below:	



<p>a. Are there important facts that are missing from the problem statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>i</sup>, equitable<sup>ii</sup>, political or economic<sup>iii</sup> issues.</p>	<p>Page 4, Lines 87-88: Suggest saying “In the short term, ongoing spread of COVID-19 in countries with low vaccination rates may lead to the development of additional variants.” The connection between vaccination levels and occurrence of new variants relative to other potentially influential conditions has not been conclusively established. This would also bring the sentence here into alignment with the sentences that follow in lines 88-93 which use “could language” which allows for a bit more flexibility with the causal/correlational connections that may be present. This is key as variants also may occur in places with higher vaccination levels/rates. In addition, this seems like it be consistent with the content on the same page in lines 96-105. That part acknowledges that variants such as the Omicron variant have been found in the U.S. and other countries, which, although not directly stated in the text, have higher vaccination rates. This would make it more likely that the content in the two sections would be seen as complementary versus potentially being read as partially contradictory.</p> <p>Page 3, Lines 109 -111: Suggest directly describing the impact of the COVID-19 pandemic on measles vaccinations in 37 low-income countries. Did it reduce measles vaccinations?</p> <p>Page 5: Lines 131- 133: “Though advanced economies suffer from both trade and economic costs of the pandemic, most of these costs stem from their trade linkages with unvaccinated countries which limit exports and imports.” Please consider clarifying whether this</p>	
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	<p>statement reflects data associated with reference 12. It may be connected to this reference but appears a few sentences before the occurrence of reference 12. This may cause some to inquire about supports or citations for the statement.</p> <p>Economic Impact on Low-Wage and Informal Workers Section (Page 5: Lines 129-151): The first sentence in this section argues that “Broad access to vaccination impacts education and economic outcomes, as well as supply chain development.” While this statement is true, the content that follows, unfortunately does not present strong direct support for the statement. The content describes the economic and labor related consequences of the pandemic and the ways social divisions vary experienced impacts. However, strengthening direct connections between vaccine access and economic or education impacts is important to have this section achieve its full potential. How does vaccine access affect education and economic outcomes? With the way the first sentence is configured, a second relevant question is as follows: How does broad access to vaccination impact supply chain development? (distinct from access to vaccination reflecting the status of supply chain development in a given country)</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p>	<p>The content on application of regulations in the General Agreement on Trades and Services could be strengthened by elaborating its potential utility in advancing the goal of patent relaxation or removal. It is not clear how application of the</p>	

<p>a. Is/are the proposed strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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</p>	<p>regulations mentioned would support the target objectives.</p> <p>Page 8 Lines 222-228: It is not clear how these statements support the larger goals and claims of the section. Specifically, how do they relate to the emphasis on waivers and technology transfer supporting arrangements?</p> <p>It is agreed that misinformation and vaccine reluctance require attention. This is the first mention of the influence of misinformation and reluctance occurs in the evidence section. This separates the influence of such factors from the larger context of need described in the problem statement. The characterization there is heavily focused on access issues and challenges. Presenting information on misinformation and reluctance in the evidence section might appear to minimize the importance of work here relative to work that will expand access. That might be the objective. However, it may be key to consider how to better integrate the area of need attached to this strategy area into the case made in the problem statement, as this could create a more comprehensive description of the multidimensional challenge that is the focus of the proposal.</p> <p>The final section “Implement Social and Economic Approaches to Prevention Learned from Historical Examples”, while important, could connect more concretely to the larger goal of the policy to expand access to vaccine. The section lightly touches on the complementary subject of increasing uptake in particular countries, in a manner similar to what is done in the section on vaccine misinformation and</p>	
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	<p>reluctance. But the approach presents the challenge in a way that may not effectively communicate its centrality or complexity within a multi-level, multi-component strategy for vaccine use as a tool for reducing COVID-19 burden. The proposed title of the policy solely emphasizes justice in access which may unintentionally leave the domains emphasized in this section to assume minor roles.</p> <p>These are global challenges, so require a national/international framework. To the extent members of Congress have leverage in these conversations, the call-to-action seems reasonable for states/locals to exert influence on local members of Congress.</p> <p>Please consider including mention of veterinary vaccines (e.g. rabies, Rift Valley fever) to reduce risk of zoonotic diseases (to tie back to the mention of viral spillover in problem statement in line 107). Please also consider how vaccines can reinforce (not simply replace) other risk reduction strategies to support prevention at source and containment of spread. In some cases, we can expect that vaccination will not be cost-effective, and even as seen for something like polio and rabies, last-mile vaccination is likely to be extremely difficult.</p> <p>Provided references to show outcomes related to similar initiatives for topics other than COVID-19. The empirical strength of the evidence within the context of COVID-19 is, as might be expected, constrained by the limited time within which motivated parties have had real opportunities to propose such</p>	
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	strategies, achieve their adoption at appropriate levels, and obtain the levels and kinds of evaluation data that can most effectively characterize effectiveness.	
<b>Opposing Arguments</b>  a. Does the proposal include a summary of opposing or alternative viewpoints?  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?	Consider alternative viewpoints  The opposing arguments are presented and refuted but some are lacking and/or need additional evidence.  The statistics presented in lines 310-316 seem cherry-picked. As of November 2021, Liberia had only ~10% uptake of the vaccine, and doses were expiring. There are many reasons for hesitancy unrelated to availability – strengthening health literacy and creating a whole-of-society imperative for vaccination is extremely important yet not typically invested in as part of vaccination campaigns.  Address the within-country policy challenges occurring in Global South nations? The burden of this problem rests in the Global North, but there are unique issues existing within lower- and middle-income nations as well. For instance, did some reject vaccines initially or not encourage them? Those situations are used as opposing arguments that negate efforts to address this problem. They should be mentioned either here or in the problem statement. The person-level acceptance levels in sub-Saharan Africa are addressed, but not the systems-level concerns.  Provide examples of LIC and MIC that have successfully addressed the access issues if available and note	

	<p>what can be learned from them (i.e., assets rather than deficits framing)?</p> <p>The viewpoint that LMICs do not have the capacity to produce vaccines themselves is only partially refuted. Some LMICs may have the capacity needed. But is it truly the case that all have such capacity? It may not be necessary to try to infer that all have such capacity. A better approach might be to directly acknowledge that LMICs with limited capacity could benefit from capacity building and capability enhancement strategies that could go hand in hand with the technology transfer strategy covered in the evidence section. This suggestion would connect well with the proposal's statement on page 9 in line 290-291 that "Continued support from the WHO would ensure that vaccine quality and safety are not compromised in the manufacturing and distribution process of vaccines." which some might interpret as implying a need for help with capacity or capability. The same could be said for content in lines 301 – 308 which actually accentuate the benefits of capability enhancement efforts that could rapidly expand expertise, medical education, and research capabilities.</p> <p>The following statement may not effectively support refutation of the viewpoint that LMICs lack vaccine production capacity. "Pharmaceutical companies seek to profit from the work of LMICs in vaccine production demonstrating that the decision to prevent LMICs from producing vaccines is not based on material capacity." What this sentence may do instead is make the case that access expansion is being halted for a different reason. This directs</p>	
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	<p>attention to a different challenge rather than completely neutralizing the argument about capacity deficits. The reality could be that both capacity limitations for some countries <u>and</u> profit motives are obstacles to global vaccine equity.</p> <p>References to the vaccine acceptance rate of countries such as sub-Saharan Africa are used to refute the position that populations in LMICs will not take available vaccine. While this may be the case for sub-Saharan Africa, can it be said that this is the case for all LMICs? This is a key question because the evidence section, as mentioned earlier, contains two sections directly focused on combating misinformation, reducing reluctance, and on the ground efforts to enhance individual level vaccine uptake. Statements in lines 310-316 might seem to conflict with the proposal that efforts in the two evidence sections mentioned are important. These statements might imply that all that is needed is access in all LMICs?</p> <p>Other opposing positions or discussions of related factors that might impact efforts to expand access to consider include those relating to vaccine nationalism, challenges presented by active cultivation of concerns about current or future scarcity in HICs (that may drive “hoarding” behaviors), and the inherent complexity of achieving success in obtaining the policy and legal revisions needed across multiple countries (e.g., some might argue that with the many different layers of patent law active, implementation of a global strategy for patent relations would be nearly impossible) .</p>	
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<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> <li>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ul>	<p>Below are action steps not substantively preceded by relevant content in the Evidence-based Strategies. These need to be better linked to the problem statement and evidence based strategies:</p> <ul style="list-style-type: none"> <li>● Calls on the WHO and HIC governments to commit additional financial and other resources to support broader vaccine production;</li> <li>● Calls on pharmaceutical companies to voluntarily pledge the non-enforcement of intellectual property rights and to share the IP and technology needed to produce treatments and vaccines;</li> <li>● Calls on the President and Congress to ensure that domestic mRNA COVID-19 vaccine manufacturing capacity is publicly owned;</li> <li>● Calls on the President, CDC Director, and Congress to repeal non-evidence-based immigration and asylum policies implemented under the auspices of COVID-19 precautions;</li> </ul> <p>While the above proposed actions may be related and understandable, they do not align sufficiently with the specific evidence based strategies proposed in the early sections of the proposal. In addition, some actions would be strengthened by revising the actions to parallel others.</p> <p>The idea of manufacturing capacity being publicly owned is not described in the Evidence-based strategies (i.e., Provide example of how it has been</p>	



	<p>accomplished or attempted in other situations.)</p> <p>What organizations in the “broader public health community” should be called up to address vaccine misinformation and vaccine reluctance in different countries? What organizations are the credible voices that have not been doing it or need to continue doing it?</p> <p>In the PS and/or EBS, describe evidence /more persuasive evidence that is more tailored to the stakeholders included in the AS.</p> <p>Include AS related to LMICs, such as:</p> <ul style="list-style-type: none"> <li>○ Information and awareness through multisectoral approach</li> <li>○ Improving accessibility and delivery by strengthening outreach of health system</li> <li>○ Free-of-cost vaccination / Reducing opportunity costs</li> </ul>	
<p><b>References</b></p> <p>Are the references properly formatted, up-to-date, and peer-reviewed?</p>	<p>The references are properly formatted, up-to-date, and largely peer-reviewed. A few suggestions for more recent references are offered elsewhere in this table.</p>	

## A3: A Call to Cancel International Debt for Global South Nations and Increase Public Financing of Health Systems

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

<b>Criteria</b>	<b>Write a summary statement and include recommendations to the author.</b>	<b>Author's Response</b> <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	Recommend a revision of the title possibly using more of the wording of your action steps i.e., <ul style="list-style-type: none"> <li>Expand international debt relief for all developing countries to increase access to public resources for health care.</li> </ul> Debt relief includes canceling debt, and it is what you are addressing more broadly. You are not suggesting canceling debt for the whole Global South. Also, there has been considerable debt cancelation already	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING</b>	Delete 200026- This policy statement was archived in 2020 (only active statements should be listed)	

<p><b>APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)</p>		
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> <li>Identify any relevant ethical<sup>i</sup>, equitable<sup>ii</sup>, political or economic<sup>iii</sup> issues.</li> </ol>	<p>The problem statement (6.5 pages) is overdeveloped compared to the Strategies and Opposing Arguments sections, to the detriment of the arguments being made. It reads as you spent a long time defining the issue and then did not take an equal amount of consideration in assembling the evidence. There needs to be more facts within the “User Fee” section. This section is good at showing us how this affects the average person however it does not go in depth. There needs to be more elaboration in this part of the policy.</p> <p>Address the following as you redraft the proposal:</p> <ul style="list-style-type: none"> <li>The fees cover for people who already use the current health system</li> <li>How does it affect them as individuals and families?</li> <li>How does it affect the overall poverty of individuals and families?</li> <li>How does it affect the current system?</li> <li>How do these fees contribute to debt?</li> <li>How do these fees impact access to care</li> </ul>	

	<p>that is already difficult to receive for most?</p> <p>Standardize terms used across the proposal. They should be defined and used consistently e.g., moratorium versus temporarily paused, relief versus forgiveness. Types of debt and financing should also be outlined early in the proposal to help the reader as the argument skips between different global and historical precedents.</p> <p>Corruption is a big issue in many developing countries, and it should be dealt with in the problem statement as it impacts whether debt relief will result in more in more resources devoted to health care.</p> <p>There has been an evolution over the past 20 years in the process of providing international loans by well-known funders such as IMF and World Bank as critiques have identified problems. There should be a clear recognition of this.</p> <p>Some of the information is not current for example Ref 16, (2016 IMF Fact Sheet). A 2021 fact sheet from the IMF (link below) provides more up to date information about debt cancellation as well as the impact on social spending.</p> <p><a href="https://www.imf.org/en/About/Factsheets/Sheets/2016/08/01/16/11/Debt-Relief-Under-">https://www.imf.org/en/About/Factsheets/Sheets/2016/08/01/16/11/Debt-Relief-Under-</a></p>	
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	<p>the-Heavily-Indebted Poor - Countries-Initiative</p> <p>It is too limiting to look only at the impact of debt relief on health spending. Impacts on other sectors can impact health. One researcher found (reference below) that participation in HIPC is associated with a 16% and 12.5% reduction in child and infant mortality. HPIC was also associated with an increase in government expenditure on education and agriculture but not on health.</p> <p><a href="https://www.cgdev.org/event/debt-reduction-life-impact-heavily-indebted-poor-countries-initiative-child-mortality#:~:text=He%20found%20that%20participation%20in,of%20governance%20and%20institutional%20quality.">https://www.cgdev.org/event/debt-reduction-life-impact-heavily-indebted-poor-countries-initiative-child-mortality#:~:text=He%20found%20that%20participation%20in,of%20governance%20and%20institutional%20quality.</a></p> <p>While the extent of the impact of the invasion of Ukraine is unknown, because of the importance of Russia and Ukraine in providing fertilizer, natural gas and wheat there are likely to be additional cost increases that will be difficult for countries already hard hit by COVID - 19. While we are not suggesting adding information about the conflict in Ukraine the debt and pandemics section should be broadened to include disasters natural and otherwise to make the policy more evergreen.</p> <p>The very last sentence of the section (287 -289) fails to provide a reference, after a</p>	
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	<p>well-supported summary of pandemics and debt. Consider using several (but at least 1) of the earlier citations provided that demonstrate the limited progress toward public health expenditures like UHC due to debt requirements –to support first half of the sentence. For the second half “but also undermine effective global mobilization...” consider using one of several publications from Peter Hotez about LMIC countries’ ability to respond to current pandemic.</p> <p>The problem statement should include some focus on political and economic issues. For example, why have some funders offered debt relief and other have not?</p> <p>From an economic perspective there are issues related to the impact of debt cancellation on future availability of funds that is not addressed. The IMF fact sheet referenced in the statement (45) as well as the one highlighted above discuss this issue</p>	
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<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ul style="list-style-type: none"> <li>a. Is/are the proposed strategy/strategies evidence-based?</li> <li>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ul>	<p>This section is under-developed and insufficient. A near minimum number of references (3 new) included. Each action step recommended should be described and fully supported in this section.</p> <p>Additionally, the strategies are focused on the IMF but both the Problem Statement and the Action Steps frame the issue more broadly as involving other multilateral institutions and international collaborative efforts.</p> <p>It is recommended that each specific debt relief strategy be described --- who are the providers of debt relief and which category of countries would be on the receiving end. Also, what is the evidence that this would result in more resources toward UHC. You provide categories of loan providers in the problem statement--these should be reflected here. You do not need to specify COVID -19 affected countries as this makes the policy less evergreen. Describe who is responsible for canceling the debt? Provide more detail on how the plans will have a mechanism for increased public health spending, otherwise money could just go elsewhere.</p> <p>There are many mechanisms for “relief” as described in this section. The various avenues to providing relief or forgiveness need to be defined clearly, spelled out with their strengths</p>	
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	<p>and limitations as they pertain to public health and/or economic impacts. “Structural adjustment programs” should be defined early in the EB Strategies section and the evidence of strengths and limitations of this approach should be outlined in detail.</p> <p>This policy statement assumes that funds freed from debts would be used constructively and in support of needed programs in Global South nations. However, the evidence provided to show that in past instances where debts were relieved that those monies were, in fact, used to support needed programs is missing or extremely limited. If there is no evidence that the proposed strategies have worked in the past, then you will need to augment those proposed strategies to acknowledge this concern here and in the Opposing Arguments section and include recommendations in Strategies section on how to avoid it.</p> <p>Development banks, featured in Action steps later, should be defined and role explained in EB strategies when the section describes how WB, IMF can mobilize grant and financing resources through them.</p> <p>The section beginning on line 301: Add an expanded definition of “Special Drawing Rights” here and provide a reference of the mechanism and benefits. Also, please define “DSSI and give more</p>	
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	<p>details on the CCRT. All of these statements of possible avenues/ options available need references to support</p> <p>Consider addressing, even at a brief, high - level narrative with just a few sentences, how the debt will serviced/absorbed/reallocated. Include what programs can potentially “pay” for this debt, or perhaps a few sentences dedicated to a case study of a country wherein debt forgiveness at any level.</p> <p>Add evidence as to the extent to which debt relief programs have resulted in more public resources being directed to health care or even in improvements in health indirectly. Several references focus on the targeted debt relief of countries hard - hit by the Ebola epidemic and the resulting increased capacity by these countries to combat the epidemic. However, this experience may not be indicative of what will happen in non -critical health emergencies.</p> <p>Address:</p> <ul style="list-style-type: none"> <li>• What will it also mean for struggling countries if donor organizations cut back on availability of funds?</li> <li>• How these strategies would impact the US economy? For example, given that that US is a major</li> </ul>	
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	contributor to the IMF and World Bank wouldn't they increase the tax debt of member countries?	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ol style="list-style-type: none"> <li>Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>Were any opposing views missing?</li> </ol>	<p>The entire section is under - developed, under -referenced, and therefore insufficient. Each opposing argument (only 2) needs to be supported by at least 1 - 2 references demonstrating the use and context of the arguments that are observed.</p> <p>Ref 45 in the first section is citing a petition by an advocacy group contrary to (i.e., countering) the opposing argument and NOT evidence, peer -reviewed or otherwise.</p> <p>The second section (328-333) has only one reference and it supports the final sentence which is not concisely worded. It is unclear if this is a counter thought to the opposing argument as it is tangential to the sense of obligation being described: The initial capital, leading to the described greater growth and resources to invest in public services, is the direct incentive to borrow and is not related to the incentive to lend or to repay debt.</p> <p>The sense of obligation to repay a debt is not the only reason markets track credit and debt balances. The importance of risk and not over - extending balance sheet in</p>	

	<p>commercial markets are real and in most international markets debt is not erasable by generating new currency the way the US does. Please factually describing the risks of forgiving national debt balances whole cloth, beyond even inflation (although this is related). To counter the argument the you can describe the various tools available to G20 and IMF to provide funding to balance the forgiveness and the slower approach that SAPs provide to relieve the adverse effects of debt.</p> <p>The assumption that debt relief funds will be used for public health services cannot be made without supporting evidence. Corruption is a detestable, but real problem within government systems across the world -including Global South nations. Even if debts are relieved, there is no guarantee that those freed monies would be used to fund public health and infrastructure initiatives/systems. Therefore, address this as an Opposing argument, with cited evidence and then refute argument with strong evidence and point to the added Strategies (recommended above) to ensure debt relief goes into public health and wellbeing initiatives and to avoid misallocation of funds which are freed by debt forgiveness.</p> <p>Reduced capacity of lenders to continue to provide loans is</p>	
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	<p>missing. Ref 48 goes into this in detail and can be used here.</p> <p>Description and analysis of the cost benefit of providing debt cancellation versus other aid or supports is missing. Seek to answer the question: Would debt cancellation have a negative effect on donor countries' willingness to give more money as loans?</p> <p>Line 324-327 Clarify the statement about the relationship between debt repayment and GDP.</p> <p>Please clarify in the text if the comment on benefits of expanding trade is an Opposing Argument or counterargument?</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> </ul>	<p>Cut the first 1.5 sentences from "The United States has outsized..." to "and drives a global economic crisis," as this is 1) redundant to prior language and 2) unnecessarily COVID-19 specific when the argument is quickly generalized beyond the current era by this policy.</p> <p>Is "pressure" the best verb to use in referring to the US Congress and Presidents' stance toward the G20, WB, and IMF? What about "encourage", "request", "urge", "charge the G20, WB, and IMF with..."1. Does the phrase "countries in greatest</p>	

<p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>debt distress” refer to HIPC’s? If so, say so; or define/reference a threshold measure here or state who determines greatest distress if this is a fluid demarcation.</p> <p>Can the G20, WB, or IMF mobilize resources through supporting development banks? If that is a purview of any of these groups identify them specifically or consider moving to a new section targeting another group</p>	
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## A4: Support Decent Work for All as a Sustainable Strategy for Improving Population Health and Well-being

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p><b>Title</b></p> <p>Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?</p>	<ul style="list-style-type: none"> <li>• Suggest a more focused title and, in the problem statement, an explanation of the limited scope.</li> <li>• Decent work for all depends not only on the quality side encompassing a living wage, job benefits, input into decision making etc. It also includes economic development that creates new jobs and workforce development (e.g., literacy improvement, higher education, certificate programs, apprenticeships, retaining programs, etc.)</li> <li>• A living wage and access to childcare might intersect both sets of strategies. The title describes the first set. A policy proposal must focus to clarify its limited scope.</li> </ul>	

<p><b>Relationship to existing APHA policy statements</b></p> <p>Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)</p>	<ul style="list-style-type: none"> <li>• Include a standard citation for the ILO publication (in addition to its Internet address).</li> <li>• Delete content covered in other current proposals. E.g., if Policy Statement 20218 addressed issues during the current pandemic, perhaps they are unnecessary in this proposed policy statement.</li> <li>• Please identify Policy Statement 2027 (or correct its number).</li> </ul>	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<ul style="list-style-type: none"> <li>• Related to the recommendation regarding the title, explanation of this proposed policy statement's narrower scope compared to the model it cites, the ILO conventions.</li> <li>• Re write the last two sentences to remove "we" statements.</li> </ul>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>a. Are there important facts that are missing</p>	<ul style="list-style-type: none"> <li>• The problem statement is strong but could emphasize more (1) affording childcare and (2) the Child Tax Credit, important issues for parents and caregivers.</li> </ul>	

<p>from the problem statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>iv</sup>, equitable<sup>v</sup>, political or economic<sup>vi</sup> issues.</p>	<ul style="list-style-type: none"> <li>• Problem statement cites key facts re: work &amp; trends in worker health &amp; gaps in data. More detail is recommended. Homeless workers should be described.</li> <li>• A problem that is implicit that could be explicit is the lack of a unified approach to labor in the US. Splintered interventions by disparate government agencies and non-government groups have focused on some workers but ignored others. Consider whether this divided situation might be stated explicitly.</li> <li>• Line 6: change “inherent to good jobs” to “inherent to positive work experiences.”</li> <li>• Line 8: define “free association” for the reader.</li> <li>• Line 13: provide evidence of in what ways COVID exacerbated health disparities.</li> <li>• Line 29: define “standard part-time workers” and “gig work.” Is their mention even necessary? Do Lines 33-34 address their differences? Consider stating that “unstable work hours are common in ‘standard part time workers’” and “alternative work arrangements.”</li> <li>• Include more information on how to protect gig workers from abuse</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Lines 42-43: What is meant by Congressional Staff here—cooks, interns, low- ranking staff, or other?</li> <li>• Line 50: Does evidence support that support the Affordable Care Act helps obtain benefits?</li> <li>• Lines 60-61: Define right-to-work law is and how it weakens unions.</li> <li>• In section, “Work as a determinant of health,” please cite supporting statistics for these claims.</li> <li>• Section, “Vulnerable populations” also has no statistical support. Placing this near the front would set the premise that vulnerable populations are addressed in every section so far.</li> <li>• Line 100: Indicate where the reader can find this information above.</li> <li>• In section, “Limitations of federal legislation,” Are there any data to indicate how this impacted the workforce?</li> <li>• Page 7, Line 96: Sexually should be sexual.</li> <li>• Additional citations are suggested:</li> <li>• Wagner, SL et al (2016) Mental health interventions in the workplace and work outcomes: a best-evidence synthesis of systematic reviews. The International Journal of Occupational and</li> </ul>	
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	<p>Environmental Medicine 7(1), 1-14.</p> <ul style="list-style-type: none"> <li>• <a href="https://www.health.pa.gov/topics/disease/coronavirus/Pages/LTC-RISE.aspx">https://www.health.pa.gov/topics/disease/coronavirus/Pages/LTC-RISE.aspx</a> This program in Pennsylvania will support safety for workers and residents in long-term care facilities.</li> <li>• Include data of workers experiencing or at risk of homelessness and housing instability as well as workers serving these populations (California Policy Lab, Homelessness Policy Research Institute, National Alliance to End Homelessness).</li> <li>• Include in the problem statement information about persons with disabilities and the accommodations they require for work; noting women's continuing burden in the workplace; and rural workers.</li> <li>• Immigrant workers are a concern, but due to other issues perhaps a note could acknowledge that this urgency cannot be addressed in this policy.</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p>	<ul style="list-style-type: none"> <li>• This proposal presents a very comprehensive array of strategies to address the problem but is a bit of a laundry list that makes it difficult to define integrated strategies. On the other hand, you have made a great</li> </ul>	

<p>a. Is/are the proposed strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>effort to include impact research for all the strategies identified.</p> <ul style="list-style-type: none"> <li>• Lines 144-150: Under the Income strategy consider guaranteed income for vulnerable populations—Chicago is currently running such a program: <a href="https://chicago.sun-mes.com/city-hall/2022/2/24/22949608/guaranteed-basic-income-pilot-program-chicago-lower-500-dollars-5000-families">https://chicago.sun-mes.com/city-hall/2022/2/24/22949608/guaranteed-basic-income-pilot-program-chicago-lower-500-dollars-5000-families</a>.</li> <li>• Another suggestion is how Universal Basic Income could support other strategies.</li> <li>• Lines 169 -170 need reference(s).</li> <li>• There is a lack of “proposal” aspect, i.e., how to implement them realistically? It is unclear if the strategies are ethical, equitable and reasonable, because the strategies are not accurately described well enough for an action plan. They all hold ethical and equitable standards, but they are not fully fleshed out to determine their rationale. The strategies need supporting evidence—how will they apply to our current needs?</li> <li>• However, the proposed actions are strong in that a variety of interventions are described that could have real implications for improving workplace quality.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• In section “Labor market strategies,” the United States also has programs like this. It might be a stronger stance to see what the research tells us about the success of these efforts. If there are no evaluations of strategies that address decent work, their absence should be stated.</li> <li>• In the strategy section there should be a clearer statement of the strategy and how it should be implemented.</li> <li>• Page 10, Line 172: “high-road” employers—please define or use different words.</li> <li>• A strategy of partnering with organizations representing or working with vulnerable populations—for example, One Simple Wish and the Nsoro Foundation are nationwide programs supporting young adults who’ve aged out of foster care to pursue college and certifications and secure a safe and stable employment.</li> <li>• Use acronyms OSH and OSHA consistently.</li> <li>• Strategies are comprehensive and reasonable. More discussion of how they interrelate &amp; relate to equity would help.</li> <li>• Strategies or Action Steps should include business start-ups and disparities in rural areas.</li> </ul>	
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<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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.)?</p> <p>c. Are alternative viewpoints, ethical,</p>	<ul style="list-style-type: none"> <li>• Resiliency Infrastructure Supports, &amp; Empowerment program: Protects long-term care patients &amp; workers. A4 doesn't refute opposing views or mention disability. It should cite Americans with Disabilities Act &amp; an Action Step of partnerships with community organizations.</li> <li>• Opposing arguments with supporting evidence are missing from the proposal</li> <li>• Choose three or four of the major opposing arguments, describe each with two or three referenced sentences and then a brief refutation. For example, discuss minimum wage and unionization as causes of job loss. Another could be that workers should be responsible for their own education and training etc.</li> <li>• Second and third sentences seem jumbled and irrelevant, please clarifying for a stronger argument.</li> <li>• Perhaps, if the Evidence Based Strategies described practical ways to implement them, this section might address justifiable approaches.</li> <li>• Alternate viewpoints are difficult to understand.</li> </ul>	

<p>equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<ul style="list-style-type: none"> <li>• The opposing views need to be strengthened and include rebuttal of opposing views and supporting evidence.</li> <li>• Opposing view omits discussion of negative impacts of employee benefits.</li> <li>• Opposing views have much less evidence than problem statement. A4 needs local &amp; state initiatives.</li> <li>• Several additional references, especially for opposing arguments:</li> <li>• Regarding the opposing view that minimum wage could result in job loss— <a href="https://www.healthaffairs.org/doi/10.1377/hpb20180622.107025/">https://www.healthaffairs.org/doi/10.1377/hpb20180622.107025/</a></li> <li>• Regarding the opposing view that employers don't have a responsibility for worker health—Kessler, RC (2012) The health costs of depression. <i>Psychiatric Clinics</i> 35(1) 1-14.</li> <li>• To provide evidence for the ROI of employers investing in worker health—Kelly LA et al (2021) Impact of nurse burnout on organizational and position turnover. <i>Nursing Outlook</i> 69 (1) 96-102.</li> <li>• Regarding mention of opposition to undocumented workers refer to efforts to expand H-2A and H-2B visas— <a href="https://www.dhs.gov/news/2021/04/20/dhs-make-additional-22000-temporary-">https://www.dhs.gov/news/2021/04/20/dhs-make-additional-22000-temporary-</a></li> </ul>	
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	non-agricultural-worker-visas- available	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ol style="list-style-type: none"> <li>Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>Focused on policy/principle, and not on specific legislation/regulation ?</li> <li>Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain?</li> <li>Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ol> <p>*If additional action steps are needed, note whether you believe authors need to exceed the 10 page, 50 reference limits to address gaps and if so by how much.</p>	<ul style="list-style-type: none"> <li>Please explain, briefly, if possible, the rationale for ratifying ILO conventions.</li> <li>While Action Steps flow logically from the strategies, Action Steps can include more activity at the state level. For example, Action Step 4 asks the US Congress to “remove administrative and legal obstacles for workers to form unions.” Yet there has been a lot of successful anti-union activity at the state level such as the new right-to-work laws.</li> <li>Action Step 5 can focus on NIOSH and not CDC, since NIOSH is a part of CDC. The part of the Action step for NIH should be much more specific in terms of identifying priority areas.</li> <li>Action Step 6 can be expanded to include collection of additional data reflecting “decent work” conditions to complete refinement of data on worker and employment status.</li> <li>Action Step #8 regarding state legislatures (Item b) seems covered under (a) “eliminate loopholes for contracted work.” Is (b) a practical way to address the problem? Also isn’t the evaluation of models more of</li> </ul>	

	<p>a NIOSH-state collaboration with the state legislatures taking a more active role in funding local programs? Also, shouldn't the action steps call for funding more OSHA workplace inspectors?</p> <ul style="list-style-type: none"> <li>• Address why there is so little attention to rural unemployed, under-employed, and employed workers.</li> <li>• Consider if some of the action steps feasible, as they point to legislation? Line 242: Please format the subtitles correctly—tab and capitalize</li> <li>• Line 255: Please check the formatting. Some are referred to as (a) and some referred to as b). This may be easier to read if laid out similar to line 242, separating the subtopics.</li> <li>• Please note the Action Steps should be feasible and align with the evidence based strategies.</li> </ul>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<ul style="list-style-type: none"> <li>• References are connected to text</li> <li>• References are up to date and seem to be from peer-reviewed sources</li> <li>• There are exactly 50 references.</li> </ul>	



## B1: The Overlooked Public Health Crisis of Healthcare Waste: A Call for Oversight Protections and Tracking

### Spring Assessment: Conditional

Note to Authors: Acronyms used in the comment Problem Statement (PS), Evidence-based Strategies (EBS), Opposing Views (OV), and Action Steps (AS).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The comprehensive and engaging title might overstate its urgency, since the concern is hazardous waste exposures that contain little medical waste. Consider revising the title with words "investigation" or "research" or "evaluation."	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	<p>P4, L15: Delete LB20-04 (Structural Racism is a Public Health Crisis: Impact on the Black Community.) It expired in 2021; not a current APHA policy.</p> <p>P4, L22-L25: Delete 20017 (Research and Intervention on Racism as a Fundamental Cause of Ethnic Disparities in Health) and 8911 (Resource and Solid Waste Management); they are archived policy statements. Policy No. 202116 is listed twice.</p> <p>You are encouraged to review Policy No. 20197: Addressing Environmental Justice to Achieve Health Equity. This prior policy statement is an example of a</p>	

	more robust and rigorous use of references to inform and nuance challenges and needs related to environmental hazards in disproportionately impacted communities.	
<p><b>Rationale for consideration</b><sup>[OBJ]</sup> <sup>[OBJ]</sup></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>P4, L28: Committee not “Commission”</p> <p>P4, L29-34: Delete text that refers to archived policies, and LB20-04 (expired in 2021)</p> <p>P5,L2 re: Delete the URL for the folder with eight documents. Only one is listed as a reference.</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>a. Are there important facts that are missing from the problem</p>	<p>You include a broad variety of examples of environmental/human health impacts from the healthcare industry, but the proposed policy statement fails to provide a consistent and concise definition of ‘healthcare waste’. As a result, there appears to be a disconnect between the examples and scope of problem described in the problem statement and the subsequent Evidence-based</p>	

<p>statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>1</sup>, equitable<sup>2</sup>, political or economic<sup>3</sup> issues.</p>	<p>Strategies (EBS) and Action Steps (AS).</p> <p>The strength and appropriate referencing of supporting evidence is variable in quality and relevance. Incorporate more up to date and peer-reviewed references (from rigorous journals) to support their arguments. For example, in the introductory paragraphs of the problem statement, the statement cites reports and studies from more than 30 years prior. These should be completed with more recent peer reviewed articles to confirm and specify the scope of the issue to be addressed. You note this proposed policy's relationship to Policy No. 20197 (Addressing Environmental Justice to Achieve Health Equity) which already provides some of the historical scope of the problems.</p> <p>There is a lack of data on marginalized groups. Given this lack of evidence, problem statement could lead with the environmental implications of healthcare waste and use the impacts of EJ as supporting evidence/need.</p> <p>Reviewers suggest the others provide more evidence on the portion of hazardous waste that is generated from healthcare services. Ref 6, Tait et al, is over-interpreted: It finds health risks related to municipal wastes, not medical wastes." Most of its &gt;90 reviewed publications were poor, and the highest rating was average. While the hazardous wastes studies contained some healthcare wastes, Tait et al. don't disclose the number or proportion of healthcare wastes in the hazardous wastes, and</p>	
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	<p>likely they do not know. You seem to assume that the hazardous wastes in the review of Tait et al. were all or largely medical. Tait et al. also note that most or all of the &gt;90 studies involved dated incinerators, and incinerators of more recent design possibly emit fewer toxins. Their scope of their review of English-language publications was international, so many may not be applicable to current practices or exposure in the U.S.</p> <p>Please provide more clarity on the scope of the problem. At present, the problem statement mentions general solid waste, healthcare waste, regulated medical waste (RMW), improper discarding of face coverings/PPE by the public, as well as mentions of antimicrobial resistance (AMR), pharmaceuticals in waterways, and greenhouse gases associated with manufacture, transport and disposal of healthcare waste and packaging. These are all important issues with potentially significant human and ecological health impacts, however, the exposure scenarios and toxicological/environmental risk factors for each of these is very different. Further evidence around causality and exposure should also be incorporated. At present, the problem statement doesn't adequately recognize this variability or fully acknowledge that the remedies would subsequently need to be quite different.</p> <p>An improved problem statement would communicate to readers the type of waste the policy statement addressing—from generation, transport and final</p>	
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	<p>disposition.) You refer on P6,L5-6 to the WHO definition of healthcare waste (i.e., generated in all types of healthcare settings from laboratories, hospitals, and home care) but the you indicate on P11, L17-19 (nearly the end of proposed policy) that is not the definition they are using. [Although, at P3, L35-41, the you use the phrase “massive healthcare industry” which suggested to reviewers that the policy is addressing waste generated throughout the industry.]</p> <p>Revisit your plan for a narrow problem scope and consider addressing healthcare waste generated within communities from all settings (e.g., private practice, community clinics, veterinary care, and home health.) Justify the decision to carve out some settings (e.g., quantitative (proportional) contribution total healthcare waste.) To the reviewers, it seems that the hazards are the same, and the need is the same to reduce, reuse, recycle. It also seems that some of the same solid waste companies are transporting and processing the waste. Perhaps there are strategies taking place in community settings and/or veterinary settings that could be scaled up and/or applied to other health service settings. Think about a logical flow to the policy statement. For example, consider kicking off the PS with information on waste</p>	
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	<p>sources/generation in the healthcare industry (e.g., paper, packaging, infectious, chemical/pharmaceutical, radiological, kitchen grocery (cans, paper towels), food waste.) Next, explaining the different ways that waste from the healthcare industry is managed (e.g., on-site incineration; sterilized and transported to landfill; offsite incinerator; whatever the options are) and provide the best data available on what percentage is managed in each of the different ways. Be explicit about the type of waste that is subject of the policy statement (e.g., just regulated medical waste? all waste generated in healthcare settings?) Then, get into the different aspects of the waste generation problem (e.g., too much is generated (i.e., packaging, single-use); failure to separate hazardous from non-hazardous; failure to recycle). And describe the adverse impact on public health, and make the case on the disproportionate impact on communities of color, low-income, rural, and/or other populations.</p> <p>P5, L4-20: Preface information on disproportionate impact with brief statement on the different ways that waste from healthcare industry is managed (e.g., Incineration, pre-processing to landfill, etc.) Each is associated with different hazards and relative risks).</p> <p>Do you equate the risks of municipal waste and hazardous industrial sites with risks of the sites that receive healthcare waste? The proportion and nature of medical wastes in the former would be helpful to readers.</p>	
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	<p>What portion of medical supplies and equipment is durable/reused versus disposed of?</p> <p>Be consistent in your use of the phrases healthcare waste, medical waste, regulated medical waste, infectious waste. You seem to use them interchangeably (which is confusing to a reader.) If you intend different meanings (whether in PS, EBS, or AS), explain the distinction. Is all healthcare waste considered “hazardous waste” or does it just become so because it is not separated appropriately? You suggest in EBS (P9,L30) that EU has a different definition of healthcare waste.</p> <p>P.6, L14-20: The focus solely on Black communities should not be generalized to “communities of color.” Rephrase the point being addressed or include additional evidence to describe the impact on other non-Black communities.</p> <p>Is part of the problem that most healthcare waste is managed as if it is hazardous waste or a mixed hazardous and non-hazardous (i.e., not sorted) thus missing opportunity for recycling and/or processing as municipal non-hazardous solid waste? This component of the waste generation problem is unclear.</p> <p>Is an additional problem a lack of research to better document the health impact (including well-being) for communities living near waste management facilities, as well as analysis of interventions to address the disparities related to which communities bear the burden of waste. Research topics could also include lifecycle analysis, and</p>	
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	<p>environmental justice impacts related to different waste management strategies (e.g., sterilization and reuse; on-site sterilization before landfilling; incineration, etc.) Medical Care Section comment: research/analysis on the option of closing landfills/incinerators that are located close to housing and neighborhoods rather revamping the healthcare industry's supplies and waste management.</p> <p>Define EJ communities. (For example, Ref. 4 (The New School Report) includes a definition of EJ community taken from another organization. Is that the commonly used definition? If so, use it, or provide an appropriate one.)</p> <p>Communities with disproportionate impact may also be rural localities where municipal solid waste and hazardous waste landfills are located. Commenters note the market-driven reasons that landfills are located in rural areas, including available space, land costs are lower, disinvestment in rural areas leads them to allow landfills as revenue source. Data from EPA's Landfill Methane Outreach Program (LMOP) could be a place to obtain more data on landfill locations nationwide. It contains locations of active and closed landfills across the country.</p> <p>You do not provide much current evidence on the health and well-being impact on communities living near or in the transport route of medical waste. You provide some data on disproportionate prevalence in communities with people of color and of low wealth. This appears to be part of the problem is the lack of</p>	
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	<p>data. This seems to be what Action Step #1 is looking to help solve. If that is the your intent, be more explicit about it.</p> <p>P5, L16-19 uses the phrase “dumped or processed” but Tait et al (Ref. 6) is about incineration sites (not landfills (dumped) or other waste management processes). In addition, the health risks of medical wastes once transported from sources aren’t well documented. Hazardous waste site operations with violations in EJ (or other communities) might not include much medical waste. Ref 6, Tait et al, may be mis-interpreted/over-interpreted (i.e., not specific to medical waste.)</p> <p>P5, L4-20 does not focus specifically on medical waste. Is there more evidence on communities impacted specifically by medical waste?</p> <p>AS#1 says Congress to “delineate federal definitions of medical waste,” however, the you don’t discuss this issue as part of the problem. If it is, explain that, but if not, remove the AS.</p> <p>P5, L 121-14: Consider revising to read: As of 2019, 73 municipal solid waste (MSW) incinerators are located in the U.S. and 79% of them are located in EJ communities.</p> <p>P5, Line 18: you write “dumped or processed,” The paper you cite (Ref. 6) is systematic review of incineration. (Throughout document, use the term “stored” or “landfilled” instead of “dumped.” Use the term “tipping fee(s)” instead of “dumping fee(s).”</p>	
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	<p>There are also several instances where the policy statement language either is not supported by or is incorrectly summarized relative to the reference to which it is linked. For example:</p> <p>P5, L16-19: Use more precise language/consistent your word choices, when summarizing Ref. 6 (Tait, et al.) An option would be: A systematic review of studies published between 2002 and 2017 on the health impacts of waste incineration identified 61 papers reporting an adverse outcome. This included 34 reporting exposure to elevated levels of known pollutants, nine papers for each of the following outcomes: increased risk of developing neoplasia, correlation with adverse reproductive outcomes, and a link to hypertension, reduced lung function and other diseases.</p> <p>P5, L18: You say the study shows” that adverse health effects....could...occur...in communities nearest sites where hazardous waste is dumped or processed.” However, the source article only links effects to sites near incinerators (not dumps or other types of processors). Greater specificity is important here as it will have significant impact on the potential remedies that could be employed.</p> <p>Are some of the papers in the systematic review by Tait specific to the U.S. system? Do those papers have useful info for PS and/or EBS?</p>	
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	<p>P5, L21-23: Ref. 8 (WHO, 2014 [sic-correct the date]): Relevant information on the increase in medical waste because of COVID-19 could be from p. 8 of the report. Globally, it notes, many healthcare facilities classified 100% of COVID-19 healthcare waste as hazardous and treated as infectious---although the primary route of exposure is airborne transmission. See page 5 of the report on WHO’s advice about management of healthcare waste from COVID-19 patients, noting that no special precautions were needed. (i.e., the proliferation of waste classified and thus unnecessary processed as hazardous waste.) WHO and United Nations Children's Fund. (2020 July 29). Water, sanitation, hygiene and waste management for SARS-CoV-2, the virus that causes COVID-19. Geneva: WHO and UNICEF. United Nations Children’s Fund; 2021  <a href="https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-WASH-2020.4">https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-WASH-2020.4</a></p> <p>Ref. 8 at page 15 has a list of recommendations for reducing the production of healthcare waste. Are there examples in the U.S. or elsewhere of healthcare institution/clinics using their purchasing power to require less packaging from suppliers? Are their options available for PPE in the U.S. that are made with renewable, biobased or recyclable materials? Are their examples of “reverse logistics” ? Examples of such would be items to include in EBS.</p> <p>Page 5 line 20: You say that the referenced data “highlight the</p>	
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	<p>burden of waste on communities of color” but should be clarified to say “highlight the burden of waste on communities of color and/or low wealth” based on the reference cited. Alternately, you could provide an alternate reference that specifically explores the impact on communities of color.</p> <p>P5, L21 – The policy cites a NC regional report from June 20 (just a couple months into the pandemic) and a WHO report from 2014 as evidence that the “C19 pandemic accelerated these unaddressed inequalities dramatically with increased healthcare waste from testing, biowaste, vaccinations and single use plastics.” These references predate the pandemic and are not appropriate as cites here. Use citation 43 (Das et al 2021) or others.</p> <p>P5, L23. Ref. 7 Delete. Letter does not adequately support the sentence.</p> <p>P5, L26/27. The reference (Ref. 6 (Tait)) provided does not support the conclusion re: multi-generational impacts on US-based communities of color. The paper cited was a systematic review and included studies from countries around the globe. No specific US conclusions were stated, and it did not focus on community composition just on proximity to incineration and population outcomes.</p> <p>P5,L30: “the fate of much healthcare waste” ---put in context-----% of healthcare waste is disposed of in these two ways. (For example, is it 90%, 50%, 10%?)</p> <p>P6, L7: awkward phrasing “public health implications of personal</p>	
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	<p>protective equipment”... Perhaps it should read: The public health implications of healthcare waste, including used PPE, single-use plastics, pharma...”</p> <p>P6, L7: You call out PPE as a separate category of healthcare waste. It’s unclear from the current text whether PPE is a major component of healthcare waste. For example, more so than packaging or single use plastics? In addition, if the topic of PPE is included in the policy statement, you should define what they mean by it (e.g., designed to protect the wearer from exposure to biological pathogens, antineoplastic and other hazardous drugs); Distinguish disposable PPE (e.g., gloves, N95s, plastic face shields, Class II surgical gowns) some of which (perhaps most) shouldn’t be considered hazardous---although perhaps it often is.</p> <p>P6, L8-9: unclear where the “5-6 million tons” estimate comes from (i.e., can’t locate it from Ref. 13). More helpful would be a breakdown of % of medical waste managed by landfilling, incineration, or thermal disinfection.</p> <p>P6, L10: Check Ref. 20 (Healthcare Plastics Recycling Council) vs Ref. 13 (Practice Greenhealth).</p> <p>P6, L17: revise sentence to read something akin to: Healthcare organizations are required to provide PPE to employees who are at risk of exposure to chemical, biological, and physical hazards. Gloves, gowns, and face coverings are also worn to hinder the spread of pathogens from the public to people who are ill.</p>	
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	<p>P6, L21-22: Discarded face coverings is something we are seeing because of COVID-19. Are you considering this healthcare waste (part of the definition for this policy statement?) It seems face coverings on sidewalks, roadways, etc, are no different than other household and business waste that is not disposed properly. Likewise the you mention of “other plastic items litter streets...”</p> <p>P6, L13-14. Ref 15 (Tran, 2022) very remotely addresses home and community antibody/diagnostic testing for COVID-19. Add more detail.</p> <p>P6, L11-14. If this remains in the policy statement, no need to mention LabCorp as there are quite a few manufacturers of COVID-19 testing kits.</p> <p>P6, L15-16: Statement is out of place. (We, APHA, are public health professionals. Having this policy statement will indicate are acknowledgement/recognition of the problem and it serves as a tool to inform/educate the larger public.</p> <p>P6, L20: Superscript 16 (Ref. 16) belongs after “citizens worldwide,” noting that Ref 16 does not include any information on the reliance of healthcare facilities on reusable respiratory protection.</p> <p>P6, L21-22: Is mask-use by the public considered “medical waste”? This is not the responsibility of the healthcare industry or manufacturers.</p>	
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	<p>P6, L27: This line cites the percent of medical waste plastics that are IV bags – but the reference is 20 years old. I question whether this is still relevant regarding waste volume and regulation? A more current reference should be provided.</p> <p>P6, L27-28 re: single-use plastic in healthcare facilities. What evidence that it “grew exponentially”? Wasn’t there a heavy use of single-use plastic in health care before COVID? [Note: If COVID created a growth in single-use plastic, an opposing view would be that with far fewer COVID hospitalizations, the single-use plastic issue is not significant.</p> <p>P6, L28-30. None of the references provided (Refs 16, 22, 23) support the statement “multiple locations in the US paused recycling programs” because of COVID. Need reference to support the statement that U.S. healthcare facilities/clinics in the US paused recycling programs.</p> <p>P6, L30-32: Isn’t petroleum (fossil fuel) the feedstock for all plastics? Are there types of plastics being used in healthcare (or other applications) that are not petroleum based?</p> <p>P6, L30-32: The topic of climate change and healthcare waste is not well developed. The topic seems out of place in this part of the policy. [PS, para 4, climate change is mentioned as an intersecting issue but not developed there either. APHA is a signatory on the “U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda (2019) which calls for improved waste management practices in healthcare.</p>	
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	<p>(p.5)  <a href="https://climatehealthaction.org/media/cta_docs/US_Call_to_Action.pdf">https://climatehealthaction.org/media/cta_docs/US_Call_to_Action.pdf</a>  Mentioning climate change in this particular policy statement is not essential because APHA has a policy agenda and is engaged in advocacy on climate action.</p> <p>In the Evidence-based Strategies (EBS) (P9, L28-30), you indicate that Canada requires proof that medical waste has been treated before being disposed of in a landfill. If this is not the case in the U.S., describe this in the Problem Statement. Also at P9, L28-30, you mention “exorbitant disposal fees and illegal dumping.” Are one or both of those documented problems in the U.S.? (Since you use the Canada program as an EBS strategy, the Problem Statement should introduce these topics as problems with the current U.S. system. (Otherwise, if they are not problems, then using Canada’s program as an EBS doesn’t make sense.)</p> <p>P7, L1: Ref 14 (WHO, 2018) mentions pharmaceutical waste (as one of eight different categories of healthcare waste) and describes it within healthcare context of “expired, unused, and contaminated drugs and vaccines.” Manufacturing of pharmaceuticals, however, is not part of the definition they use for healthcare waste.</p> <p>P7, L4-6: According to the U.S. Geological Survey, the main sources of pharmaceuticals in waterways are human urine and feces and improper disposal in toilets of unused medications of pharmaceuticals; and run-off from agriculture lands animal</p>	
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	<p>waste that contains veterinary pharmaceuticals. No reference provided for statement about discharges from pharmaceutical plants.</p> <p>Regarding the topic of antimicrobial resistance (AMR). This topic is highly studied in the environmental/ecotoxicology field. You suggest that the primary problem is discharges from pharmaceutical manufacturing – but the abundance of data indicate that the bulk of drugs in waterways come from residential wastewater (urine containing the drugs or their breakdown products) or agricultural sources (similar route). See this reference or others <a href="https://link.springer.com/article/10.1007/s10311-021-01194-y">https://link.springer.com/article/10.1007/s10311-021-01194-y</a>. The AMR issue is extremely important as an ecological threat, but is not addressed in any of the proposed policy solutions is not as likely to be disproportionate re: impact on communities, and has such different control needs than the other healthcare waste. Reconsider including this topic in the policy statement. If it is to remain in the document, consult with an ecotoxicologist, environmental fate and/or exposure scientist to better describe the issues and potential remedies.</p> <p>P7, L3-8, Reviewers were unable to match up the content of these sentences with Ref. 25. It doesn't include the topics mentioned in L3-8; (Word searched: discharges, manufacturing, resistance; income;</p>	
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	<p>pregnant; vulnerable; community; community-acquired)</p> <p>P7, L11: Distinguish “regulated medical waste” from healthcare waste. (Is regulated medical waste a subset of healthcare waste?)</p> <p>P7,L11: Explain to readers that states and territories are primarily responsible for regulating medical waste, including how it is defined and managed. [P8, L19: How many states/commonwealths/territories do not have their own laws (you use the term “independent laws”) on RMW?]</p> <p>In the Action Steps, you say that the state-by-state regulation of medical waste “perpetuate EJ issues.” (This would be a topic to first address here in the PS.) Explain and/or provide examples of how the state-by-state approach contributes to environmental injustice. Are some state regulations of medical waste better than others?</p> <p>The following, for example, are ones from Massachusetts and Washington. Commenters provided information about healthcare waste regulations in their states.</p> <p>Commonwealth of Massachusetts. Department of Health, Minimum requirements for the management of medical or biological waste. 105 CMR-480.000 <a href="https://www.mass.gov/doc/105-cmr-480-minimum-requirements-for-the-management-of-medical-or-biological-waste-state/download">https://www.mass.gov/doc/105-cmr-480-minimum-requirements-for-the-management-of-medical-or-biological-waste-state/download</a></p> <p>Washington State (Utilities and Transportation Commission), see <a href="https://www.utc.wa.gov">https://www.utc.wa.gov</a>.</p> <p>Also, at P9, L22-24 refers to healthcare waste management in</p>	
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	<p>North Carolina. Is it an example of a state with good regulations on healthcare waste?</p> <p>Are there reports or other sources of information with interstate comparisons of waste management methods and strategies to help identify best practices?</p> <p>P7, L16. Ref. 30 (CDC, 2003) does not include the terms “dioxins and furans.” Is the citation meant to go with the previous sentence (ending with “...or incinerated.”)? Provide references to demonstrate that current incineration facilities release dioxins and furans---and/or that the resulting ash contains those contaminants and is then transported and disposed in landfills.</p> <p>P7, L16 “infectious waste” new term? (if not, use consistent terminology (see notation above about defining healthcare waste)</p> <p>P7, L17-18. Ref 8 (WHO, 2014 [sic], 2020) includes information on 8 billion doses of SARS-CoV-2 vaccine. Reviewers did not see a reference however for the statement that the vaccinations created “additional 143 tons of regulated medical waste.”</p> <p>P7, L20-21: Ref. 31 mentions cremation processes generally, but does not describe increases in air permit violations (in the U.S. or elsewhere)</p> <p>P7, L20-21: Ref. 32 does not say that air permit violations occurred; instead it suggests the South Coast Air Quality Management District was monitoring/limiting cremation</p>	
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	<p>services in order to prevent elevated air emissions that would exceed air quality standards.</p> <p>P7, L22-23: Ref. 33 (Faghri, et al) does not mention workers who handle waste. (Reviewers searched for words: waste, medical waste, disposal, sharps, plastic)</p> <p>P7, L25-27: The “For instance” suggests to a reader that the Asfaw paper is about healthcare waste. Restate with greater accuracy/precision the methods and findings of the Asfaw paper (and perhaps move it elsewhere.) Note the paper is a window into three potential work-related risk factors (specifically, ability to work from home, physical distance at work, and type of occupation) to illuminate the disproportionate risk of COVID-19 among some racial and ethnic minority groups in the U.S.</p> <p>P7, L26: change “populations” to “people”; at L27, change “These populations” to “They”</p> <p>P7, L27-28: change “than others in the healthcare workforce,” to “than other workers” (There are other workers in healthcare who are also people of color and are paid low wages and face more hazards. Not correct to say/no data to support that those who handle medical waste experience work and life stressors to a greater degree. Use Ref. 33 (which does discuss the topic of “essential jobs” and greater risk.)</p> <p>P7, L27 (Asfaw 2021) explores the potential for exposure to COVID-19 specifically – not to infectious agents in general as suggested. Please</p>	
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	<p>identify another reference to support their statement if the aim is to assert exposure to infectious agents in general.</p> <p>P8, L1: Re: “given the patchwork.” Provide more information for readers to see a “patchwork.” Perhaps say something like “There is a patchwork of...”</p> <p>P8, L1-22: This seems to be your views on the crux of the problem, that is, there is no federal law. It would be more clear to describe the different laws, and then end with your conclusion at L2-3 (about the scale and impacts...)”)</p> <p>Explain how a federal definition of medical waste would address the EJ problem and/or is related to the EJ problem.</p> <p>P8, P16-18: Add a sentence about how WMTA came about (i.e., impetus was several incidents of medical waste washing ashore in waterway/oceans.)</p> <p>P8, L18: Singh et al 2021 may not be the best reference regarding the role of MWTa and its expiration. See for example, GAO report (GAO/RCED-90-86 (1990). See also the Report to Congress as required at the expiration of MWTa: Lichtveld, MY, Rodenbeck, SE, Lybarger, JA. The findings of the Agency for Toxic Substances and Disease Registry Medical Waste Tracking Act report. <i>Environ Health Perspect.</i> 1992;98:243-250.</p> <p>P9, L18-22, needs additional details and supporting evidence to present a clear argument. The current language</p>	
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	<p>cites “Many states” and “some states” and do not include references. Provide examples/description.</p> <p>P10, line 28 –cites Health Care w/o Harm (Ref 11) to support their claim that “we know that communities surrounding landfills and incinerators experience adverse health effects.” Ref 11 is focused on climate change and seems to have no reference at all to landfills. Identify a more relevant reference to support this point. Is the solution a federal law that is enforced/administered by the states? (Similar to other laws administered by EPA?) And with more robust assessment of EJ pursuant to Executive Order 12898 and/or other federal policy? The federal standards/state enforcement model is one that is repeated in several laws administered by EPA. Could a strategy be an amendment to RCRA?</p> <p>Reviewers need clarification on the issue of federal agencies with regulations on healthcare waste. (Some agencies are mentioned, but we wonder whether there are others.) We understand the statement to be saying that EPA does not have specific healthcare waste <u>tracking</u> regulations. If this is the case, rephrase page P8, L14 to be definitive. Start the sentence with something like: There are no federal regulations for tracking RMW....” Tracking seems to be a different matter than the issue of how healthcare waste is to be handled/managed/processed. If that’s true, clarify that point (i.e., there are federal regulations on how hazardous waste (which includes healthcare waste) must be</p>	
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	<p>handled/processed, but the gap is in the transport and final disposition). Is that the problem?</p> <p>OSHA, DOT, Veterans Admin (maybe others) have their own regulations or they point to OSHA's bloodborne pathogens regulation (29 CFR 1910.1030). OSHA's rule is not applicable to final disposal of medical waste (where it is sited.) (See OSHA Interpretation letters (2003 and 2007) for further information):  <a href="https://www.osha.gov/laws-regs/standardinterpretations/2003-01-02">https://www.osha.gov/laws-regs/standardinterpretations/2003-01-02</a>  <a href="https://www.osha.gov/laws-regs/standardinterpretations/2007-10-26-0">https://www.osha.gov/laws-regs/standardinterpretations/2007-10-26-0</a></p> <p>P8, L11-13: U.S. Dept of Transportation regulations should be described in a couple of sentences. This document may be helpful: DOT, EPA, DOD, et al. (2019) "Managing Solid Waste Contaminated with a Category A Infectious Substance" (p.xi)</p> <p><a href="https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/transporting-infectious-substances/6821/cat-waste-planning-guidance-final-2019-08.pdf">https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/transporting-infectious-substances/6821/cat-waste-planning-guidance-final-2019-08.pdf</a></p> <p>P8,L10-13: Unclear. Do FEMA and USDA have healthcare waste regulations also?</p> <p>P8, L5 (Ref 35) The OSHA standard does not simply "advise" employers to have a plan to manage infectious waste, but it is required in order to protect potentially exposed employees.</p> <p>P8, L8-9: What is the evidence that incinerators in the U.S. do not comply</p>	
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	<p>with the Clean Air Act's Hospital Medical Infectious Waste Incinerator standards? Is that a factor in the communities being over-burdened? If incineration is part of the problem proposed a strategy to address the problem.</p> <p>P8, L2: You mention privatization of medical waste handling. Is there a non-privatized option? Is it more effective at addressing the problem of medical waste transported through and/or managed in EJ communities? If so, describe problem of privatization vs the non-privatized system. Or is your point that the fact that it is privatized (as nearly everything is in the U.S. system, that more regulation is needed?)</p> <p>The Joint Commission (and perhaps the Accreditation Assoc. for Ambulatory Health Care and other accrediting bodies) has standards on healthcare waste. (Joint Commission, Facility: Hospital. Chapter: Environment of Care. EC.02.02.01). What is missing from these---or is it that oversight inadequate? Could intervention involving The Joint Commission be an opportunity? Is it that the Joint Commission standards do not cover the transport and disposal component of healthcare waste.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what</p> <p><b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed</p>	<p>P8, L25-26: (Ref. 39): Mention of "the 6 Rs" was not seen in the reference (an NGO pamphlet.)</p> <p>P9, L11: Reviewers need clarification. Could the statement read: "An alternative to incineration is pre-treating regulated medical waste (i.e., sterilized by autoclave,</p>	



<p>strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>irradiated) which allows it to be disposed of as non-hazardous solid waste.”</p> <p>P9, L11-13: Ref. 42 does not seem to have the term “Sterilwave” (Searched for words: Steri, Steril, wave)</p> <p>P9,L10-11: EPA (2021) document suggests that the incineration process in the U.S. is safe: EPA (2021) Community Guide to Incineration. (<a href="https://semspub.epa.gov/work/HQ/401609.pdf">https://semspub.epa.gov/work/HQ/401609.pdf</a> ) Cite examples that indicate that existing incineration practices in the U.S. are “quite harmful.”</p> <p>P9, L15-16: “Existing programs”: Provide an example of a take-back program (voluntary or mandatory), and a reference.</p> <p>P9, L20-22: No need to restate a problem. Save space to focus on the EBS.</p> <p>P9, L22-24. Ref. 44 Weak reference. The Powerpoint slides do not describe an initiative/program. (The EBS section is meant to highlight strategies that are in place and/or being tried.)</p> <p>P9, L27: Delete: “To improve its own poorly regulated system” Begin with “The U.S. can look...” Or simply “In Canada...”</p> <p>Additional sources of information to consider:</p> <p>*National Research Council. Committee on Health Effects of Waste Incineration. Waste</p>	
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	<p>Incineration and Public Health. Washington (DC): National Academies Press, 2000. It includes information on medical waste. Perhaps it includes useful definition(s)</p> <p><a href="https://www.ncbi.nlm.nih.gov/books/NBK233614/?report=reader">https://www.ncbi.nlm.nih.gov/books/NBK233614/?report=reader</a></p> <p>*U.S. Department of Transportation definition of “Regulated medical waste is at: 49 CFR 171.134.</p> <p>* Mohai,P., Saha,R. (2007). Racial Inequality in the Distribution of Hazardous Waste: A National-Level Reassessment, Social Problems, 54(3), 343–370.</p> <p>*Soliman, M. R., Derosa, C. T., Mielke, H. W., &amp; Bota, K. (1993). Hazardous wastes, hazardous materials and environmental health inequity. Toxicology and Industrial Health, 9(5), 901-912.</p> <p>*Vinti et al (2021). Municipal Solid Waste Management and Adverse Health Outcomes: A Systematic Review. Int J Environ Res Public Health. 2021 Apr; 18(8): 4331.</p> <p>*Streed, S. A. (1992). The medical waste conundrum revisited. Infection Control &amp; Hospital Epidemiology, 13(7), 385-386.</p> <p>Are there cost-benefit analyses/cost-effectiveness analyses on the use of healthcare waste for other products?</p> <p>Assess whether the disparity issues/EJ issues are adequately addressed by the EBS and AS. Even with implemented strategies, would low wealth communities still bear most of the burden for healthcare waste?</p>	
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	<p>The strategies offered are of mixed rigor relative to their evidence base. The suggestion that the US should look to other countries for waste handling is not adequately researched. You are strongly encouraged to reconsider their recommendation that the US follow ‘innovative strategies’ for waste handling in China and India (P10). The references they provide indicate some of the current approaches in these countries but also note that these processes have been overwhelmed by the COVID-19 pandemic, facilities are aging and unable to meet demand, etc. Consider also the significant environmental hazards and community exposures in China/India making promotion of their practices problematic.</p> <p>The evidence base for a recycling strategy could be further strengthened by adding a more robust and nuanced view of the opportunity as well as its potential challenges (economic, environmental, logistical, etc). For example, Ref 42 (Wyssusek et al 2019) indicates “ until recently a significant portion of the worlds’ recycled plastic, paper and scrap metal have been exported to China. Up to 70% of the world’s plastic waste alone was exported to China and Hong Kong in 2016 (Coghlan, 2018). However, recently China has put a ban on such waste imports causing a global panic around where else to divert the increasing volumes of recyclable waste (Coghlan, 2018), raising the question of sustainability of recycling after all.”</p> <p>P9, L3-4, Provide evidence and Reference. In addition, the UCLA</p>	
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	<p>example on reusable surgical gowns is not adequate evidence of the feasibility/cost implications. Also assess/address how adopting this practice could pose liability issues (consult with Medical Care, Legal, and/or Ethics Section), or demerits on accreditation standards (e.g., Joint Commission, Accreditation Assoc. for Ambulatory Health Care (AAAH)) (and/or do accrediting bodies need to be involved in waste-reduction efforts.)</p> <p>P9, L1-3: Please check to see if the pilot project converted to a permanent solution, and the result/expansion to other departments/impact. (The factsheet is dated Dec. 2015. Don't want to point to a strategy that is no longer in place/wasn't sustainable.)</p> <p>P9, L1-3: Modify wording, such as: In a pilot study, the Ronald Reagan UCLA Medical Center switched to reusable surgical gowns. Over 3 years, 297 tons of waste were diverted from the landfill. The gowns were thicker, offering more protection than traditional single-use gowns.</p> <p>P9, L6-7, In Ref. 42, reviewers cannot find Kaiser Permanente or Cleveland Clinic mentioned. If they have programs, it would be helpful to describe what they do differently than other healthcare facilities. (e.g., what are they recycling and how are their programs unique/more effective.)</p> <p>P9, L8-10: Ref.44 is a weak. It speaks generally about re-using, but doesn't mention autoclaving as a way to improve efficiency of recycling; is</p>	
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	<p>largely about disposal. Reuse/recycling is barely mentioned.</p> <p>P9, L10-11: How is “out-of-date” defined? Are “out-of-date” incinerators not subject to Clean Air Act regulations? The following document suggests that all medical waste incinerators are subject to the Clean Air Act. DOT, EPA, DOD, et al. (2019) “Managing Solid Waste Contaminated with a Category A Infectious Substance” (p.xi)  <a href="https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/transporting-infectious-substances/6821/cat-waste-planning-guidance-final-2019-08.pdf">https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/transporting-infectious-substances/6821/cat-waste-planning-guidance-final-2019-08.pdf</a></p> <p>P9, L22-24: if NC is an example of a state with good regulations on healthcare waste, use info from their rules/program as an example in PS, or model for EBS.)  It seems that the Evidence-Based Strategies favored are change in law. They mention five countries, but it’s not clear how the laws/regulations in these countries are different from U.S. law and/or regulatory approach. Is it that these countries have national requirements? If so, you provide a few comparisons of provision(s) in their laws to difference in U.S. federal/state laws. How do the laws in these countries address the environmental injustice issues?</p> <p>P9, L32/P10,L1: Provide more information about the Queensland, Australia program. Ref. 42 briefly describes a color coded bags (black, yellow, red, clear, orange) to distinguish different types of waste. Is that a strategy not used in the U.S. (or not mandated) and one you are proposing?</p>	
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	<p>P10,L5-7: The example from Hubei, China (Ref. 43) suggests this was an emergency measure during COVID-19 ----being that Wuhan (in Hubei province) was the sentinel location for the virus. Are you proposing mobile incineration as a preferred strategy for healthcare waste (at facilities that don't have incineration in place already)? Is it appropriate to hold up China as a model (e.g. the country is not the largest annual contributor to CO2 emissions.)</p> <p>P10, L8, Use of the word "lessons," but you don't provide any lessons/evidence.</p> <p>P10, L8-11. Delete. Save space for EBS by deleting this part which simply restates the problem.</p> <p>P10, L11: Delete "missed"</p> <p>P10, L12-14. Use IRS Tax Code (Section 501(r)(3) for the reference.</p> <p>P10, L14-15: By design, CHNA's are based on a community assessment---not a predetermined list of what must be identified as a community need. This IRS webpage (and there are other sources) describes requirements for the CHNA provision of the ACA, including requirements for community engagement in developing a CHNA. <a href="https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3">https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3</a></p> <p>P10, L15. [Delete] Instead, include examples of CHNAs that have looked beyond the most common health indicators used (e.g. access to care, obesity, diabetes, insurance)</p>	
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	<p>and included built environment topics or others. Look to EJ leaders who have examples to use as evidence of the ways that CHNAs have been used to identify less-typical “health needs.”</p> <p>P10, L15-18: Delete (not an EBS---a sentiment.)</p> <p>P11, L3-4: is the research/investigation on disinfection examining the potential/warding off the potential for “regrettable substitution” with hazardous agents being used for disinfection?</p> <p>Consider the following as other possible strategies:</p> <ul style="list-style-type: none"> <li>• Is there is a role for quality improvement officials within health care facilities/clinics respect to waste management/waste reduction strategies. What departments are typically responsible? (Environmental Services Departments?) Are there examples from the relevant department on other issues that could be replicated regarding healthcare waste?</li> <li>• Are there examples of community risk assessments or novel evaluations to investigate exposure routes/scenarios that generate risk for communities, and appropriate interventions?</li> <li>• Would educational initiatives targeted to healthcare workers, waste handlers, and communities waste disposal and handling, and</li> </ul>	
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	<p>regulatory/legal interventions available to reduce exposure be useful?</p> <ul style="list-style-type: none"> <li>Does LEED certification include waste reduction as criteria for day-to-day operations of healthcare facilities/clinics? If so, add examples</li> </ul>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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.)?</p>	<p>The strength of the evidence used to refute the opposing viewpoints is mixed. Each opposing view should be stated and then responded to with evidence (i.e., an evidence-informed rebuttal.) At the end of this Section, reviewers provide additional opposing views for you to consider.</p> <p>P10, L20-24: To free up space, delete this information and go directly to each opposing/alternative view.</p> <p>P10, L27-28. [OV #1] Ref. 11 does not really address the topic of communities near landfills and incinerators. (Searched for words: landfill, incinerators, communities.)</p> <p>P10, L25: [OV #1] add “disproportionate impact on communities of color and low-wealth...”</p> <p>P10, L26-27. [OV #1] Instead of saying “there is no way of knowing” write something like this (of course, check for accuracy): “There is not a national system to track the transport and disposal (landfill or incineration) of regulated medical waste, and only [#] number of states have a tracking system to examine potential health disparities. However,</p>	



<p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<p>[next add data on locations of incinerators and landfills more likely being in these communities.</p> <p>P10, L28-30. [OV#1] You could be more explicit and say something like: “As of 2019, 73 municipal solid waste (MSW) incinerators operate in the U.S. and 79% of them are located in EJ communities. (Ref. 4). What data is available on landfills that are permitted to accept regulated medical waste?</p> <p>P11, L1-3 [OV#2]: Statement is not clear. Is the opposing view that healthcare facilities are required to use single-use plastics to protect patients and staff from biohazards? Are you only talking about single-use plastic PPE in this OV?</p> <p>P11, L1-3 [OV #2]: More clearly refute the argument for the need for single-use plastic. “given the ecological impact and use of fossil fuels” use evidence/data in rebuttal (rather than just citing a document) The sentence that begins “Disinfection and reuse...” is difficult to understand.</p> <p>P11, L1-L6 [OV #2] The feasibility of re-use of single use PPE is unclear even per the source cited “recycling without risking infection of individuals working as recyclers in middle- and low-income countries is limited by the low proportion (15–25%) of healthcare waste that is not contaminated.” (Ref 49)</p> <p>P11, 1-6: [OV#2] (Economic issue) Healthcare waste is made up of a lot of non-hazardous waste, with a small portion regulated medical waste. Is an opposing argument that it is</p>	
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	<p>impractical and/or too costly for healthcare facilities to separate into recyclable non-hazardous, solid waste non-hazardous, food waste, and regulated medical waste? If this is an opposing argument, what is the rebuttal? (Is there data that would allow us to say something like: X% of healthcare facilities have effective programs to divert waste from landfills and incinerators?)</p> <p>P11, L7-11: [OV#3] Are these two different opposing arguments, i.e., (1) waste to energy and (2) recycling to create new products? You do not rebut, but instead, make the case for waste-to-energy. Also, is making new products from waste a bad idea?</p> <p>Additional opposing arguments for consideration:</p> <p>(1) Small healthcare systems, especially those serving rural communities and/or providing care to the uninsured/indigent may not be able to implement these changes (improved hazardous waste management/source reduction, as well as CHNA) because of cost or lack of expertise.</p> <p>(2) The potential for new recycling or handling requirements to increase costs of healthcare and healthcare supplies in a way that would disproportionately impact disadvantaged populations in terms of costs and/or access to care.</p> <p>(3) Laws/policies that require packaging and biopharma manufacturers to pay the cost of waste will result in cost shifting to healthcare providers, then to patient/patients.</p> <p>(4) Concern about the potential for infectious risks associated with re-using medical supplies and/or PPE,</p>	
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	<p>other medical products; Liability issue for healthcare providers/clinics/facilities if supplies/equipment are not disinfected properly and leads to adverse outcome in patients or employees.</p> <p>(5) Cost of implementation. (e.g., Initial implementation costs and ongoing cost.)</p> <p>(6) Healthcare industry is reeling from a pandemic----opposition to adding new requirements/mandates on the industry (which links to possible cost-shifting/equity issues)</p> <p>(7) Limited data on the link between specific health effects related to each waste management method.</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>c. Supported by the evidence or rationale documented in the proposal?</li> </ul> <p>Are the action steps evidence-based, ethical,</p>	<p>The evidence base or rationale for the proposed AS vary in their rigor and completeness. In a revision to the policy statement, be more intentional about linking AS to EBS and evidence presented in the PS. The ethics and equitability of these proposed AS should be discussed in the PS or EBS. For example, there should be a more complete discussion of the potential risk--benefit tradeoff of moving away from single use materials for healthcare (e.g., infection risks, unintended effects of recycling process, elevated costs, etc.)</p> <p>It is also unclear whether some of the proposed actions on recycling and waste management might reduce impact on EJ communities in the US but transfer the impact to other communities globally as this phenomenon is prevalent already.</p> <p>P11,L20-21: Do you simply want a GAO report (that could possibly lead</p>	

<p>equitable and feasible? If not, please explain?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>to legislation) or do they want legislation? You call for GAO report, but don't explain its value. Include in the PS a mention of the March 1990 GAO report on medical waste which made recommendations. Perhaps part of the problem is that there was no or inadequate follow-up on the recommendations. Does the 1990 GAO report identify gaps that remain today that bear repeating?</p> <p>P11, L21: Delete "public"; nearly all congressional hearings are public.</p> <p>P11, L26-28: Is there a reason that the you do not call on Congress to pass legislation akin to the MWTA? L30-31 mentions requirements for data reporting of states and private waste management companies. Presumably this would need to be mandated by Congress in something like WMTA? If you are calling for a new WMTA, they could list a couple of things the law should include.</p> <p>P11, L29-30: Unclear. Nothing is mention previously in the statement about Superfund (CERCLA) or Brownfields (RCRA). Do these sites have something to do with regulated medical waste?</p> <p>P11, L30: The term "waste flow patterns" is not explained elsewhere in the document.</p> <p>P12, L1: Health Impact Assessments are not described in the PS or EBS so this Action Step doesn't flow from what has been presented previously. The phrase "must consider" is unclear. Are the you calling on state legislatures to study this issue? To pass laws requiring HIAs for new and existing sites that process medical waste?</p>	
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	<p>P12, L 4-5: AS#3 (directed at local governments) says they “should consider.” By “considering implications of existing and future waste management” how does that actually address the problem? Or is the point that this is a means to assemble more data to characterize/document the scope of the problem? This AS doesn’t seem to be specific to healthcare waste. Is that intentional?</p> <p>P12, L1-5, AS#3: re: state and local governments. PS or EBS should discuss this topic (e.g., what type of assessments are currently required, examples of best-practices from states/localities, and their demonstrated benefit.) (An opposing argument would likely focus on the economic and technical capabilities of local governments to conduct the proposed cumulative impact analyses should also be included (e.g., technically challenging, methods often unavailable, and resources can be limiting.)</p> <p>P12, L9-12: See comment re: P9,L15-16: about “existing programs” (take-back). Information in AS describes problems with take-back/polluter pay programs. This would be a topic to include in PS or EBS.</p> <p>P12, L13-14, AS#6: The topic of supply chain management is not addressed in the EBS. The feasibility of the proposed supply chain modifications and reuse scenarios is unclear. The issue of re-use is an important consideration and should be incorporated, but might be better focused on the need for research and incentives to drive change.</p>	
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	<p>P12,L 13-17: The topic of supply chain management/sustainability experts are not addressed in EBS.</p> <p>P12, L18-22: You don't describe in the PS the current OSHA education and training requirements and how they are deficient. (For example, OSHA doesn't have general education and training requirements for supervisors or workers. Some specific standards require worker training on the hazard and OSHA requirements. Is there one you have in mind? For example standard on hazardous waste and emergency response (1910.120), bloodborne pathogens (1910.1030) Or others? <a href="https://www.osha.gov/sites/default/files/publications/osh2254.pdf">https://www.osha.gov/sites/default/files/publications/osh2254.pdf</a></p> <p>P12, L18-22: Nuance the language. That is OSHA standards place responsibility on employers to ensure hazards are eliminated or controlled, not putting the onus on workers to protect themselves (when many have no control over their work environment.)</p> <p>P12, L23-27: You don't describe "waste management plans" elsewhere in the document. Are there existing rules requiring these plans? If not, are their models to point to in EBS section?</p> <p>P12, L28-33: The issue of waste management workers not having PPE is not mentioned in the PS. Is there evidence that PPE required by OSHA or state regulations is being violated?</p> <p>P11, L31: EJ Screen is not mentioned elsewhere in the document. Consider adding it as and EBS</p>	
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	<p>Are there actions to proposed at the local level?</p> <p>Is another AS to increase funding for local governments to be able to provide more and better protection to communities who are most affected by healthcare waste. (Are their examples of other EJ issues that have resulted in targeted funding?)</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>Numerous notations above about text that is not supported by the Reference provided.</p> <p>Ref. 8 (WHO, 2014) --- the correct date is 2022.</p> <p>Ref. 21: Acknowledge that this research was in just a few hospitals in a single U.S. and may not be representative of the nation.</p> <p>Ref. 26 (survey of just 5 of 50 top drug firms) seem to be low-validity. Note that the evidence is very limited; information gaps/research needed could be part of the PS.</p>	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>A revised version of this proposal would benefit from additional review from individuals with expertise in environmental toxicology and environmental health.</p> <p>Consult with Law Section, Medical Care, Ethics on the liability, legality of re-using medical supplies, as well as accreditation standards for health care providers (e.g., Joint Commission)</p>	

## B2: Public Health Opportunities to Address the Health Effects of Gas Stoves

### Spring Assessment: Negative

IMPORTANT: Action Step 9 is plagiarized (text lifted verbatim) from the report: Seals, B.A. & Krasner, A. Health effects from gas stove pollution. (2020) Rocky Mountain Institute, Sierra Club, Physicians for Social Responsibility. [ <https://rmi.org/insight/gas-stoves-pollution-health>]. Plagiarism violates our professional ethics. The document is listed in the references, but no citation is provided for language. It must be appropriately cited and rephrased.

Note to authors: Acronyms used in the comment Problem Statement (PS), Evidence-based Strategies (EBS), Opposing Views (OV), and Action Steps (AS).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	Revise the title to reflect that the hazards are the emissions from gas stoves which is the Public Health concern	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the	Delete 200012. This policy statement was archived in 2020 (only active statements should be listed here).	



proposal updates the science of the older policy statements?		
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>a. Are there important facts that are missing from the problem statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>6</sup>, equitable<sup>7</sup>, political or</p>	<p>The problem should be positioned in some way with respect to housing quality for low income and/or Black, Indigenous, and People of Color, (BIPOC) people. Health disparities exists because of poor quality housing, disinvestment in communities, discrimination, housing costs, energy costs, etc. Emissions from gas stoves are only one source of indoor air contaminants and other hazards in housing which drive health disparities. Interventions to address housing quality could involve ones that target several indoor air contaminants.</p> <p>Add language noting the investment and approaches needed to support an inclusive and equity-based transition away from fossil fuels. APHA is a signatory on the “U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda (2019) which calls for a “transition away from wood burning, oil, and natural gas use for home heating and cooking.” (p.3)  <a href="https://climatehealthaction.org/media/cta_docs/US_Call_to_Action.pdf">https://climatehealthaction.org/media/cta_docs/US_Call_to_Action.pdf</a></p> <p>You describe the problem with respect to air contaminants from gas stoves and provide some evidence, but the evidence</p>	

<p>economic<sup>8</sup> issues.</p>	<p>appears incomplete. The studies cited show association, not causation due to other variables in vulnerable community households. It is hard to assess to what extent gas stoves contribute to the adverse health outcomes.</p> <p>Clarify the causal interpretations of the presented studies, for example by presenting some additional evidence on the causal pathway (e.g. dose response questions (i.e. do adverse outcomes increase with people who cook more frequently); are appropriate confounders, (i.e., presence of mold, pests, etc.) taken into account and how does that change findings? do health effects go away if people get their gas stove replaced with electric or move elsewhere? Also, suggest adding the threshold at which we start to see health effects would be useful.</p> <p>Evaluate whether the international studies are relevant to US households. For studies with high internal validity (from other countries, for example), address external validity to U.S.</p> <p>In addition, substandard/low quality housing also includes the issue of people who do not have any kind of working stove which can exacerbate poor nutrition.</p> <p>There is only one study (Ref. 3) indicating that gas stoves in US are a major contributor to global</p>	
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	<p>change. This may well be true, but we do not usually base policy on one study. [CM Note: Ref. 3, 4</p> <p>A deficiency in this proposed policy is the financial feasibility (new appliances, portable cooktops, installation/maintenance of filtration devices, ventilation hoods, central ventilation.) This is particularly relevant for people living in some places in the country, gas heat, water heaters, appliances result in lower monthly energy bills than electric power; as well as the unreliability of the electricity grid (in rural places) where gas is more reliable. Need to address this equity issue for families who do not have the resources to absorb the additional upfront cost of replacement and higher monthly energy cost. Equity issues: need to make sure any new standards do not financially harm people with lower incomes and that supports are provided to help with the transition. This document may be relevant for both the evidence-based strategies section and action steps with respect to additional investment and approaches needed to support an inclusive and affordable transition away from fossil fuels.  <a href="https://rmi.org/insight/outdoor-air-quality-brief/">https://rmi.org/insight/outdoor-air-quality-brief/</a></p> <p>P5,L153-154: Provide page number in References for Ref. 11.</p>	
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	<p>Add information about thresholds at which PM<sub>2.5</sub> and NO<sub>2</sub> emissions from gas stoves become adverse to health. For example, are interventions long-term solutions to reducing risk?</p> <p>Suggest adding additional studies re: impacts on adult health and not just children and young adults; could add more evidence from systematic reviews, if available. Are studies available documenting exposures in restaurants or industrial kitchens which could help strengthen the evidence of exposure and harm?</p> <p>Add pregnant people to list of vulnerable populations (impact of PM 2.5 on fetal outcomes)</p> <p>The problem statement could describe briefly the regulatory landscape to address household indoor contaminants. Who is or is not responsible? Does HUD have any requirements on IAQ? Army/Marine Corp bases? State/localities? Is the problem that no one is responsible for indoor air quality in residences?</p> <p>Climate change and its impacts on communities, and the need for a sustainable clean energy supply are complex topics to link in this policy statement. You already take advantage of the section “Relationship to Existing APHA Policy Statements” to mention those on natural gas extraction, climate change.</p>	
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	<p>Deleting content on climate change will free up space for further information on Evidence-based Strategies and Opposing Arguments. Be explicit that this policy statement is addressing two problems: direct health effects of emissions from gas stoves and use of gas as a contributor to climate change. [40% of U.S. electricity generation is powered by natural gas. (EIA. Electricity explained: Electricity in the U.S. Table: Sources of U.S. electricity generation, 2020. <a href="https://www.eia.gov/energyexplained/electricity/electricity-in-the-us.php">https://www.eia.gov/energyexplained/electricity/electricity-in-the-us.php</a></p> <p>P4, L134, change “of” gas appliances to “from” gas appliances</p> <p>P5, L146-147: PM2.5 is also associated with lung cancer.</p> <p>P5, L153: Include data on types of energy source for cooktops (Data from 2020 is available from U.S. Energy Information Agency. Table HC3.1 It indicates 31.9% of U.S. households used a range powered by natural gas (28%) or propane (3.8%). [DATA Tables: U.S. Energy Information Administration (EIA). (2022, March 30). Residential Energy Consumption Survey (RECS), 2020 Survey Data. <a href="https://www.eia.gov/consumption/residential/data/2020/hc/pdf/HC%203.1.pdf">https://www.eia.gov/consumption/residential/data/2020/hc/pdf/HC%203.1.pdf</a></p>	
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	<p>The EIA data suggests that gas stoves prevalence (by household income) is comparable across most income levels: about 15-17% for income levels \$20K-40K, \$40K-60K, \$100K and above. Gas stove prevalence 22% for household income \$60K-100K. (Prevalence 8% in household income less than 20K, and 3% in household income less than \$10K.) [DATA Tables: U.S. Energy Information Administration. (2022, March 30). Residential Energy Consumption Survey (RECS), 2020 Survey Data. <a href="https://www.eia.gov/consumption/residential/data/2020/hc/pdf/HCE%203.1.pdf">https://www.eia.gov/consumption/residential/data/2020/hc/pdf/HCE%203.1.pdf</a> ]</p> <p>P5, L154: delete “it is no surprise then, that”</p> <p>P5, L154: use different reference to support stronger reference for the statement of unique vulnerabilities of children (for example, papers by experts who are affiliated with the Children's Environmental Health Network (CEHN); Pediatric Environmental Health Specialty Units (PEHSUs))</p> <p>P5, L160-161: Rephrase for clarify, such as: “Surveillance data from 2006-2010 among asthmatic children in Massachusetts reported the prevalence in homes of environmental asthma triggers. Gas stoves were the most prevalent (54%) followed by pets and bedroom rugs and carpeting.”</p>	
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	<p>P5, L164. Rephrase for clarity, such as: “A prospective study from Massachusetts and Vermont found children with asthma had more severe asthma symptoms from NO<sub>2</sub> at concentrations of 11 ppb and their symptoms were exacerbated in a dose-response manner.”</p> <p>P5, L166: Delete parentheses “(for which...)”</p> <p>P5,L174. Delete “though”</p> <p>P6,L203-206: Referring to current APHA policy on climate change (20197) is already identified in “Relationship to existing APHA policies”</p> <p>P7, L214-216: Delete/unnecessary: “It has long been assumed by.” Delete “groundbreaking”</p> <p>P7, L220-221. Stretching the meaning of the text in the EPA report. The text concerns electricity consumption (from fossil fuels) for all household needs (lighting, heating, AC, refrigeration, cooking.) Having the statement doesn’t add much value.</p> <p>P7,L221 Provide a page number for the Ref #28 (it is difficult for reviewers to find the information referred to in the long EPA report.)</p> <p>P7, L221-223. The point you are making is unclear. Natural gas</p>	
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	<p>does burn cleaner than coal (see Energy Information Agency). If you want to provide context on contributions of natural gas to CO2 emissions generated in the U.S., say something like: Since about 2016, natural gas surpassed coal as the second highest source of CO2 emissions from fossil fuels. [Ref. 28] or remove the sentence altogether.</p> <p>P7, L223: Elaborate (in 1-2 sentences) on concept of supply chain (or delete the topic)</p> <p>P7, L224. Rephrase: APHA policy 20183 did not “condemn”</p> <p>P7, L236-237: Unnecessary. If adopted as a policy statement, we (APHA/health experts) will be expressing our concern/offering action steps to address the problem.</p> <p>Additional sources of information to consider:</p> <p>Zhu Y, Connolly, R, et al. (2020). Effects of residential gas appliances on indoor and outdoor air quality and public health in California. UCLA Fielding School of Public Health.  <a href="https://coeh.ph.ucla.edu/effects-of-residential-gas-appliances-on-indoor-and-outdoor-air-quality-and-public-health-in-california/">https://coeh.ph.ucla.edu/effects-of-residential-gas-appliances-on-indoor-and-outdoor-air-quality-and-public-health-in-california/</a></p> <p>Adverse health effects, commenter suggests adding info about indoor air quality and gastrointestinal conditions. (See:</p>	
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	<p>Vignal, C., Guilloteau, E., Gower-Rousseau, C., &amp; Body-Malapel, M. (2021). Epidemiological and animal evidence for the role of air pollution in intestinal diseases. <i>Science of the Total Environment</i>, 757, 143718.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>Evidence-based Strategies (EBS) should address equity issue with respect to poor housing, practical issue of costs of replacing gas stoves, installing ventilation hoods or filtration devices. Provide examples from U.S. cities (or from abroad) on how interventions have been instituted/financed. Are there examples of pilot projects or other initiatives to point to involving upgrades for other housing quality problems? How were they paid for/implemented? If and/or how well have they addressed the disproportionate impact on low-income communities?</p> <p>Beginn the EBS Section with P8, L252-253 instead of L240-243 because the statement focuses on the adverse respiratory health effects of emissions from gas stoves</p> <p>Cite EBS of how individuals can evaluate their risk and receive the information/tools to protect themselves? (If not on gas stoves, specifically, are their examples of comparable household hazards in which residents are the primary actors to implement interventions? (e.g., radon?)</p>	

	<p>Identify opportunities for HUD or DOD to act on this issue in ways supported by federal funding, e.g. requirements for Section 8 housing and housing on military bases?</p> <p>Discuss subsidies or grants for improved ventilation and/or electric appliances. Do the authexamples where such programs have been put in place for remediating/addressing hazards in homes?</p> <p>Address relevant indoor air quality regulations/guidelines from other countries?</p> <p>P8, L243-245. You mention the Berkeley, CA ordinance. If you are proposing it as a strategy, they should say more about how well the ordinance is working. What is the status? Is it effective? Was there a health impact assessment when proposed that describes the projected costs/benefits?</p> <p>P8, L245-246: In Ref. 32, the list and description of action in the 54 California cities/counties largely use the phrase “all-electric,” not similar policies to Berkeley. (That example refers to a “phase out of gas hook-ups). Instead of saying “have adopted similar policies” say something like phasing in requirements for all-electric energy service. Are there health impact analyses (HIA) from any of these cities that were motivator for the ordinances? Is their data</p>	
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	<p>in those HIAs that could be integrated into this proposed policy statement?</p> <p>P8, L247: Is there a Reference for info about New York City and other cities? (It would be helpful to be able to point to other places outside of California. One reason is that natural gas is inexpensive source of energy in some parts of the country (compared to electric)).</p> <p>P8, L248: Clarify/explain and/or provide Ref with respect to subsidies for “fossil-fuel appliances”? If you consider Ref. 33 appropriate, it doesn’t include the word “subsidies”</p> <p>P8, L250: “zero-polluting” or “zero direct polluting”? The term in the Ref. is “zero direct combustion emissions.”</p> <p>P8, Strategy 1 (indoor air pollutant guidelines): You don’t describe a strategy. Is it connected with what they describe in Action Step #2? <i>Clarity needed for reviewers:</i> Is it that EPA standard for PM2.5, CO, others in outdoor air have been effective at reducing illnesses and deaths. Since EPA does not have authority to regulation indoor air contaminants, should the guidelines simply be equivalent to the standards for outdoor air? OR is this strategy not about EPA guidelines, but rather EPA’s support for the items called for in the 2020 ASHRAE Position</p>	
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	<p>Document (e.g., research, review of appliance standards, product information)? If so, elaborate and then include as an Action Steps for EPA, or for Congress to mandate and/or fund these activities.</p> <p>Does EPA's Office of Air and Radiation develop outreach materials, collaborate with health and other professional organizations, and state agencies? Is there a role for this EPA office in public education and training?</p> <p>Action Step #11 refers to EPA recommendations for gas stoves/combustion products (Ref.46). Perhaps the related EPA recommendations for maintenance and venting outdoors should be mentioned in the section of the document.</p> <p>P8, L258-261/P9, L282-283: There seems to be a disconnect (or it is unclear) about the strategy for ventilation. You point to ANSI/ASHRAE standards on ventilation, but later indicate at L282-283 that ventilation is not effective for NO2 emissions. Perhaps the third strategy (at L280) should only mention filtration?</p> <p>P8, L258: Re: ANSI/ASHRAE: Do city/state residential building codes typically integrate ANSI/ASHRAE standards? If so, say that because then it would align with AS #3 about building codes. If not, explain why ANSI/ASHRAE codes are</p>	
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	<p>important/useful; who/how are they used?</p> <p>P8, L259: Add/include in References the ASHRAE standard (62.1-2019)</p> <p>P8, L265-266. The ASHRAE document on unvented combustion devices doesn't seem to mention warning labels. If so, please provide a page number.</p> <p>P8, L267-268: EBS#2 (replace or reduce use of gas stoves with electric). Are there examples of programs that have financed the cost of replacing stoves (or other products found to be polluting/hazardous)? (e.g., "Cash for clunkers" program?) [But, since you don't have a replacement-themed Action Step, an example may not be needed.)</p> <p>P8, L270: add "median" before "kitchen concentrations..." (to align with text in the study)</p> <p>P8, L271 Replace the word "swap." For example, writing something like: "Replacing a gas stove with an electric one is often most feasible at the end... ["swap" implies something that is easily accomplished]</p> <p>P8, L274 Consider replacing the phrase: "or lack of authority to swap appliances" with something like: "or permission from a landlord or other authority"</p>	
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	<p>P8, L275-277: Reducing use of gas stove (by using other appliances) will require outreach/education. Are there examples of effective programs akin to this related to household practices (e.g., community health workers teaching about asthma triggers?)</p> <p>P8, L275-277: This could be the place to mention the resolutions by medical societies and specifically their effectiveness. Such as, have they resulted in city ordinances, bills introduced in state legislatures, grants for appliance upgrades or filtration)</p> <p>P9, L280-301- Separate the information on ventilation and filtration. If filtration with HEPA filters is more effective than ventilation, mention filtration first.</p> <p>P9, L280-301. For clarity for readers, distinguish between local ventilation (exhaust hood) and central ventilation, and be consistent using the terminology.</p> <p>P9, L293-294: The phrase that begins “maintaining ventilation as an avenue....” Is unclear to reviewers.</p> <p>P9, L284: add “median” before “kitchen NO2 levels....” (to align with text in the study)</p> <p>P9, L285-287. Webpage at Ref. 38 indicates that the 2016 study would be published in 2019. Was</p>	
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	<p>it? Since the study was funded by HUD and involved the New York City Housing Authority is there additional follow-up information? Did the results lead to broader application of the intervention. For example, has HUD funded upgrades to central ventilation in places? Grant funds for cities/building owners?</p> <p>P9, L287: add “reported” before “health outcomes” (to align with study design)</p> <p>P9, L287-288: The phrase “This difference in results” is unclear to the reviewers.</p> <p>P9, L297: Add Ref. for ASHRAE 62.2</p> <p>P9, L298: should the word “standards or building codes” go after the word “construction”?</p> <p>P9, L299-301: “...though this may...” can be shorted to something like “if weather and outdoor air quality conditions permit.”</p> <p>Review the following two documents as support for EBS:</p> <p>EPA. (2021). Indoor air quality guidelines for single-family renovations. Pub.No. EPA-402K21001; and EPA. (2022). Indoor air quality guidelines for multi-family renovations. Pub.No. EPA-402K21002</p>	
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	<p><u>Ideas for Additional Strategy or Alternative Strategy</u></p> <p>Ref. 46 (EPA document) suggests that maintenance of gas stoves can reduce emissions. Is this another strategy? Are there best practices with respect to appliance maintenance that is available to homeowners, landlords, renters, used on military bases?</p> <p>EPA has its Energy Star program, but it does not appear that stoves are included in the program. Has Energy Star been used to promote appliance features beyond energy conservation/efficiency)?</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS?</b></p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>b. Is the proposed approach justified in comparison to opposing/altern</p>	<p>Each opposing view should be stated and then responded to with evidence (i.e., an evidence-informed rebuttal.)</p> <p>State more succinctly the two opposing arguments they mention from the American Gas Association (AGA). There's no need to mention specifically the AGA because there are other groups/lawmakers who hold these views, too.</p> <p>P10,L326: "robust body of scientific literature...." is imprecise. More accurately, there is a body of literature on exposure to NO<sub>2</sub>, PM<sub>2.5</sub>, CO, with some studies that specifically investigated emissions from gas stoves.</p>	



<p>ative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<p>Include these additional opposing/alternative views:</p> <p>(1) The costs of replacing gas stoves, installing ventilation or filtration devices; how is it paid for? Added expense for homeowners who may already face high housing costs. Renters may see cost of upgrades reflected in rent increases.</p> <p>(2) Consumer preference among all income levels for gas stoves (because of ability to better control cooking temperatures.)</p> <p>(3) For people in substandard housing, is replacing a gas stove their priority for upgrades to their housing? Are their investments in their housing that are more beneficial or preferred?</p> <p>(4) The California Restaurant Association's report may include other opposing arguments. (Tormey, D. &amp; Huntley, S. (2020) Issues that render the Sierra Club/UCLA study of Effects of Residential Appliances on Indoor and Outdoor Air Quality and Public Health in California, Not Useful for Decision-Making Purposes. California Restaurant Association and Catalyst Environmental Solutions. <a href="https://www.calrest.org/sites/main/files/file-attachments/ucla_study_-_natural_gas_stoves_-_tormey_critical_review.pdf">https://www.calrest.org/sites/main/files/file-attachments/ucla_study_-_natural_gas_stoves_-_tormey_critical_review.pdf</a></p> <p>(5) Discuss Environmental impact of increasing electricity use</p>	
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<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> <li>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ul> <p>*If additional action steps are needed, note whether you believe authors need</p>	<p><b>IMPORTANT:</b> Action Step 9 is plagiarized (text lifted verbatim) from the report: Seals, B.A. &amp; Krasner, A. Health effects from gas stove pollution. (2020) Rocky Mountain Institute, Sierra Club, Physicians for Social Responsibility. This is wholly inappropriate.</p> <p>[Link to full report in this webpage:  <a href="https://rmi.org/insight/gas-stoves-pollution-health">https://rmi.org/insight/gas-stoves-pollution-health</a> ) The document is listed in the References, but no citation provided for language lifted and used verbatim for Action Step 9. Citation must be provided and the language redrafted.</p> <p>Action Steps should address topics that were described in the problem statement and/or evidence-based strategies. That's not always the case (e.g., 5,7,8,10,11)</p> <p>Barriers to implementing these changes may be stronger among people with less control over their housing environment and thus such policies may be more likely to increase structural inequities even further. Recommend incorporating recommendations to reduce inequities throughout action statements</p> <p>A number of the AS, such as those that would mandate improved ventilation or filtration are likely have adverse economic impact on low-</p>	
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<p>to exceed the 10 page, 50 reference limits to address gaps and if so by how much.</p>	<p>income communities. For example, building code requirements may increase cost of rents/housing; improvements, replacement costs will be passed onto renters which will increase inequities. Without attention on strategies to ensure lower income communities benefit, disparities will increase; we see this potential consequence with AS #3, 4, 5, 6, 9, and 10. Consider adding AS that will benefit groups who may not have the capacity/finances to address the hazard.</p> <p>AS #1 and #2 are directed at many different players and some are not necessarily the best messengers for public health information (e.g., White House, Congress). Think about the role/responsibility of each actor and whether the AS is relevant/appropriate for them.</p> <p>AS #1: Uses the verbs “promote” and “recognize” but those don’t align with what we expect of these actors. For example, through what mechanism does Congress promote electric stoves or recognize the link between gas stoves and indoor air pollution? Congress passes laws and appropriates funding to agencies. Are there AS in which Congress would pass a law or appropriate funds for EPA, HUD, or CDC to do something?</p> <p>AS#1: The evidence presented in the document on the relationship between the use of gas stoves and asthma does not lend itself to the term unequivocal.</p>	
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	<p>AS #2: (P11, L352-353): Rationale for this AS should be moved to EBS and/or it may already appear elsewhere in the document. Delete "...which has achieved..."</p> <p>AS#2: Include information/examples in EBS describing instances in which EPA doesn't have statutory authority to regulate, but has used guidelines in an effort to do as much as it can.</p> <p>P11, L353-354: Reviewers know that EPA considers economic impacts when it proposes and finalizes regulations, but we are not familiar with the agency doing that when it develops guidelines. (Do you know otherwise?) In addition, it seems that having some cost information in guidelines may actually be helpful for homeowners, landlords. Some interventions may not be expensive as consumers realize and/or the guidelines might include information on programs for low-income people to cover cost of home improvements.</p> <p>P11, L354-358: Move the last sentence: "Although these EPA indoor..." to EBS, if not already mentioned there.</p> <p>P11, AS #3: The EBS about building codes is not well explained so it makes it difficult to assess this AS. Do local/state residential building/fire codes include the topics of central ventilation and/or outdoor-</p>	
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	<p>venting exhaust hoods? (This topic is explained well in EBS.)</p> <p>P11,L360-361: This is the first mention of “national ventilation guidelines.” Are these different from ASHRAE guidelines? How do these connect (or not connect) with building codes?</p> <p>P11, L359: add “residential” after “ensure”</p> <p>P11, L359-360: add “residential” after “new”</p> <p>P11, AS#4: (1) The topic of warning labels is not mentioned elsewhere in the document; (2) is the requirement for “appropriate ventilation to the outdoors for all new gas stoves...” a different requirement from the building codes in AS#3?</p> <p>P11, Lines 364-367: Are there examples of localities or states requiring warning labels on appliances or household furnishings or other consumer products? If so, describe in the Evidence-based Strategies. If no, is this an AS for Consumer Product Safety Commission (CPSC)? (Does that make sense and does the CPSC have authority to do it?)</p> <p>AS#9: A role for CPSC is not mentioned in the PS or EBS. What does CPSC “opening a docket mean”? How does it help address the problem?</p> <p>AS #9: Does CPSC have the statutory authority to give renters</p>	
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	<p>“the authority to fix the problem”? Can CPSC mandate carbon monoxide (or other) contaminant detectors, or replacement of appliances?</p> <p>P11,L368-369: AS about public health practitioners taking measures similar to tobacco are not described elsewhere in the document. Do the you have particular PH practitioners in mind? (e.g., community health workers? health departments? researchers?) If this is an important AS, you should include something about it in the PS or EBS. Once described elsewhere in the document, the AS can be concise.</p> <p>Combine AS #5 and #6 (public awareness efforts by respected voices). Consider addressing in EBS the ways that structural barriers can be diminished for individuals from whom interventions are not feasible (i.e., in order to prevent further health inequities.)</p> <p>AS#8: Should be directed at government or other funders. (Researchers can’t do it without funding.)</p> <p>Is there an appropriate AS on public education, for example by EPA, NIEHS, CPSC, CDC?</p>	
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<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>Ref. 28, provide a page number.</p>	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>Consult with F&amp;N Section about the language on P8, L275-277: (“shift some cooking events from their gas stove to other small electric appliances they already own, like microwave ovens, electric kettles, and toaster ovens”) Do these have potential adverse effect on diet and nutrition?</p> <p>Consult with CHW, MC, PHN about the capacity of CHWs, nurses, and/or physicians to take engage in public education about emissions from gas stoves and ways to reduce exposure.</p>	

## B3: Ending the Practice of Conversion Therapy Among LGBTQ+ Populations

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

<b>Criteria</b>	<b>Write a summary statement and include recommendations to the author.</b>	<b>Author's Response</b> <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	Clarify in title if policy is on the entire LGBTQ+ population, just LGBTQ, and/or minors and youth.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	Related APHA policy presented include: 1) APHA Policy Statement 20189: Achieving Health Equity in the United States 2) APHA Policy Statement 20185: Violence is a Public Health Issue: Public Health is Essential to Understanding and Treating Violence in the U.S 3) APHA Policy Statement 20178: Housing and Homelessness as a Public Health Issue 4) APHA Policy Statement 20169: Promoting Transgender and Gender Minority Health through Inclusive Policies and Practices	



- 5) APHA Policy Statement 201415: Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health
- 6) APHA Policy Statement 20143: Sexuality Education as Part of a Comprehensive Health Education Program in K to 12 Schools
- 7) APHA Policy Statement 20142: Reduction of Bullying to Address Health Disparities Among LGBT Youth APHA
- 8) APHA Policy Statement 200410: Proposed Resolution Condemning Actions Against LGBT and HIV Related Research and Service Delivery

No current (past 10 years) policy covers conversion therapy specifically. The policy is supported conceptually by the above prior policies. This focus potentially expands the way APHA supports efforts to promote and protect the health of diverse LGBTQ+ populations.

Remove the second sentence beginning "Often, this population is left out..." as confusing (transgender and gender minority pop is left out of research/policies advancing LGBTQ+ inclusivity?) Might involve a typo.

Third sentence beginning "Additionally, APHA has a policy that..." belongs more in the rational for consideration section. Consider clarifying that this is a policy APHA has "as an organization" not as a membership-approved policy.

<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>Please address the following queries:</p> <ul style="list-style-type: none"> <li>• P3, L64: while I'm aware of the intentional use of different acronyms (LGBT, LGBTQ+, LGB, etc.), others readings this may not be. Please clarify for the readership.</li> <li>• P3, L69: just homosexuality or another term that is more broad?</li> <li>• P3, L71: just familial relationships?</li> <li>• P3, L75-76: last sentence seems like it would be better served if it was moved up in the paragraph.</li> <li>• P3, L83, highlight lack of protections for LGBTQ+ youth when it comes to conversion therapy</li> <li>• P3, L84: the policy goes back and forth between SOGI, just SO, and just GI, please be consistent or explain the inconsistencies.</li> <li>• P3, L86: is a small case study that best evidence available?</li> <li>• P4: APA vs. American Psychiatric Association vs. American Psychological Association gets confusing because APA acronym is used inconsistently.</li> </ul>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>a. Are there important facts that are</p>	<p><i>Major concerns</i></p> <ul style="list-style-type: none"> <li>• The Rationale for Consideration starts the Problem Statement (PS). That full section begins the arguments needed in the PS and should be moved down below. If you want to keep the first two references (citing</li> </ul>	

<p>missing from the problem statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>i</sup>, equitable<sup>ii</sup>, political or economic<sup>iii</sup> issues.</p>	<p>prevalence of the LGBT and T communities) in Rationale everything else belongs in the Problem Statement. Only the final paragraph of “Relationship to existing APHA policy statements” contains content for the Rationale.</p> <ul style="list-style-type: none"> <li>• Within the Rationale language (again, recommended to move to PS): Expand and describing the relationship between conversion therapy and health impacts at greater length. Citations #7, 14, 15, appear to offer much more detail of relationships and effect sizes for various types of harm that can occur.</li> <li>• The problem statement should also add a section (1 or more paragraphs) reviewing the evidence connecting homophobia, transphobia, etc. and health outcomes.</li> <li>• Importantly, at the beginning of the section you need to define each of the explicit terms included in the L.G.B.T.Q. and also “+” so that these are not implied.</li> <li>• THEN you need to define the various terms for the intervention being described in this policy: CT, RT, SRT, etc. Are there nuanced differences between these treatments? Are the terms interchangeable? State clearly if they are perfectly synonymous.</li> </ul>	
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- There is alternate between the terms conversion therapy and reparative therapy with some frequency. Either chose one standard term (and state the reason why chosen) or define each term and then use as appropriate to their nuanced differences.

*Minor concerns:*

Within the current “Rationale for Consideration”

- Line 71 & 73 is an example of conversion therapy and reparative therapy terms being used in alternating sentences. This needs to be prevented through standardization and clear use when differentiation is necessary. Repeated issue extended on lines 80, 81, 82, 83, and 85 but the reason is unclear.
- Line 75, “61% of individuals were affiliated” please clarify if these individuals are therapy participants or “providers”.
- Line 99: Suggest adding ‘Conversion “Therapists often misrepresent...”’
- Line 104: beginning of the Problem statement starts with a two-part statement/claim. We suggest separating these – 1) youth are often coerced /forced and 2) Coerced participation can lead to trauma and neg. mental health

	<p>and dividing the citations appropriately.</p> <p>In addition, the following should be addressed:</p> <ul style="list-style-type: none"> <li>Line 110-112: The final sentence of the Problem Statement actually belongs in the Rationale for Consideration or even as an introduction to the Action Steps. It's not a statement of the problem though.</li> <li>Suggest adding some additional sources including the Trevor Project, who are doing this work. The guide they prepared on so-called "Conversion therapy" may help to fill in holes. So-Called "Conversion Therapy" and LGBTQ Youth Mental Health – The Trevor Project. For instance, include some discussion of the effects of family acceptance/rejection and links to suicidal behaviors. They also note the federal level work of Rep. Jackie Speier and the Stop Harming Our Kids Resolution to protect LGBTQ+ youth from conversion therapy.</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed strategy/strat</p>	<ul style="list-style-type: none"> <li>Section first characterizes the lack of evidence that conversion therapy is effective and science questioning the methodological rigor of studies/efforts that have described conversion as successful. It then discusses research on affirmative therapy approaches for supporting the health of persons identifying as LGBTQ+ and positions of</li> </ul>	

<p>egies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>organizations such as the APA, AMA, American Psychiatric Association, and National Association of Social Workers opposing the use of conversion therapy. The above culminates with a statement of the Caucus goal: “The goal is to have all states adopt complete bans on the use of conversion therapy on minors.”</p> <ul style="list-style-type: none"> <li>• The strategy of legal bans could benefit from more elaboration. How were laws present in 21 states and the District of Columbia achieved? Given that lines 175 – 178 acknowledge that conversion therapy is often done underground, what complementary strategies would be needed to surface such activities to trigger necessary enforcement activities? What strategies needed to complement the anticipated passive deterrence effect that the presence of bans / laws is hoped to cause?</li> <li>• Lines 114-127: The first paragraph of the EB Strategies section belongs in the Problem Statement based on the content of the argument made – except for the last sentence (lines 126-127), which is again a Rationale or Action Step statement of what is called for.</li> <li>• We suggest putting the Strategies evidence (which is nearly already chronological in describing reforms starting on</li> </ul>	
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	<p>line 141 with 1973) into chronological order – moving the reforms described by citations #16-18 (in the Problem Statement but unclear why since they represent progress) and inserting between 1988 (ending line 145) and 2015 (starting line 146). We also recommend expanding the descriptions of the 1997 and 2007 APA Resolution steps as these are critical to the shift away from conversion therapy as an appropriate treatment option.</p> <p>As suggested for the Problem Statement, the shifting acronym applied to different strategy statements (LGBQ in line 131; LGBT in 134) need to be clarified when they change in proximity like that. By checking references it's clear that citation 26 speaks to transgender-affirmative approach to CBT when 25 does not, but the reader should have this information made explicit</p> <p>Explain and provide evidence for why conversion therapy is problematic and should be ended, include a lit review of historical advocacy in this area and perhaps note those doing this work - academics and community practitioners/researchers/advocates / activists -- and the outcomes of and barriers to this work, which should illuminate proposed actions.</p>	
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<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing</p>	<p>The Opposing Arguments/Evidence section itself does not sufficiently refute the opposing viewpoints. However, other sections in the proposal itself do provide content that does sufficiently and effectively refute such perspectives and may counter related, representative research.</p> <p>Missing Opposing Arguments:</p> <ul style="list-style-type: none"> <li>• Religious / Ideological Freedom</li> <li>• Public health cannot impose a set of moral values on those who have homo-negative attitudes (or whatever their motivation really), i.e. it's inappropriate to dictate values to others who may self-select accessing CT.</li> </ul> <p>Recent references on potential opposing perspectives offered for consideration include the following. These would show that the you are aware of recent work either supporting or calling for re-examinations of conversation therapies.</p> <ul style="list-style-type: none"> <li>• Ashley, F. (2020). Homophobia, conversion therapy, and care models for trans youth: Defending the gender-affirmative approach. <i>Journal of LGBT Youth</i>, 17(4), 361-383. doi:10.1080/19361653.2019.1665610</li> <li>• Conine, D. E., Campau, S. C., &amp; Petronelli, A. K. (2022). LGBTQ+ conversion therapy and applied behavior analysis: A call to action. <i>Journal of Applied Behavior Analysis</i>, 55(1), 6-18. doi:10.1002/jaba.876</li> </ul>	
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views missing?	<ul style="list-style-type: none"> <li>• Sullins, D. P., Rosik, C. H., &amp; Santero, P. (2021). Efficacy and risk of sexual orientation change efforts: A retrospective analysis of 125 exposed men. F1000Research, 10 doi:10.12688/f1000research.51209.1</li> <li>• Pela, C., &amp; Sutton, P. (2021). Sexual Attraction Fluidity and Well-being in Men: A Therapeutic Outcome Study. Journal of Human Sexuality, Vol. 12. Link to study <a href="https://df6a7995-cBclef92e2cf904.filesusr.com/ugd/ec16e9d6b14c067ae64bf095bb19c4757e8ff9.pdf">https://df6a7995-cBclef92e2cf904.filesusr.com/ugd/ec16e9d6b14c067ae64bf095bb19c4757e8ff9.pdf</a></li> </ul> <p>The retraction of the study by Spitzer should be discussed and the rationale should be explained for why it negates the Opposing Argument made.</p> <p>Like the 2012 Spitzer retraction, each Opposing Argument should be refuted with as much peer-reviewed or consensus evidence (labeled/characterized accordingly). This is not done.</p> <p>Line 198 to 199: We recommend removing the phrase “...but we urge APHA to not support such harmful practices.” or moving it in some form to the Action Steps, where that intent is meant to be conveyed.</p> <p>Can you explain more about the rationale among psychoanalysts to suggest and/or use conversion therapy and among adults who seek conversion therapy?</p>	
<b>Action Steps</b>	The action steps logically flow from the strategies defined in the	

<p>Are the <b>ACTION STEPS:</b></p> <p>a. Externally directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p> <p>b. Focused on policy/principle, and not on a specific legislation/regulation?</p> <p>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?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not,</p>	<p>proposal except. “[APHA] Urges Congress and state legislatures to enact legislation to protect the rights and legal benefits of LGBTQ+ populations who have been subjected to conversion therapy.”</p> <p>While the basis for this action can easily be inferred, it is neither substantively linked to the problem state nor the evidence sections of the proposal. This could be addressed by adding content in earlier sections to describe the need for this action and to place the strategy it would connect to into a clear background and a relevant evidence base.</p> <p>Minor concerns:</p> <p>Strongly recommend numbering the action steps instead of using bullets. This improves interpretation and discussion of the steps.</p> <p>Suggest “Therefore,” instead of “Namely,” for grammatical purposes.</p>
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describe why not.		
<b>References</b>  Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	The references are properly formatted, up to date, and peer reviewed. Suggestions appear through the review to assist with potential additions that could assist with reference updates	
<b>Social justice and human rights metrics</b>  Does the proposal <b>primarily</b> focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below: <ul style="list-style-type: none"> <li>a. Does <u>International Human Rights Law</u> [<a href="http://www.asil.org/erg/?page=ihr">http://www.asil.org/erg/?page=ihr</a>] support this issue?</li> <li>b. Is the proposal consistent with the <u>Universal Declaration of Human Rights</u> [<a href="http://www.un.org/en/documents/udhr/">http://www.un.org/en/documents/udhr/</a>]?</li> <li>c. Is the proposal</li> </ul>	This proposal is very much aligned with the principles of human rights and social justice, including as declared by the IHRL, UDHR and CSDH.	

<p>consistent with the <u>WHO Commission on Social Determinants of Health</u> (CSDH) [<a href="http://www.who.int/social_determinants/thecommission/en/">http://www.who.int/social_determinants/thecommission/en/</a>]?</p> <p>d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the <u>International Human rights Committee</u> and the <u>Ethics Section</u>?</p>		
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## B4: Insuring Women’s Inclusion in HIV-Related Clinical Research

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	<i>Author’s Response</i>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the title accurately reflect the evidence provided?	If the you do decide to have the broader focus on women’s inclusion in clinical trials that they seem more interested in, the title should be revised to reflect that. If you instead enhance the focus on the HIV-specific pieces, the title can remain as is. Also, depending on what is addressed in the rest of the review, may need to specify is this policy is for cis women or truly inclusive of all women.	
<b>Does the PROBLEM STATEMENT</b> adequately describe the extent of the problem? d. Are there important facts that are missing from the problem statement? If so, describe them.	The problem statement should be edited to make the actual problem the statement is focus on clearer. It should include information about the details of the impact of excluding women from HIV trials (e.g., does it mean we don’t have effectiveness/dosing information for women?).  Clarify whether their concern is that pregnant people are excluded from trials or if people with the capacity for pregnancy are excluded from trials.	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p>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.?</p> <p>f. Identify any relevant ethical<sup>vii</sup>, equitable<sup>viii</sup>, political or economic<sup>ix</sup> issues.</p>	<p>You list 4 different reasons women are excluded from trials, but really only focus on two of them (non-evidence-based contraception requirements and concern about people becoming pregnant while in the trial). You do not focus on the other pieces. Recommend including a focus on all four of the components they list rather than solely focusing on the pregnancy pieces, which do not really get addressed in action statements.</p> <p>While the inclusion of transgender women is important, please clarify how the issues affecting their participation differ from issues of cisgender women. Specifically, they should name things such as transgender women not having the capacity for pregnancy, but also note that there are additional challenges in terms of questions of subgroup analyses and strategies for inclusion and retention in research.</p> <p>Concern about women becoming pregnant while in a clinical trial is not an issue that only affects HIV research; you should reference this broader topic and note why the risk/benefit calculation may differ for HIV, e.g. are the medications/interventions being tested potentially uniquely harmful or teratogenic to fetuses?</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>Research has highlighted sex-linked differences in vaccine responses, HIV pathogenesis, responses to HIV treatments, and HIV reservoir size and dynamics. Yet, women's representation has only been 19.2% in antiretroviral therapy (ART) studies, 38.1% in HIV vaccine studies, and 11.1% in HIV cure studies. Excluding women in clinical research only widens gap in understanding around HIV-related sex/gender differences. The proposal needs to elaborate on this "gap in understanding around HIV-related sex/gender differences" and the effect of lack of women's participation in research (Reference 19 is a good source to elaborate).</p> <p>Further, there are ongoing efforts (including by the FDA) to address the broader question of inclusion of women and inclusion of pregnant people in clinical trials more broadly. These seem highly relevant to this policy statement and should be acknowledged and discussed in the problem statement. See, for example: <a href="https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials">https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials</a> for pregnant and lactating women. Connected to this, it seems that the unresolved questions in terms of the guidance is not about inclusion of women, but rather inclusion of pregnant and lactating people. A clearer statement</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>about this would improve the problem statement.</p> <p>Recommend adding a discussion of PrEP studies and use in women</p> <p><i>From the Ethics Section:</i></p> <ul style="list-style-type: none"> <li>• The problem statement does not explicitly indicate why the inclusion of women in HIV-related clinical research is a public health issue and what the goal of the policy statement is for APHA to address. The problem statement doesn't elaborate that public health's commitments to health services for all are foundational values that ensure ethical practice in public health. The problem is stated in general terms and reference only to women in HIV-related clinical research. Not giving reasons for inclusion of women, in general, in most research studies. Need clarification to promote equitable distribution of burdens, benefits, and opportunities for health for ethical principles. Some discussion on integrating the standards of ethics within the structure of research, practice, and services in public health</li> </ul>	



Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>provided, is critical and must elaborate.</p> <p>Consider:</p> <ul style="list-style-type: none"> <li>- Adding a focus on prevention and not just treatment</li> <li>- P3, L103 mentions both trans and cis women as one group, I'd like to see more about them. Their unique experiences participating in HIV-related research may differ.</li> <li>- Are all epi data inclusive of both trans and cis women?</li> <li>- Clarify the sentence "Women's participation in research varies depending upon the type of research being conducted." A reader may not be an expert in HIV prevention, care, and treatment research.</li> <li>- Are you focusing on clinical trials for HIV-related medications? Medical devices? Anything clinical?</li> </ul> <p>The problem statement rightfully focuses on ethical and human rights arguments. It should be strengthened, though, by including things like estimates of the number of women excluded from research based on the different criteria and information about the health impacts of this exclusion.</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>The contraception-based critique should be strengthened with evidence about effectiveness of different contraception methods at preventing pregnancy to explain why the criteria as written are not evidence-based (on top of excluding large numbers of people). Unintended pregnancy is common and updated estimates of unintended pregnancy rates in the U.S. and globally should be added, so thinking about the implications of that for clinical trials does make sense.</p> <p>Consider adding a review of the literature on the number of women who become pregnant each year and number of women who become pregnant while in a clinical trial. This would be important in terms of understanding the magnitude of the actual risk.</p> <p>The line on 123-125 seems to contradict itself – one says that people don't have access to services and the other says that we should trust people to prevent pregnancy on their own. This should be edited.</p> <p>Consider adding more data about who in the U.S. and globally is unable to get low-cost/free contraception.</p> <p>Recommend editing the critique about informing a doctor immediately if someone becomes pregnant. Things to consider in the editing are that</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>there are appropriate reasons to do so – i.e. stopping the medications being tested, counseling people about their options for medications if they are going to continue their pregnancy, and whether they might want to consider abortion.</p> <p>A few more peer reviewed references would strengthen the statement:</p> <ol style="list-style-type: none"> <li>1. Mendez KJW, Cudjoe J, Strohmayer S, Han HR. Recruitment and Retention of Women Living With HIV for Clinical Research: A Review. AIDS Behav. 2021 Oct;25(10):3267-3278. doi: 10.1007/s10461-021-03273-1. Epub 2021 May 14. PMID: 33990902; PMCID: PMC8419017.</li> <li>2. Westreich D, Rosenberg M, Schwartz S, Swamy G. Representation of women and pregnant women in HIV research: a limited systematic review. PLoS One. 2013 Aug 23;8(8):e73398. doi: 10.1371/journal.pone.0073398. PMID: 24009750; PMCID: PMC3751870.</li> </ol> <p>Some of the barriers and facilitators (retention methods) suggested by Mendez et al. (2021) are missing. Including them will strengthen the statement.</p> <p><i>From the Medical Care Section:</i></p> <ul style="list-style-type: none"> <li>• Are women using substances, sex workers an issue also in</li> </ul>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>being excluded from trials? If so, state how.</p> <ul style="list-style-type: none"> <li>• Injury to the fetus if women become pregnant on clinical trials is considered. Is this not a real risk? Can women take the risk for the fetus? Not sure about this. More explanation might help a reader understand the issue more clearly.</li> </ul> <p>The gaps in knowledge should be made clearer.</p> <p>Recommend adding additional information about how many women become pregnant in a given time period, how quickly people discover their pregnancies, challenges recruiting women to participate in clinical trials, and the extent of sex bias in decisions to not include women. If this information is not yet known, recommend that you say this directly.</p> <p>Recommend adding information about whether the HIV medications/interventions being tested are uniquely harmful to fetuses.</p> <p>The proposal can be strengthened by adding more recent examples from studies (also listed above):</p> <ol style="list-style-type: none"> <li>1. Mendez KJW, Cudjoe J, Strohmayer S, Han HR. Recruitment and Retention of</li> </ol>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>Women Living With HIV for Clinical Research: A Review. AIDS Behav. 2021 Oct;25(10):3267-3278. doi: 10.1007/s10461-021-03273-1. Epub 2021 May 14. PMID: 33990902; PMCID: PMC8419017.</p> <p>Westreich D, Rosenberg M, Schwartz S, Swamy G. Representation of women and pregnant women in HIV research: a limited systematic review. PLoS One. 2013 Aug 23;8(8):e73398. doi: 10.1371/journal.pone.0073398. PMID: 24009750; PMCID: PMC3751870.</p> <p>The problem has a disproportionate impact on women in terms of vaccine responses, HIV pathogenesis, responses to HIV treatments, and HIV reservoir size and dynamics.</p> <ul style="list-style-type: none"> <li>• Elaborate on these disproportionate impacts; for example, a combined effect of hormones, genes, and socio-behavioral and environmental influences increases the risk of acquiring HIV and non-AIDS morbidity in women, and could potentially result in a more efficacious immune response to vaccination.</li> </ul> <p>Reference 19 (Scully et al, 2018) is a good reference.</p> <p>Consider:</p> <ul style="list-style-type: none"> <li>- Naming sex workers and people who use alcohol/drugs</li> </ul>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>as additional populations who may be excluded from trials</p> <ul style="list-style-type: none"> <li>- If going to retain focus on transgender women, include information about unique factors affecting trans women and their inclusion in trials</li> </ul> <p>Additional attention to the ethical reasons for both avoiding and doing clinical trials with pregnant people or people who might become pregnant is warranted, as are the broader ethical issues related to inclusion of women in HIV-clinical trials. Consider this paper: Lyerly et al (2009). Risk and the Pregnant Body. Hastings Center Report. 39(6):34-42</p> <p>Consider noting whether and how this calculus might also change if abortion becomes illegal again in part or all of the U.S.</p> <p>Acknowledging the ongoing work to address the questions re: inclusion of pregnant and lactating people in clinical trials  <a href="https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials">https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials</a> is important to include and would help identify the relevant ethical arguments here</p> <p>Equitable issues are documented with clear action steps.</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>The proposal can be strengthened by including the economic and other effects of lack of women's participation in HIV research.</p> <p><i>From the Ethics Section:</i>  The proposal does not adequately describe the ethical and moral case of inclusion of women in HIV-related research. The discussion presents the need in general terms that do not address the ethical considerations from public health perspectives. Please review the <i>APHA Code of Public Health Ethics</i> and align protecting and promoting the health for all in a more synthesized argument for this policy statement.</p> <p>Consider:</p> <ul style="list-style-type: none"> <li>- The problem statement doesn't elaborate that public health's commitments to health services for all are foundational values that ensure ethical practice in public health.</li> </ul>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>d. Is/are the proposed strategy/strategies evidence-based?</p> <p>e. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>f. What other strategies, if any, should be considered? Should additional evidence for the</p>	<p>The evidence-based strategies is primarily a list of policies and guidelines that focus on including women in research and that people living with HIV/AIDS are meaningfully involved in research affecting them. Recommend clarifying whether the issue is that these are not being followed in general or for HIV in particular, and what strategies (funding, advocacy, more attention to implementation, etc.) are needed to change this and what evidence exists for these strategies.</p> <p>The proposal lists certain policies and guidelines on equity and inclusion (in the 1990s and one in 2016). However, what is also needed are the specific strategies in these policies and guidelines and the scientific evidence that they have been effective in addressing the problem. Some of the references contain the specific evidence-based strategies (e.g., References 22, 29) that need to be listed in the proposal. For example, strategies suggested in the resources below can strengthen the proposal:</p> <ol style="list-style-type: none"> <li>1. Mendez KJW, Cudjoe J, Strohmayr S, Han HR. Recruitment and Retention of Women Living With HIV for Clinical Research: A Review. AIDS Behav. 2021 Oct;25(10):3267-3278. doi: 10.1007/s10461-021-03273-1. Epub 2021 May 14.</li> </ol>	



Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p>proposed or other strategies be included? If so, please provide data or references that should be considered.</p>	<p>PMID: 33990902; PMCID: PMC8419017.</p> <p>The Society for Women's Health Research, United States Food and Drug Administration Office of Women's Health. Dialogues on diversifying clinical trials: Successful strategies for engaging women and minorities in clinical trials. 2020. Available at: <a href="https://www.fda.gov/files/science%20&amp;%20research/published/White-Paper-on-the-Dialogues-on-Diversifying-Clinical-Trials-Conference.pdf">https://www.fda.gov/files/science%20&amp;%20research/published/White-Paper-on-the-Dialogues-on-Diversifying-Clinical-Trials-Conference.pdf</a></p> <p><i>From the International Health Section:</i></p> <ul style="list-style-type: none"> <li>Consider supplementing the policy and research strategies with advocacy-based strategies. With the increasing women's movement and women-led campaigns, there are substantial effective strategies that would be appropriate and applicable to add in this section.</li> </ul> <p><i>From the Community Health Workers Caucus:</i></p> <ol style="list-style-type: none"> <li>Please consider the role of CHWs in promoting and supporting this work. Please consider including references for CHWs interventions for women of color related to HIV related research - - <a href="#">Using</a></li> </ol>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p><a href="#">Community Health Workers to Improve Clinical Outcomes Among People Living with HIV: A Randomized Controlled Trial</a></p> <p>Consider:</p> <ul style="list-style-type: none"> <li>- Adding community health workers as frontline workers to advocate for racial equity and HIV interventions for women of color throughout. Consider citing: Kenya S, Jones J, Arheart K, et al. Using community health workers to improve clinical outcomes among people living with HIV: a randomized controlled trial. AIDS Behav. 2013. 17(9):2927-2934</li> <li>- Naming advocacy as a possible strategy, including working with women's health advocates</li> </ul> <p>The strategies seem to be best practice lists. Recommend you instead review the literature about whether and why different strategies are not being implemented and what has worked to get them implemented. This could be HIV specific or more general. Recommend distinguishing between strategies re: including (non-pregnant) women, where there are likely to be primarily implementation issues, from the strategies re: including pregnant</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>people, where the barrier to doing so is scientific and ethical guidance.</p> <p>Additional evidence-based strategies are needed to complement the action steps outlined. For example, Action Step 1: "Congress and the NIH to permanently fund the Office of Research on Women's Health (ORWH) and Sexual and Gender Minority Research Office (SGMRO)." The proposal will be strengthened by demonstrating the evidence that such funding addresses the problem.</p> <p>Additional items to consider:</p> <ul style="list-style-type: none"> <li>- NIH Revitalization Act of 1993 was written at a time where there was little to no HIV research. Does the 2001 update reflect the changing nature of the epidemic?</li> <li>- Same thing with GIPA—came to fruition at a time where there was virtual no discussion of the impact of HIV on women. Same thing with the 1998 Demographic Rule. Same thing with the 998 Investigational IND Application</li> <li>- Does the 2016 Diverse Women in Clinical Trials adequately address the concerns of the proposed statement? Given this is the only recent piece?</li> </ul>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>The proposal does not include scientific evidence that the proposed strategies are likely to have an impact on reducing the problem, and does not describe the magnitude of its impact. The proposal should add references or scientific evidence about the effectiveness of the different strategies.</p> <p>The general strategies seem ethical, although the ethical question of how to handle risk of pregnancy needs to be addressed.</p> <p>The proposal does not adequately describe the ethical and moral case of inclusion of women in HIV-related research." Please "review the <i>APHA Code of Public Health Ethics</i> and align protecting and promoting the health for all in a more synthesized argument for this policy statement."</p>	
<b>Opposing Arguments</b>  Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS?</b> <ul style="list-style-type: none"> <li>e. Does it adequately refute the opposing/alternative viewpoints presented using</li> </ul>	<p>The proposal does not sufficiently refute the opposing viewpoints presented with scientific evidence. The proposal need to provide a clear conclusion from the two examples given in the "Opposing arguments" section.</p> <p>Recommend adding additional information to refute the argument about possible teratogenic effects on fetuses. A 2018 example where the effects weren't as bad as initially thought is insufficient. There is a real reason to be concerned. The question</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p>evidence? If not, please explain.</p> <p>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.)?</p> <p>g. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>h. Were any opposing views missing?</p>	<p>is how big of a risk it is and also whether there are ethical risks to not including people with the capacity for pregnancy.</p> <p>More examples should be added, especially from the past decade.</p> <p>Recommend adding a refutation of the argument that women are harder (or too hard) to include, including estimates of cost.</p> <p>Do any of these arguments apply to trans women? Please specify.</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p><b>Action Steps</b> Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>e. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>f. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> </ul> <p>Culturally responsive to the under-represented</p>	<p>Action Steps 1 – 4 do not logically flow. Clarify whether you are focusing on inclusion of women in HIV research in particular or focusing in inclusion of women in clinical research in general. Assuming they will retain the focus on HIV in particular, they should revise the initial action steps to reflect this.</p> <p>The strategies' section has listed policies but it needs to include specific strategies contained within those policies. Therefore, the action steps will need to be aligned specifically with those strategies; e.g., action steps related to inclusion of women in general and pregnant people in particular.</p> <p>Consider including an action step that acknowledges the FDA (and other) work on guidance for inclusion of pregnant and lactating people in clinical trials and what you want APHA to do in relation to this work (<a href="https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials">https://www.fda.gov/regulatory-information/search-fda-guidance-documents/pregnant-women-scientific-and-ethical-considerations-inclusion-clinical-trials</a>)</p> <p>It is not clear where the SGM focus comes from. While you include a focus on transgender women, the details around this are underdeveloped in the rest of the policy statement. If the you want to retain this action step, recommend</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p>and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>that they add additional information in the problem statement and evidence-based strategies section to lead up to it.</p> <p>If you add something about sex workers and people who use substances and people involved in the criminal justice system as people often excluded from HIV-related clinical trials, consider: Adding action step of outreach to sex workers and people who use substances as well as people involved in the criminal justice system</p> <p>Many of the action steps are not directly supported by the evidence or rationale documented in the proposal. It is difficult to gage from the current steps how they relate to the evidence. It would strengthen the proposal if: (1) the evidence/rationale is presented in certain themes; (2) the strategies are presented under those same themes; and lastly, (3) the action steps are also presented under those same themes.</p> <p>To address the section about concerns about out-of-date and unethical contraception-related requirements for women's participation, consider including an action step related to contraception. One possible action step to consider would be to include something ensuring that people who want to participate and do not want to become pregnant are able to get the</p>	

Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<p>contraceptive of their choice. Another to consider would be about helping people discover their pregnancies earlier. Another to consider would be to ensure that inclusion criteria related to contraception are consistent with current evidence regarding contraceptive effectiveness rather than more restrictive than necessary and based on outdated evidence. Alternatively, identify any existing guidance about women's inclusion in clinical trials that addresses risk of pregnancy and include an action step about ensuring that such guidance is more routinely followed.</p> <p>There is good attention to action steps to increase equity. The core ethical question of what happens if a trial participant becomes pregnant needs to be addressed, though, in the action steps.</p> <p>Consider explaining that the mandates and rules delineated in Action Step 8 are feasible.</p> <p>Consider adding a time-frame to the action steps.</p> <p>Consider:</p> <ul style="list-style-type: none"> <li>- For Action steps, change NIH supporting women only trials to NIH supporting clinical trials that purposefully include women</li> </ul>	



Criteria	Write a summary statement and include recommendations to the author.	<b>Author's Response</b>  <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
	<ul style="list-style-type: none"> <li>- Action steps are very NIH-focused. While it is understood the NIH lead the DHSS clinical trials efforts, is this policy limited to governmental clinical research? If not, what about the role of pharma, biotech, academia, etc.?</li> </ul>	
<b>References</b>  Are the references properly formatted, up-to-date, and peer-reviewed?	Careful attention to the reference format is recommended. There are some typos common to endnote-formatted references.  Many of the references are websites and guidelines rather than peer reviewed research. Recommend including additional citations from the research literature.	

# C1: A Strategy to Address Racism and Violence as Public Health Priorities: Community Health Workers Advancing Racial Equity and Violence Prevention

## Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The current title of the proposal does not speak to the strategy(ies) being described in the proposal. Revise the title as written. E.g., Utilizing Community Health Workers as a Public Health Strategy to Advance Racial Equity and Violence Prevention  As noted in the Author Guidelines for Proposed Policies, endorsements are from APHA Units. Delete the names of organizations that are not APHA Units.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the	A total of 19 policy statements are identified as related to the existing proposal. It is not clear how all of these policy statements are related to CHWs, racism and violence. Select the most relevant policies	

<p>related existing policy statements by number and note if the proposal updates the science of the older policy statements?</p>	<p>statements to include in this section.</p> <p>In addition, as noted in the Author Guidelines, the list should only include existing policies. It should not include archived policies or policies that were late breakers (and not subsequently submitted for a full review (i.e., LB20-04)). We identified at least three archived policies in your list.</p>	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>Revise the rationale to get to the point which seems to be in L 207: a comprehensive strategy for CHWs...to address root causes of poor health outcomes and mitigate harm. If in getting to page 7, this is the point of the policy statement it should be stated much earlier with in the document.</p> <p>Make it clear why a CHW only policy is needed. There are existing policy statements addressing the important role of and support for CHW (2014-14; 2009-1). Should this policy be submitted as an update to those (e.g., before they are archived)?</p> <p>Review the following proposed policy and add an explicit description of how this proposed policy on CHW integrates with it: D1: “ Defining Public Health Leadership to Achieve Health Equity: Merging Collective, Adaptive, and Emergent Models.”</p>	

<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> </ol>	<p>The problem statement is unclear.</p> <p>It includes the topics of racism and violence, but the focus seems to be more on structural-and-social-determinants-of-health. It begs the question of why the title is not more general to health equity. While racism and equity are centered in the focus on Historically Oppressed and Other Peoples Experiencing Inequities, violence seems on the periphery of your argument.</p> <p>Arguments about the public health problem of racism and violence should be more clearly articulated in the problem statement.</p> <p>You indicate that CHWs need support to realize their full potential, but where that centers on racism and violence is unclear. (Based on your text, it is slightly clearer for racism, but less so for violence). Clarify the problem statement to speak directly to the roles CHWs can play intervening in both racism and violence. (If that is in fact what the topic of the proposed policy.) The problem statement could be strengthened by adding detailed data related to violence in the United States to frame the current challenges in this space and making more direct connections about how CHWs can prevent/intervene. Adding a definition of “health system” would be helpful. Do you mean CHWs embedded in</p>	
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c. Identify any relevant ethical <sup>4</sup> , equitable <sup>5</sup> , political or economic <sup>6</sup> issues.	traditional health care clinics/practice, local public health, non-governmental agencies, etc? or something else?  Define at the beginning of the policy statement whether particular acronyms are meant to encompass all of the following (CHWs, REAs, etc.)—that is, the acronyms are interchangeable. As presented, the inconsistent	
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<sup>4</sup> **Public health ethics** can be subdivided into a field of study and a field of practice.

As a field of study, public health ethics seeks to understand and clarify principles and values which guide public health actions. Principles and values provide a framework for decision making and a means of justifying decisions. Because public health actions are often undertaken by governments and are directed at the population level, the principles and values which guide public health can differ from those which guide actions in biology and clinical medicine (bioethics and medical ethics) which are more patient or individual-centered.

As a field of practice, public health ethics is the application of relevant principles and values to public health decision making. In applying an ethics framework, public health ethics inquiry carries out three core functions, namely 1) identifying and clarifying the ethical dilemma posed, 2) analyzing it in terms of alternative courses of action and their consequences, and 3) resolving the dilemma by deciding which course of action best incorporates and balances the guiding principles and values.

CDC. Advancing excellence and integrity of CDC science. Public health ethics. Available at: <http://www.cdc.gov/od/science/integrity/phethics/>. Accessed March 18, 2014.

<sup>5</sup> **Health equity** is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

CDC. Chronic disease prevention and health promotion. Health equity. Available at: <http://www.cdc.gov/chronicdisease/healthequity/>. Accessed March 18, 2014.

<sup>6</sup> **Economics** is the study of decisions—the incentives that lead to them, and the consequences from them—as they relate to production, distribution, and consumption of goods and services when resources are limited and have alternative uses. CDC uses economics to identify, measure, value, and compare the costs and consequences of alternative prevention strategies.

CDC. State, tribal, local and territorial health public health professionals gateway. Public health economics and tools. Available at: <http://www.cdc.gov/stltpublichealth/pheconomics/>. Accessed March 18, 2014.

	<p>terminology is confusing to readers.</p> <p>The proposal could benefit from additional detail on the economic issues and framing of CHWs within health systems. Page 13 had some good health system return on investment information but it was less connected to direct violence prevention outcomes. (Elsewhere in the document, however, (L 289-290; L294-295) you indicate that ROIs analyses lead to negative effects on CHW. This is confusing to readers.)</p> <p>More consideration should be given around the challenges of payment systems and hiring practices that limit hiring non-clinical positions within a health system paradigm due to limitations with insurance reimbursement for these positions.</p> <p>Consider if CHWs are/would be required to be regulated in some manner by state professional bodies. This could also create new barriers for the very populations intended to serve in these roles.</p> <p>Remove footer(s) (e.g. P7)</p> <p>P9, Line 275: In what reference (26, 27, or 42) does the quote appear?</p>	
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<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ol style="list-style-type: none"> <li>Is/are the proposed strategy/strategies evidence-based?</li> <li>Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ol>	<p>Recommend this section of the proposal be substantially reworked.</p> <p>L357-359: APHA policy statements about CHWs and related are already mentioned in the EBS. (In an of themselves, they are not evidence—but they include references that may be helpful should you chose to examine it.)</p> <p>Use the EBS section to provide examples and evidence of strategies to address the issues described in the Problem Statement. Use sources from the peer-reviewed literature or grey literature; avoid weak/unclear sources such as links to an organization(s) website, titles of presentations, etc.</p> <p>Strengthen descriptions of the evidence. This section begins at L357, but you don’t begin describing evidence until L381. If those proceeding lines are about evidence, it is not described. This is the place in the policy statement to explain the evidence about strategies to address the issues described in the PS. You need to describe the evidence for readers (i.e., the public) not simply to provide references.</p> <p>L367-371: You should be more precise about the source of this funding.</p> <p>L384: what is “SC”</p> <p>L384-397: the connection to violence prevention is unclear. It is not clear how “Striving to Reduce Youth Violence Everywhere” is an evidence-</p>	
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	<p>based strategy. It describes the program, but the evidence of violence prevention is not mentioned.</p> <p>L207 says CHW need to be trained to address the root cause of poor health. Are their strategies to address this need? What about comprehensive training for CHWs---examples of effective training tackling difficult community/social issues.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ol style="list-style-type: none"> <li>Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>Were any opposing views missing?</li> </ol>	<p>As a result of deficiencies with the PS and EBS, the opposing arguments section is deficient. After each opposing view is describes, the rebut the view.</p> <p>One possible opposing argument to consider is whether CHWs are the best intervening point to promote equity. Are there other models for promoting equity that can be described in this section?</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ol style="list-style-type: none"> <li>Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> </ol>	<p>The AS seem to speak more to a comprehensive focus on the needs of CHWs. This is confusing given the title and the evidence-based strategy that includes violence.</p> <p>There are far too many Action Steps. They can be consolidated into less than 8-10 core ones.</p>	



<ul style="list-style-type: none"> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> <li>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ul>	<p>P15/L472-474: Delete “White House.” The White House does not pass legislation, Congress does. What would the legislation do that would “uplift the work of CHWs”</p> <p>P16/L475: You are introducing a new topic, Health in all Policies, which isn’t mentioned elsewhere in the document. Is there an example to include in the strategies of how this approach has effectively involved CHWs?</p> <p>P16/L477-479: Congress provides funding to agencies (i.e., not to private organizations). Is there any agency that should receive this funding? Are there examples of an agency(ies) providing grants to the organizations you mention? Is this Action Step needed? Later Action Steps mention tasks for specific agencies.</p> <p>P16/L483: This is the first time in the document that you have mentioned CHW employers. If they are a target for an Action Step(s), you need to describe elsewhere in the document (i.e., PS or EBS) their role. (See also Action Step at L492-494)</p> <p>P16/L486-487: Delete. None of this is described elsewhere in the document as an Evidence-based strategy.</p> <p>P16/L488-491: Delete. Non-specific. What organizations? Who encourages and incentivizes them? What infrastructures and safe spaces (which have not been</p>	
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	<p>described elsewhere in the document.)</p> <p>P16/L495-499: We are unable to determine elsewhere in the document whether the program called CHASM (the subject of this Action Step) is an Evidence-based strategy (and what is the evidence of its effectiveness.)</p> <p>P17/L504: We are unable to identify elsewhere in the document information about the Common Indicators Project.</p> <p>P509: Congress does not provide funding to CBOs.</p> <p>The AS should be specific and given the number of organizations listed in the policy statement external endorsement, are these kind of groups the target for AS?</p> <p>Precise language is needed for the AS. For example, “national policies should uplift the work of CHWs” is vague. What does uplifting their work mean? How does that happen? What action needs to be taken to accomplish it?</p> <p>Based on what should be included in the PS and EBS related to best practice approaches that elected officials and public health officials can act on.</p> <p>This section needs a complete revision taking in consideration the author guidelines.</p>	
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<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>As the Guidelines for Authors note, references should be formatted in AMA format. In addition, some of the references lacked critical information (which was problematic for reviewers.) See comments elsewhere in this table about the caliber of some references.</p> <p>Additional sources of information to review and consider:</p> <p>Some useful facts as to homelessness, racism, violence, and CHW are cited below:</p> <p>“Persons of color make up the majority of those experiencing homelessness (Henry et al., 2018). Black persons are the most overrepresented, making up 40% of the population experiencing homelessness but only 13.5% of the general population in the United States (Henry et al., 2018).”</p> <p>Exposure to and fear of violence further limited housing options and contributed to becoming homeless for some [study] participants. (Dereck W. Paul Jr., Kelly R. Knight, Pamela Olsen, John Weeks, Irene H. Yen&amp; Margot B. Kushel (2019): Racial discrimination in the life course of older adults experiencing homelessness: results from the HOPE HOME study, Journal of Social Distress and the Homeless,DOI:10.1080/10530789.2019.1702248)</p> <p>Similarly, study findings from UCLA’s Williams Institute support concerns that homelessness is experienced at disproportional</p>	
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	<p>rates among HOPEIs, specifically “sexual and gender minority people.” (Homelessness Among LGBT Adults in the US, UCLA School of Law, Williams Institute (2020))</p> <p>“Studies have shown that in programs serving individuals who are experiencing homelessness or struggling with substance abuse, shared life experience may be more important than shared personal characteristics.” (Integrating Community Health Workers into Primary Care Practice: A Resource Guide for Health Care for the Homeless Programs, National Health Care for the Homeless Council)</p> <p>“Integrating CHWs into a program increases job opportunities for people who have experienced homelessness. The CHW profession is a platform for vulnerable populations to gain work experience, professional skills, and personal development. Once in the field, CHWs may find opportunities to transition to social work, nursing, and a number of other health related professions.” (Integrating Community Health Workers into Primary Care Practice: A Resource Guide for Health Care for the Homeless Programs, National Health Care for the Homeless Council)</p>	
<b>Social justice and human rights metrics</b>	The social justice and human rights metrics would be strengthened if the policy	

<p>Does the proposal <b><u>primarily</u></b> focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below:</p> <ol style="list-style-type: none"> <li>Does <u>International Human Rights Law</u> [<a href="http://www.asil.org/erg/?page=ihr">http://www.asil.org/erg/?page=ihr</a>] support this issue?</li> <li>Is the proposal consistent with the <u>Universal Declaration of Human Rights</u> [<a href="http://www.un.org/en/documents/udhr/">http://www.un.org/en/documents/udhr/</a>]?</li> <li>Is the proposal consistent with the <u>WHO Commission on Social Determinants of Health</u> (CSDH) [<a href="http://www.who.int/social_determinants/thecommission/en/">http://www.who.int/social_determinants/thecommission/en/</a>]?</li> <li>Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the <u>International Human rights Committee</u> and the <u>Ethics Section</u>?</li> </ol>	<p>statement had a single equity focus.</p>	
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## C2: Address Threats to Public Health Practice

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The title is vague/too broad. Consider revising to Preserving Public Health Capacity by Protecting the Workforce and Authority	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	This PS is related to LB20-03, 2017-1, 2015-11, 2010-15, 2009-11, 2006-3, 2003-4, 2000-23. The PS does provide some updates, but these changes aren't related as much to the science as they are the instances of abuse and political manipulation.  Delete: LB-20-03. It is not an existing APHA policy, and was replaced by 2021-18.	
<b>Problem Statement</b>  Does the <b>PROBLEM STATEMENT</b> adequately	There is room to add some evidence around the changes in funding for PH. We have seen ups and downs historically and most recently significant increases post-	

<p>describe the extent of the problem?</p> <p>a. Are there important facts that are missing from the problem statement? If so, describe them.</p> <p>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.?</p> <p>c. Identify any relevant ethical<sup>1</sup>, equitable<sup>2</sup>, political or economic<sup>3</sup> issues.</p>	<p>9/11 which trickled off in a remarkably similar fashion to what we see today with COVID-19 funds. There is an added animosity or fervor to those who are against this spending, but the quick growth followed by anticipated declines are not out of the ordinary with changes in legislative bodies.</p> <p>There is little mention of the ethical principles of beneficence or justice which seem critical. Policymakers and elected officials should value these principles, or it at least claim to do so. Rather, in the described policies and action the source of the problem is asserted as an unequal preference for autonomy with little regard for these other bioethical principles.</p> <p>The statement should mention the historical distrust fostered by unethical practice within Public Health. The PS does not mention populations most hurt by ineffective responses to COVID. Equitable investments in partnerships with community-based organizations and community health workers could increase trust among local, regional and national constituents.</p> <p>In PS, it would be helpful to clarify the basis of public health authority. Perhaps move and modify the information on this topic which appears in OV. Statistics about health department (HDs) funding over the years would be helpful. Underfunded HDs means staffing</p>	
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	<p>issues which compound issues of distrust when needs can't be met. Finally, shaping messages to cite what didn't happen (illness/injuries/deaths averted) could be explored.</p> <p>P3,L87-88: You need to be more precise with respect to SCOTUS decision on the OSHA emergency rule for large employers. The majority opinion vacated an administrative stay provided by the 6thCircuit Court of Appeals, and the case was returned to that Court of Appeals. The case continues in the Appeals Court. The debate in SCOTUS was not about "individual liberty." The majority of justices instead argued that Congress did not grant OSHA the authority to regulate a hazard like the SARS-CoV-2 (i.e., the "major questions doctrine" in other words Congress' intent when it passed the Occupational Safety and Health Act in 1970.)</p> <p>P3, L 85-91. To be consistent you're your theme of threats to PH practice, they could simply say two legal challenges to national COVID-related protections were heard by the U.S. Supreme Court. Opponents of vaccination and masking mandates argued that the CMS and OSHA did not have the authority to impose the COVID-related mandates on employers. The Court rule upheld the CMS regulation and returned the OSHA case to 6th Circuit Court of Appeals with a stay. [Cite the two SCOTUS rulings:</p>	
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	<p>NFIB v. OSHA ruling:  <a href="https://www.supremecourt.gov/opinions/21pdf/21a244_hgci.pdf">https://www.supremecourt.gov/opinions/21pdf/21a244_hgci.pdf</a>          Biden v. Missouri (CMS):  <a href="https://www.supremecourt.gov/opinions/21pdf/21a240_d18e.pdf">https://www.supremecourt.gov/opinions/21pdf/21a240_d18e.pdf</a></p> <p>Page 3, lines 95-101 this example seems out of place here. Consider other or stronger examples.</p> <p>Page 4, lines 102-107 citation for this example?</p> <p>Page 4, lines 106-108: This is a great example of the ethical problem-solving facing local and state health departments every day. Explicitly point it out, especially given the reference to the Code of Ethics later on in that page.</p> <p>Page 4, lines 127- consider describing the incident with Dr Fiscus in TN who was fired for doing her job as the Medical Director over vaccine preventable diseases.</p> <p>Page 5, line 140: The “33% of the 18 of 59...” is very oddly worded. Does this mean 18 of the 59 state health official turnovers could be attributed to conflicts OR 6 of the 59 (33% of 18 of 59)? It could go either way.</p> <p>Page 5, lines 150-153: This set of sentences is a little unclear. Are you implying that this was not done during COVID? What evidence is there to support this (or the other way around)? On line 150, who are the observers? On line 153, who made those early statements? Was this across</p>	
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	<p>the field of public health? Some clarity and explicit explanations would be helpful here.</p> <p>Page 6, lines 171-177: Who is the “we” that you are referring to, starting in line 171? Is this all of public health? Or just the organizations that support them? The way this paragraph is constructed, it is difficult to tell.</p> <p>Considering including in the PS the issue of religious exemption and title VII. [Comment from the One Health SPIG and the JPC was unable to get clarification about the comment.]</p> <p>The problem statement should discuss economic impacts including the cost of mass casualties, long-term disability, etc. as well as short-term economic impacts (loss of income from inability to work). These are equity arguments which particularly relevant to people at/near the poverty line.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed strategy/strateg</p>	<p>The strategies seem as though we can educate our way out of this problem. There is not much evidence to suggest this would adequately sway public opinion amongst those opposing public health measures. The resistance is fairly entrenched and motivated by goals of individual liberties which run largely counter to those of collectivists.</p>	

<p>ies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>Please describe if there is a relationship between health equity and public health professionals being limited in carrying out their job responsibilities.</p> <p>Has the high turnover of public health professionals leaving or pushed out and the hiring and training of new public health professionals put an economic strain on their jurisdictions being served? and/or the ability of HDs to fulfill their responsibilities? (Perhaps a topic for the PS, with a strategy to address this problem included in EBS.)</p> <p>PS describes the problem of misinformation of public health information. Please provide EBS to address this problem.</p> <p>Consider the implementation of the One Health principles that would improve coordination and collaboration within agencies at various levels of jurisdiction (local-state) and between agencies...Some global efforts at work in this area  <a href="https://news.un.org/en/story/2021/02/1084982">https://news.un.org/en/story/2021/02/1084982</a>  <a href="https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762(21)00187-3/fulltext">https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762(21)00187-3/fulltext</a></p> <p>Highlight the role of the Global Health Security agenda and the IHR systems that can be used to support the set-up of integrated data systems</p>	
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	<p>Please review the GHSA JEE US report for suggested frameworks that could be complementary to the proposed strategy  <a href="https://www.phe.gov/Preparedness/international/Documents/jee-nap-508.pdf">https://www.phe.gov/Preparedness/international/Documents/jee-nap-508.pdf</a></p> <p>Is there an EBS around the topic of incorporating the public into discussions of acceptable risk and appropriate mitigations strategies. While urgent crises need executive ability to swiftly react on behalf of the whole, long-term behaviors and impact are dependent upon a certain level of cooperation and shared decision making. Recommend including aspects of exploring how community and public input can be solicited and incorporated into extended crisis management.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS?</b></p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p>	<p>The opposing argument reads as a continuation of the problem statement. This section needs to be better developed and go beyond opposing views by politically motivated people usurping authority.</p> <p>Line 212: The dominant concern for self rather than others is not an evidence-based statement.</p> <p>Might this be an opposing view: The authority of public health leaders is entirely driven by public policy and if the policy changes the authority changes with</p>	

<p>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.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<p>it. Policy determinations are made by elected officials who prioritize things other than public health (and shift or are reinforced by election results.)</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <p>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p> <p>b. Focused on policy/principle, and not on specific legislation/regulation?</p>	<p>Pay closer attention to linking the AS to the EBS. For example, L289-291: HRSA isn't mentioned in the PS or EBS. Explain elsewhere and include who this would benefit and who should participate.</p> <p>Add AS to address adverse impact of PH threats to underrepresented or underserved populations</p> <p>Use a syndemic framework for defining such public health emergencies. This framework recognizes both the disease and the ecosystem within which it thrives such as poor messaging or misinformation and violence</p>	

<p>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?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>against the public health actors on ground. Therefore an ALL of government approach at various levels working synergistically will ensure a robust response</p> <p><a href="https://www.ncbi.nlm.nih.gov/books/NBK572426/pdf/Bookshelf_NBK572426.pdf">https://www.ncbi.nlm.nih.gov/books/NBK572426/pdf/Bookshelf_NBK572426.pdf</a></p> <p>Consider action steps to address:</p> <p>*How can credibility and abstract concepts such as trustworthiness be measurable?</p> <p>*The timing and political tension around current public health communication makes this a tough policy to frame. It's an issue that definitely needs to be addressed but the blanket concern of even governing bodies (such as the CDC) accumulating public mistrust due to their messaging. Perhaps including an AS on communication training within these organization, including how to communicate with communities and politicians who have opposing views.</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>		

<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>		
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## C3: A Public Health Approach to Gun Violence Prevention

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	<ul style="list-style-type: none"><li>Reconsider a new title based on a newly drafted policy with members from C4</li></ul>	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	<ul style="list-style-type: none"><li>Clarify whether 20030 will be archived in 2023.</li><li>Include 20184 ("Reducing Suicides by Firearms") and 200320 ("Support Renewal with Strengthening of the Federal Assault Weapons Ban).</li><li>Need to carefully consider the range of prior policy statements relevant to this topic and actively integrate and update them if that is their objective.</li></ul>	



<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP</b> or <b>requested UPDATE</b> 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?</p>	<ul style="list-style-type: none"> <li>• Re write the last two sentences to remove “we” statements.</li> </ul>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>d. Are there important facts that are missing from the problem statement? If so, describe them.</p> <p>e. Document any disproportionate impact on underserved populations? For example, what is the burden of the problem</p>	<ul style="list-style-type: none"> <li>• The problem statement does go in depth with the statistical impact on underserved populations. Add information on how this burdens low-income and minority populations outside of the statistics. Sexual orientation is not mentioned. [Please review literature and other data to examine sexual orientation as a risk factor for being a target of gun violence.] This will strengthen the PS and provide the missing equity piece. Additional suggestions for other</li> </ul>	

<p>among low-income and minority populations, persons with a disparity, persons with certain sexual identity and orientation, etc.?</p> <p>f. Identify any relevant ethical<sup>x</sup>, equitable<sup>xi</sup>, political or economic<sup>xii</sup> issues.</p>	<p>groups to address are listed in the “consider” section.</p> <ul style="list-style-type: none"> <li>• There is no specific public health approach to guide the problem statement - C4 has a more successful public health approach. Please reflect on both to combine and incorporate a public health strategy.</li> <li>• Problem Statement has evidence cited that is old (primarily Ref. 12-15, 16-17) and acts a sole source in some ways that are not relevant to the majority of the US; More recent data needed from PH literature.</li> <li>• Line 79 – Suggestion to rewrite: “can be categorically divided by intent”</li> <li>• Line 79 – “In general” – are these adults? Population as a whole? Clarify, as you add information on child proportion of deaths in the next sentence.</li> <li>• Line 80-81 – Add the statistics for homicide and unintentional injury.</li> <li>• Line 81-82 – Add the statistics for homicide in children and teens</li> <li>• Line 91-92 - This reference should be strengthened. “In the U.S., over 125 fatal public mass shootings have taken place since 1982, and mass shooting events have been increasing in frequency.” This reference</li> </ul>	
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	<p>does not represent the actual number of mass shootings that have taken place in America. The actual number is far higher and further research should give far greater numbers. Search mass shootings 2014-2016</p> <ul style="list-style-type: none"> <li>• Line 99 – Suggestion to rewrite: “...caused by gun violence has led to significant economic consequences”</li> <li>• Provide some data (per capita) on gun ownership in the U.S., including distribution by states.</li> <li>• P3, L103-109. Provide more specific data (rates by the demographic info).</li> <li>• Consider risk factors for being a victim of gun violence (including suicide) that go beyond gender, race, ethnicity, urban/rural, access to healthcare/mental healthcare; Employment rates, income, military service, law enforcement occupations crime rates. Are there features/characteristics of communities that experience more gun violence? In addition, look into disproportionate exposure of LGBTQ+ people to gun violence in hate crimes; disproportionate</li> </ul>	
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	<p>impact of firearm violence (by police) on people with mental illness.</p> <ul style="list-style-type: none"> <li>• P. 3, L115-118: No transition sentences needed.</li> <li>• Line 99 – Suggestion to rewrite: “...caused by gun violence has led to significant economic consequences”</li> <li>• Lines 111-1118 – There is a lack of mention of the 2<sup>nd</sup> amendment difficulties, as well as the difficulties faced in more favored gun ownership states. Since this is addressed in opposing arguments, it should be mentioned briefly here. P3,L111-L115: More current data needed.</li> </ul> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>• The term “gun control” has been out of favor in the field of firearm injury prevention for many years, as it inhibits dialogue and discussion.</li> <li>• Second paragraph – This could benefit from comparing how gun violence stats compare to other death statistics</li> <li>• Lines 89-97 - May be beneficial to mention why they have increased (due to ease of illegal weapon creation via parts ordering, illegal weapons obtained via the streets, etc)</li> <li>• Suicides by firearms, suicide risk among veterans and</li> </ul>	
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	<p>active-duty military by firearms [Perhaps a helpful source: Miller, M., Hemenway, D. Guns and suicide in the United States. N Engl J Med. 2008 Sep 4;359(10):989-91)</p> <ul style="list-style-type: none"> <li>• Domestic/interpersonal violence with firearms, for people in law enforcement</li> <li>• Some states do not require a permit to carry a firearm. Are there features of permitting laws that reduce risk gun violence (in those states)? Is requiring a permit reduce gun violence incidence in those states that require them?</li> <li>• Economic impact: Healthcare, disability, and other costs (e.g., impact on families, impact on community/co-workers, lost productivity) could be included to strengthen the public health impact</li> <li>• Ghost guns (come in kits and usually don't have serial numbers for tracking. (See: Wintemute, G.J. Ghost guns: spookier than you think they are. Inj Epidemiol. 2021 Apr 5;8(1):13.) After researching the topic, consider the significance of the problem and whether it is worth mentioning the proposed policy.</li> <li>• Address issues such as racial injustice, and more description on how youth</li> </ul>	
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	<p>are exposed to guns in home (e.g., due to not locking up properly; no gun safe)</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>When combining C3 and C4, use C3 problem statement with additional data, such as from C4's PS). C4 includes items such as communication about firearms (with cited examples)</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>d. Is/are the proposed strategy/strategies evidence-based?</p> <p>e. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>f. What other strategies, if any, should be considered? Should additional evidence for the</p>	<ul style="list-style-type: none"> <li>This section is well written as far as why support has been hindered under these varying policies. However, what is missing in quite a few places is why the strategy is being proposed (i.e., information is provided on why they have not been successful but rarely are suggestions provided as to how to make them successful, and if evidence is provided, it is not very substantive). Lines 233-242 provide an excellent example of solid suggestions to close out a strategy. Primary prevention strategies are lacking. Identify community-based efforts to reduce gun violence. Are there some that have been effective? See for example Baltimore's Safe Streets program <a href="https://monse.baltimorecity.gov/safe-streets-new">https://monse.baltimorecity.gov/safe-streets-new</a></li> <li>Strategy about lack of research may fit better in the problem statement;</li> </ul>	

<p>proposed or other strategies be included? If so, please provide data or references that should be considered.</p>	<p>evidence-based strategy could reflect on that for more funding for research</p> <ul style="list-style-type: none"> <li>• Definitions of gun violence are incomplete or inaccurate.</li> <li>• <b>P3-P4, L122-L153 (ERPO):</b> More detail needed on ERPO, GVRO, and other “red flag laws.” E.g., mention how many states and/or cities have ERPO, GVRO or similar laws. Need details/examples about how these orders come about and are implemented. (In some states, law enforcement may confiscate weapons; in others states people who possess firearms are required to turn them in upon an order from the court. In some states, family members may request surrender of weapons.) Line 123 – Define the acronym (ERPO) since it is used in other parts of this section. What evidence is available that ERPO are effective? (Are they fairly new and data not available on impact?</li> <li>• Line 131 – 133 – this statement does not make sense. Is it countries or counties? (This law seems specific to the US.) There might be evidence that points to the strength that police have in enacting laws to their full capacity. However, the way it is written, it doesn’t make sense to the reader.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Lines 138-144 - Is all of this data specific to Washington State? Is Washington State the only state where this type of data is available? If not – why isolate to Washington State? If so – mention that Washington State has the most data to support ERPO due to these statistics.</li> <li>• Line 139 – written by who? “(as was written in 2020)”</li> <li>• Line 140: during what time period?</li> <li>• Line 145: “most gun violence” ---what does this mean? Highest rate of deaths? Highest total number of firearm-related incidents? Replace “with the most” to “with the highest prevalence of gun violence”. There also appears to be an extra space between and Wyoming.</li> <li>• Line 146 – However is used to start a sentence twice on this line.</li> <li>• Line 147 – Identify Ely’s full name</li> <li>• Section on ERPO needs a conclusion.</li> <li>• Line 157 – Change “school going children” to “School aged children” and remove adolescents. Or simply say “adolescents and adults”</li> <li>• Line 161 – “While assault files...” is a confusing sentence. Rewrite for clarity.</li> <li>• Line 162 – Be specific here. “the weapons” should say “assault weapons”, or even “they” since you state</li> </ul>	
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	<p>“while assault files” (which should be “while assault weapons”??) – update this line for clarity to the reader.</p> <ul style="list-style-type: none"> <li>• Line 162 – should “violence and criminal usage” be combined? If not – is there a statistic for violence?</li> <li>• Line 163 – Clarify if this is murder of police officers or murders BY police officers</li> <li>• Line 165 – Not a strong enough statement. Not defined enough in the paragraph it is ending.</li> <li>• Line 174 – Rewrite for clarity: “states that incorporate”</li> <li>• Line 175 – Rewrite for clarity: “were associated”</li> <li>• P5,L183-194 Move the topic of taxation to “Alternative Strategies.” Mention the current federal and state taxes; and how taxes have been used to address other public health hazards (tobacco, sugary beverages); and any peer-reviewed or gray literature proposing this idea. (Place in Alternative Strategies Section because there isn’t evidence that a taxation policy has been tested as a public health intervention for firearm-related violence.)</li> <li>• L183-194 - With taxation, pro-gun owners may not perceive it to be harmful to society in the same way drugs, alcohol or tobacco are</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Line 188 – Define RAND – it has not appeared in the policy. If it’s an acronym also, spell out.</li> <li>• P5, L202-L204 Provide evidence on the efficacy of the Assault Weapons Ban (1994-2004) for the period of time it was in place.</li> <li>• Line 210 – The sentence that states “for a long time” undermines the strength that this introductory sentence could have.</li> <li>• P5, L211: “The Dickey amendment (which has been rescinded) states that no federal funds may be used to advocate for gun control. The statement that CDC was prohibited from conducting or funding firearm research because of the Dickey amendment is inaccurate. The National Center for Injury Prevention and Control at the CDC continued to perform surveillance of firearm deaths even after the Dickey amendment was added to its appropriations bill, and publishes this information in the MMWR on a yearly basis. The National Violence Death Reporting System (NVDRS), which has been in place at CDC for over a decade and was expanded to include all states in the past 2 years, collects data on firearm related deaths and has done so since its inception. The National Electronic Injury Surveillance System All Injuries System has collected deaths on all</li> </ul>	
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	<p>injury-related emergency department visits in its sample for several years, and the data include firearm-related injuries. NVDRS and the NEISS AIS are not mentioned in the background, nor are CDC's firearm surveillance work."</p> <ul style="list-style-type: none"> <li>○ Further information about the Dickey amendment: In 2018, Congress clarified/reinterpreted the Dickey amendment to indicate there was no prohibition on gun violence research. For the past 3 years, including the current federal budget year, CDC and NIH have received appropriations for gun violence research. The current funding level for each agency is \$12.5 million dollars. After the Sandy Hook shootings, President Obama issued an executive order requesting that CDC restart firearm violence prevention research, and that Congress appropriate \$10 million for the research. He also ordered that NCIPC</li> </ul>	
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	<p>develop a public health research agenda for gun violence research. The research funding never occurred, but the research agenda was developed by the Institute of Medicine (now the National Academy of Medicine) and released in June of 2013.”]</p> <ul style="list-style-type: none"> <li>• Line 214 – Rewrite for clarity: “the CDC”</li> <li>• Line 220 – Replace should with must</li> <li>• Line 223-243: Provide examples from some states that have these restrictions. What do the laws actually require? What calibers and/or types of rounds are addressed in the laws? How do the laws work? How are they implemented/enforced? P 6: “What is the evidence that this is an effective strategy? Is this a recommendation for background checks for the purchase of large-capacity magazines? What is the evidence for taxation of large-capacity magazines?”</li> <li>• Line 235: specify city outside of just “large metropolitan city” if this is the city being referred to. Ref. indicates it was Minneapolis.</li> <li>• Include information on closing the “boyfriend loophole” (i.e., In the</li> </ul>	
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	<p>Violence Against Women Act (VAWA) domestic abusers are defined as people who are married to, have lived with, or have children with the victim. VAWA reauthorization (S.3623, signed into law March 16, 2022) did not close boyfriend loophole (included in House bill, but removed in Senate bill)</p> <ul style="list-style-type: none"> <li>• Insufficient evidence on efficacy of 1994 - 2004 Assault Weapons Ban</li> </ul> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>• P4-P5 (Assault Weapons) The issues that became apparent with the Brady Bill are not described. From the author of C4: "For example, one of the difficulties was that there was a specific reference to the name of the weapons that were included in the bill. So, if the manufacturer modified the weapon and renamed it, it was no longer covered by the Brady law provisions. The reasons for the failure to renew the Brady bill, with any revisions that might have been needed, are not described."</li> <li>• Examine the issues with the Brady law and propose something that is similar but takes into account the problems that existed with the Brady law." <ul style="list-style-type: none"> <li>○ Further Information: Look at the 2017 amendment to</li> </ul> </li> </ul>	
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	<p>Brady law that addressed deficiency in the National Instant Criminal Background Check System (NICS) (following the Texas Sutherland Springs mass killing of 26 people). Is this a model for other deficiencies? It was a bi-partisan measure signed into law in 2017. (Of course, not perfect or addressing all of the problems, but it is something....) DOJ has a report on the laws impact  <a href="https://www.justice.gov/dag/page/file/1417981/download">:https://www.justice.gov/dag/page/file/1417981/download</a></p> <ul style="list-style-type: none"> <li>• An additional criticism of assault weapon ban legislation is that the term "assault weapon" is often loosely designed and based off of cosmetic features such as the rifle's stock, which has little bearing on the technical features of the rifle. For example, an "New York compliant AR-15" has a variety of aesthetic modifications to make it compliant with stricter gun control regulations in New York State but is not severely impacted in its capabilities. Furthermore, a Ruger Mini-</li> </ul>	
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	<p>14, a rifle of similar size firing the same ammunition, is not subject to the same regulations.”</p> <ul style="list-style-type: none"> <li>• Review the following: Mattson, SA, Sigel E, Mercado, MC. Risk and Protective Factors Associated with Youth Firearm Access, Possession or Carrying. Am J Crim Justice. 2020 Feb;45(5):844-864; Allchin, A., Chaplin, V., &amp; Horwitz, J. (2019). Limiting access to lethal means: applying the social ecological model for firearm suicide prevention. Injury prevention, 25(Suppl 1), i44-i48. ); From Ethics Ind - More recent PH literature points to the Social Ecological Model to reduce GV.</li> <li>• Consider including waiting periods for firearms (or particular types of firearms (e.g., handguns))</li> <li>• Include best practices for having guns inside of homes (gun safes, gun locks, separating ammunition from guns, etc.) and education for parents and children about these safety practices.</li> <li>• Hunting/sporting organizations for youth that offer gun safety programs? Have they proven effective?</li> <li>• Is there evidence that “Stand your ground laws” contribute to gun violence? If so, is there evidence that eliminating them would</li> </ul>	
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	<p>reduce firearm deaths and injuries?</p> <ul style="list-style-type: none"> <li>• Do state regulations differ for handguns versus long guns (e.g., hunting rifles)? Does that matter for the feasibility of interventions?</li> <li>• Is there evidence that restricting handgun sales is effective at saving lives and preventing injuries?</li> <li>• Is there data showing that limiting access to firearms can hinder a suicide attempt?</li> <li>• Suicide, domestic/interpersonal violence, impacts on medical care costs and trauma related disability should be included in problem statement; and provide information in the EBS on effective interventions Is there evidence to show that laws that require a permit and/or training reduce death and injuries?</li> </ul> <p><b>To Note:</b></p> <ul style="list-style-type: none"> <li>• When combining C3 and C4: These are additional EBS to research and consider: Firearm prohibition in certain settings (e.g., government buildings, K-12 public schools, employer-prohibitions on allowing firearms in workplaces; licenses; firearm storage; education/training for owners and sellers.</li> </ul>	
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<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>e. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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</p>	<ul style="list-style-type: none"> <li>• Lines 246-252 - Counter arguments should be strengthened. With respect to ERPO, consider writing one sentence that summarizes the data on effectiveness of ERPO in CO and WA.</li> <li>• Lines 248-249 – Rewrite for clarity: “ERPO laws, when implemented, can...”</li> <li>• Line 256 – Rewrite for clarity: “unlimited.”</li> <li>• Line 259 – Line unfinished</li> <li>• Line 260 - Incomplete sentence.</li> <li>• Line 275 – Is there a formatting issue here?</li> <li>• Line 280 – Rewrite for clarity: “19.8 million modern....”</li> <li>• Line 282-285 - reword for clarity. For example, L284: “found that bans..” Is this meant to be “found that guns...”?</li> <li>• Line 287 - Add reference at the end of this sentence.</li> <li>• Line 289-296 - Are the policies adopted in Switzerland feasible in the U.S.? How are these different than policies in U.S. (e.g., states with gun license requirements, federal backgrounds?); –Re: Switzerland laws/regulations, however, consider whether they are feasible in the U.S.</li> <li>• Are there additional countries that have enacted good gun control legislation that could also be included in this section?</li> </ul>	
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<p>e in reach etc.)?</p> <p>g. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>h. Were any opposing views missing?</p>	<ul style="list-style-type: none"> <li>• Evidence not strong enough to refute opposing view about the 2nd amendment</li> <li>• Evidence from more conservative states would strengthen; More attention on antigun arguments that cause opposition from other states wherein guns are a regular part of life.</li> <li>• Opposing views should more clearly describe political and/or judicial obstacles at the federal and state level</li> <li>• Address cultural heritage of gun ownership; rural and southern states where guns are viewed as essential to their way of living; missing perspective of firearms for hunting.</li> </ul> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>• In countries that have relatively high rates of per capita firearm ownership what are their laws/regulations? (member/unit comments suggested that Switzerland, Finland, and Austria would fit into this category.)</li> <li>• Consider a strategy that emphasizes restricting ammunition production/manufacturing; limitations of retail ammunition purchases within a certain timeframe.</li> <li>• Consider an alternative strategy that requires a separate license for ammunition purchase and consider limitations on ammo production and</li> </ul>	
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	<p>retail purchased with a timeframe to appeal to owners, or a separate license to purchase ammunition.</p> <ul style="list-style-type: none"> <li>• Have there been any effective strategies on restricting advertising on firearms and ammunition (e.g., akin to restrictions on tobacco advertising)?</li> <li>• Additional opposing argument: People will still want firearms so sales will go underground—causing more illegal sales.</li> </ul>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>e. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>f. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> <li>h. Culturally responsive to</li> </ul>	<ul style="list-style-type: none"> <li>• Overall action steps are too broad; there are a lot of questions concerning evidence or feasibility of strategies.</li> <li>• Line 302: (Assault rifle restrictions): “Vague.”</li> <li>• Line 307 – Numerical inconsistency - should be point 3. [noted below]</li> <li>• Line 308: Delete (see comments elsewhere about the Dickey amendment in “Evidence Based Strategies”)</li> <li>• Line 314: is text missing or just punctuation mark?</li> <li>• Organize with a header sentence that reads: APHA calls upon, or APHA urges” and then list each AS beginning with the target organization</li> <li>• Additional possible Action Steps (if also addressed in PS or EBS) – Read through PS/EBS to see what topics are covered here and not</li> </ul>	

<p>the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>included in the action steps.</p> <ul style="list-style-type: none"> <li>• See: “Gun Shop Project” to find projects involving gun shop owners in suicide prevention (in about 10 states): <a href="https://www.hsph.harvard.edu/means-matter/gun-shop-project/">https://www.hsph.harvard.edu/means-matter/gun-shop-project/</a></li> <li>• One or more AS should address upstream prevention like investments in violence education, prevention programs, social justice, and anti-racism.</li> <li>• Provide more details about implementing action steps around ERPO</li> <li>• Action steps 1&amp;2 need to consider pathway to implementation</li> <li>• Consider an AS concerning restrictions on handgun sales Need federal and public health research funding</li> </ul>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p><b>Action Steps:</b></p> <ul style="list-style-type: none"> <li>• The document uses 46 total references and ¼ of the references are older than 10 years. Coordinate with the author of C4 on references.</li> <li>• Remove/replace newspaper articles for more scientifically sound evidence if available</li> <li>• Ensure all Refs conform to APA format. There are numerous, but these are examples:</li> <li>• Ref. 4 (no journal title)</li> </ul>	

	<ul style="list-style-type: none"> <li>• Ref. 11: incomplete (reviewers/readers cannot check the source without complete information)</li> <li>• Ref. 16: incomplete</li> </ul>	
<p><b>Relationship to current proposals</b></p> <p>Does this proposal <b>RELATE TO OTHER CURRENT PROPOSALS</b>? Would you recommend that they be combined into one proposal?</p>	Suggest that C3 be combined with C4.	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	Reviewers suggest that additional reviews be completed with Mighty Fine (APHA) and Family Violence Prevention Caucus.	

## C4: A Public Health Approach to Firearms Prevention Policy

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<p><b>Title</b></p> <p>Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?</p>	<ul style="list-style-type: none"> <li>• The title does not align with the policy. A suggested title might be: "A Public Health Approach to Firearm Violence Prevention." "Policy" is not needed at the end of title</li> <li>• Alternately, please consider inserting "Injury" or "Risks" between "Firearm" and "Prevention" (or some similar edit) to avoid the sense of preventing firearms themselves.</li> </ul>	
<p><b>Relationship to existing APHA policy statements</b></p> <p>Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)</p>	<ul style="list-style-type: none"> <li>• This policy is replacing 20184--Reducing Suicides by Firearms and linking to 20185--Violence as a Public Health Issue and to 201811--Addressing Law Enforcement Violence. The policy does consider suicide, and law enforcement violence but is broader than that statement, linking to those policies. Refute throughout the paper.</li> </ul>	

	<ul style="list-style-type: none"> <li>Should reference policy: 20213</li> </ul>	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<ul style="list-style-type: none"> <li>This policy (unless rewritten significantly) could be combined with PPS C3 Public Health Approach to Gun Violence, because both focus on the factors identified in Haddon's Matrix. (Several reviewers agreed with this). As will be described below, Haddon's Matrix, as presented, is limiting given the broader scope of gun violence prevention activities. But, a focus on the mechanical, environmental, and legal strategies makes sense as one of several policies needed.</li> </ul>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>g. Are there important facts that are missing from the problem statement? If so, describe them.</p> <p>h. Document any disproportionate impact on underserved populations? For</p>	<ul style="list-style-type: none"> <li>The problem statement is very narrowly presented and is less than a page. It does not include key arguments on why this is a public health issue, why it should be addressed using a public health approach and why this approach has not been used consistently. In addition, the public health approach needs to be specifically defined. Is this the same as science-based public health?</li> </ul>	

<p>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.?</p> <p>i. Identify any relevant ethical<sup>xiii</sup>, equitable<sup>xiv</sup>, political or economic<sup>xv</sup> issues.</p>	<ul style="list-style-type: none"> <li>• Consider reference to the IOM &amp; NRC report, Priorities for Research to Reduce the Threat of Firearm-Related Violence (2013) which covered much of the same information including potential interventions. Was that report's recommendations implemented and evaluated?</li> <li>• Line 67 – this 85% number differs from the CDC statistics. We would recommend using CDC data, unless there are problems with it.</li> <li>• Line 72 – sentence needs to be fixed: “or with a belief I that they need” perhaps by deleting “I.”</li> <li>• Line 70 – 71 – this sentence needs to be re-written. It could state, “due to improper storage of firearms.” When phrased the current way, it may insult those who own or use firearms.</li> <li>• Line 74 – We fear that “vectors of violence” is not a neutral phrase but rather possibly provocative.</li> <li>• Lines 76-81 – This closing sentence may insult gun owners and adds nothing to addressing the actual problem. May belong in opposing viewpoints. May be best to delete last sentence of the problem statement.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Mass shootings was not fully discussed, which needs more attention. Detail if firearm-related deaths exceed deaths outside of motor vehicles (which would make this problem statement more concrete). There is little supporting statistical evidence. For example, what are the statistics for firearm deaths versus motor vehicle deaths which they now exceed? Improve problem statement with more data</li> <li>• Include numbers in the problem statement (intent vs unintentional injury)</li> <li>• The claim that there is opposition to science-based public health measures by some firearm proponents needs documentation.</li> <li>• The CoA review noted that there was no discussion of rural and southern states and the culture of guns ownership.</li> <li>• Consider the implications of extenuating events (such as pandemics) on violent crime <a href="https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html">https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html</a></li> <li>• There is more data from another FBI database available <a href="https://crime-data-explorer.app.cloud.gov/pages/explorer/crime/crime-trend">https://crime-data-explorer.app.cloud.gov/pages/explorer/crime/crime-trend</a></li> <li>• The statement does not cite examples of underserved</li> </ul>	
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	<p>populations. It would be relevant and useful to include police gun violence on non-white men, impacts of IPV on indigenous women and trans women by male partners, on LGBTQ populations, mass shootings, high rates of suicide, hate crimes that are motivated by gender minority identities (occur at higher rates than religious or racially motivated crimes).</p> <ul style="list-style-type: none"> <li>• Ethical, equitable, economic and/or political issues are not addressed.</li> <li>• Suicide death is mentioned in the problem statement, but not elaborated in the proposed strategies or action steps.</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>• In problem statement note specific federal and state policies with no broad health approaches.</li> <li>• No real mention or target on root causes of gun violence</li> <li>• No ethical, political equity or economic issues that were not identified, clarity in funding limitations for research</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p>	<ul style="list-style-type: none"> <li>• Lines 92 – 94 how these will improve firearm safety? Short sentences could show how contribute.</li> <li>• Line 95 – rephrase so this is not a question. An example</li> </ul>	

<p>g. Is/are the proposed strategy/strategies evidence-based?</p> <p>h. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>might be “Given that there are firearms in our environment, public health-based best practices must be used to keep people safe.”</p> <ul style="list-style-type: none"> <li>• Line 97 – end sentence “and deaths. Haddon’s counter-measures serves as a guide to prevention and can be applied to the issue of firearm violence.” Honestly, the entire sentence is a bit confusing and hard to read. Shorter, more cohesive sentences would clarify them.</li> <li>• Line 106 – 107 – brings no value to the strategies. Rewriting for clarity would make it more succinct and understandable.</li> <li>• Line 116 – 118: This sentence is confusing and provides no information on how this relates to firearm injury.</li> <li>• Line 120 and 134– remove the link. There are only 44 citations so there is room to add this as a citation.</li> <li>• Line 123 – should be “the CDC” in this context.</li> <li>• Line 125 – remove hyphen</li> <li>• Lines 125-128 – this list may flow better as bullets. If so, it would need to be applied to other sections as well. For example, in the next paragraph, it would be helpful to understand better if they are all listed and defined.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Line 139 – provide a date that the DOJ was able to start funding research.</li> <li>• Line 144 – it would strengthen the policy to add how much funding (approximately) is put into firearm violence research as compared to another (i.e., funding put into motor vehicle death prevention, since that was a comparison factor previously).</li> <li>• Lines 146 – 149: This is a strong statement. Strengthen this by highlighting the importance of evidence-based OR reiterate the problems with collecting evidence based.</li> <li>• Line 153 – define some of these resources to validate why you even mention ACS.</li> <li>• Line 154 (communication) – this entire section needs further support. Additionally, if we are the experts (public health professionals) it does not give this paper strength to highlight how we are professionals don't always understand terminology. This section either should be strengthened with evidence-based reasoning or removed.</li> <li>• There is one small paragraph on Racism and social justice which is a huge issue with gun violence. This section should be a highlight, not an</li> </ul>	
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	<p>afterthought. There is no mention of social determinants of health or other public health concepts that may strengthen this section.</p> <ul style="list-style-type: none"> <li>• The “Data, data sources and data challenges” section has zero data. Data is hard to come by via gun violence, but it does exist.</li> <li>• The proposal does not sufficiently describe what strategies are being proposed to address the problem. You provide a table of Haddon’s Matrix; however, the description for this table is insufficient and therefore it is unclear if this is the recommended public health approach to this issue. Please consider removing the Haddon’s matrix in favor of clearer strategies.</li> <li>• Major questions to be answered: <ul style="list-style-type: none"> <li>-What is the public approach—is it Haddon’s Matrix?</li> <li>-How are decisions made about interventions?</li> <li>-How do you implement the public health approach?</li> <li>-Who should implement this approach?</li> </ul> <p>Recommendations including agencies and organizations that could be partners on these efforts.</p> </li> </ul>	
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	<p>-What will occur if this approach is implemented?</p> <ul style="list-style-type: none"> <li>• Direct Citation: A social-ecological model advises an array of programs to reduce gun violence that they do not include in the buildout of their Matrix. Following, for example, Allchin, A., Chaplin, V., &amp; Horwitz, J. (2019). Limiting access to lethal means: applying the social ecological model for firearm suicide prevention. Injury prevention, 25 (Suppl 1), i44-i48.] We would expect to see in the Matrix additional interventions involving the social-ecology of social determinants, including: <ul style="list-style-type: none"> <li>-interventions at gun shops and events where firearms are legally sold;</li> <li>-interventions at firing ranges, hunt clubs, and other legal firearm sites;</li> <li>-interventions in settings of illegal firearms use: with criminal gangs, with offenders of firearms laws, and in other settings to address illicit gun ownership and use;</li> <li>-interventions to increase access to mental health services, on the spot, at will, 'no wrong doors' for access, etc;</li> <li>-deploying values-creators in local communities, that may include faith communities,</li> </ul> </li> </ul>	
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	<p>sports and athletics communities, patriotic/civic pride communities, etc. at multiple levels throughout the community</p> <ul style="list-style-type: none"> <li>• Much emphasis is on the use of Haddon’s Matrix—there is one editorial reference but no reference to the many publications that have described this matrix. His matrix as applied to firearm violence is presented with no referencing except an opinion piece that uses the concept of energy to identify 10 strategies for accident presentation that focus mostly on the environment. While these are important components of a public health approach; there appear to be factors missing, especially in the socio-cultural arena and social determinants such as poverty.</li> <li>• There is then a comparable table where research results pertinent to preventing firearm violence are displayed. However, there is no information about how to use the matrix in decision making nor any clear relationship with the principles and concepts identified as important.</li> <li>• You provide strategies to address the problem that may be evidence-based but</li> </ul>	
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	<p>the evidence is not directly referenced.</p> <ul style="list-style-type: none"> <li>• The major strategy is to use a comprehensive public health approach. The first part of this approach are recommendations for principles and concepts as a foundation for strategies. There is no definition of these concepts, no referencing as to the choice of these principles, and no indication of how they are to be used in the comprehensive approach.</li> <li>• Some of the information in the Evidence-based strategies section (e.g., P6, Lines 142-145); P7, Lines 164-170) could be in the Problem Statement. With respect to funding (P.6 Lines144-145) provide data to make their case that it is underfunded compared to “other issues and risk factors that are related to death, injury, and disability.”</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>• Are the Communication and Racism and Social Justice sections strategies or part of the problem statement?</li> <li>• It is suggested to be more specific around the agencies and parties that should be considered accountable for addressing and implementing proposed core principles and practices.</li> </ul>	
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	<ul style="list-style-type: none"> <li>Consider as an additional strategy a critical review or meta-analysis of interventions and evaluations to determine effective approaches.</li> </ul>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>i. Does it adequately refute the opposing/alt ernative viewpoints presented using evidence? If not, please explain.</p> <p>j. Is the proposed approach justified in comparison to opposing/alt ernative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)?</p> <p>k. Are alternative viewpoints, ethical,</p>	<ul style="list-style-type: none"> <li>On what basis do you believe that people presume firearm owners don't support firearms control? The 2nd sentence might betray an unhelpful bias for APHA to promote.</li> <li>Please cite groups that resist good measures against firearm violence and describe their reasons. Are there any that provide data or analyses that can be countered? The limited and poor research found by Holly et al (42) does not disprove education's effect on lowering firearm violence.</li> <li>Line 172 – "...violence has taken ON a number of forms."</li> <li>Line 173-174: citation on owner's current views?</li> <li>Line 175 – resist what measures?</li> <li>Line 176 – "...people kill people." Other...."</li> <li>Opposing viewpoints are needed. Many of the arguments are simply followed by citations, but additional information and data can be included. Consider more opposing arguments and add refutation(s) with references to opposing arguments.</li> </ul>	

<p>equitable and reasonable?</p> <p>I. Were any opposing views missing?</p>	<ul style="list-style-type: none"> <li>• Nothing is provided under Alternative Strategies and this could be a valuable opportunity to point out what has worked, and what has not worked in gun prevention efforts.</li> <li>• The arguments presented are only ones directed to individuals and organizations that oppose a science-based public health approach. A major argument is missing: Many organizations and researchers follow single strategies to impact firearm use rather than a comprehensive approach. A variety of reasons account for this—limited funds, limited time, etc.</li> <li>• Political views not included in opposition</li> <li>• Opposition to limits on police use of gun violence, especially when concerning mental health crisis, and within that group people of color.</li> <li>• No discussion of rural and southern states (heavy on 2nd amendment rights), which causes major issues with resistance. Missing information on 2<sup>nd</sup> amendment rights pointed out by several member/units.</li> </ul>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <p>i. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p>	<ul style="list-style-type: none"> <li>• APHA policy statement guidelines require actions by non-APHA entities rather than by APHA or its units. Please make action steps by persons or organizations external to APHA. Action steps 1, 2, 5 and 6 are written to be part of APHA work</li> </ul>	

<p>j. Focused on policy/principle, and not on specific legislation/regulation ?</p> <p>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?</p> <p>l. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p> <p>*If additional action steps are needed, note whether you believe authors need to exceed the 10 page, 50 reference limits to address gaps and if so by how much.</p>	<p>rather than externally policy focused. Action steps 3, 4, 7 and 8 are broad and not specifically targeted to appropriate agencies/actions.</p> <ul style="list-style-type: none"> <li>• The action steps flow logically from the strategies, but the steps themselves are not specific.</li> <li>• Consider if any should include Haddon’s Matrix (since it is so prominent in the evidence-based strategies section).</li> <li>• Estimate what constitutes “adequate” funding or provide perspective relative to other activities’ support.</li> <li>• More concretely indicate what “a foundation in social justice, equity, and anti-racism” means?</li> <li>• The specifics of these steps can be elaborated more in the entirety of the policy. For example, in lines 207-209 there is no mention of how education or other activities has played a role in preventing or increasing firearm violence.</li> <li>• No mention is made of underserved populations. They specifically seem omitted in the entirety of the policy. Including partner organizations, community-based organizations/community collaborators facilitate more culturally responsive action steps.</li> <li>• Please consider removing the matrix to allow expanding the proposal.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Community Health Workers and other outreach programs not mentioned</li> <li>• Strengthen evidence-based strategies using other prevention strategies (e.g., CHW, CURE Violence, Health Alliance Violence Intervention)</li> <li>• Additional strategies—national archives, primary death causes via vital statistics, crimes via DHS.</li> <li>• Equitable liability may result in requesting funding.</li> <li>• More specific action steps around who needs to take ownership</li> <li>• Action steps do not include specific forms of firearm violence</li> <li>• Action steps should be organized by priority</li> <li>• Expand more tailored action steps that center equity</li> </ul>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<ul style="list-style-type: none"> <li>• No substantive references about Haddon’s matrix and outcomes of its use. The references provided in the Everytown Research are often not peer reviewed articles although the data are important.</li> <li>• Reference #20 is incomplete.</li> <li>• References 16, 17, and 32 have typos.</li> <li>• Reference 24 – Does a USA Today article diminish scientific rigor?</li> <li>• As noted above, please consider reference to the IOM &amp; NRC report, Priorities for Research to Reduce the</li> </ul>	

	Threat of Firearm-Related Violence (2013).	
<p><b>Social justice and human rights metrics</b></p> <p>Does the proposal <b>primarily</b> focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below:</p> <ol style="list-style-type: none"> <li>Does <u>International Human Rights Law</u> [<a href="http://www.asil.org/erg/?page=ihr">http://www.asil.org/erg/?page=ihr</a>] support this issue?</li> <li>Is the proposal consistent with the <u>Universal Declaration of Human Rights</u> [<a href="http://www.un.org/en/documents/udhr/">http://www.un.org/en/documents/udhr/</a>]?</li> <li>Is the proposal consistent with the <u>WHO Commission on Social Determinants of Health</u> (CSDH) [<a href="http://www.who.int/social_determinants/thecommission/en/">http://www.who.int/social_determinants/thecommission/en/</a>]?</li> <li>Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the <u>International Human rights Committee</u> and the <u>Ethics Section</u>?</li> </ol>	<ul style="list-style-type: none"> <li>Due to the lack of data, examples, and flow, this paper does not adequately address human rights and social justice as it should.</li> </ul>	
<b>Relationship to current proposals</b>	<b>Action Steps:</b>	

<p>Does this proposal <b>RELATE TO OTHER CURRENT PROPOSALS</b>? Would you recommend that they be combined into one proposal?</p>	<ul style="list-style-type: none"> <li>Recommended merging this statement with C3</li> </ul>	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<ul style="list-style-type: none"> <li>Once a concrete paper has been presented, invite a review by Mighty Fine (APHA); as he has strong interests in gun control.</li> </ul>	

## C5: A More Equitable Approach to the Enforcement of Commercial Tobacco Control

**Spring Assessment: Negative**

**IMPORTANT:** Action steps are taken from a joint statement from a consortium of public health organizations. These need to be appropriately cited and rephrased to avoid plagiarism. Plagiarism violates our professional ethics.

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	<p>The title is: A More Equitable Approach to the Enforcement of Commercial Tobacco Control. However, if the proposed policy is only for the enforcement of tobacco control policies (and not the actual crafting/writing of these policies or their content), then it should be very specific and restrict the statement only to the enforcement.</p> <p>Note that the policy proposal focusses specifically on the US</p>	<p><i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i></p>

<p><b>Relationship to existing APHA policy statements</b></p> <p>Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)</p>		
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>The focus of this proposal calls for equitable regulation of tobacco products, including removal of PUP laws and move from criminal to civil penalty structure of all tobacco laws</p> <p>Articulate more clearly how this is a policy gap. As written the Rationale for Consideration does not help the reader to understand the true rationale for this policy statement nor its relationship to other policy statements. The “urgent priority of health equity and the recognized faults of currently tobacco prevention and control laws serves as a rationale for this policy statement”, but that point is not a necessary conclusion for a reader to make. If this is true, the points in the previous paragraphs should lead to that conclusion.</p>	



	<p>Add information about unequal access to services/products to help with tobacco addiction. Cessation and counseling are mentioned in the introduction to the Action Steps, but not addressed in Problem Statement and/or Evidence - based Strategies</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ul style="list-style-type: none"> <li>g. Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> <li>i. Identify any relevant ethical<sup>xvi</sup>, equitable<sup>xvii</sup>, political or economic<sup>xviii</sup> issues.</li> </ul>	<p>Add data and evidence to describe the prevalence of criminal enforcement of tobacco control laws. If no data is available, indicate the lack of data (and perhaps call for funding to collect data.)</p> <p>Make a distinction between criminal enforcement of tobacco control laws and other means of enforcement and/or interventions. For example, laws on minimum age for purchase of tobacco products are enforced but are not criminal violations in all jurisdictions. Using precise and consistent language on these different interventions (i.e., ones that are appropriate and ones that are not) would make the statement more clear to reader.</p> <p>The problem statement adequately describes the</p>	

	<p>extent of the criminalization of tobacco use and issues with purchase, use, and possession laws. Is the issue of criminality within tobacco prevention found uniformly across US regions? Is it more prevalent in certain regions than others? One region in particular, Ocean City, Maryland is mentioned. How much does the criminalization of tobacco cost the US taxpayer? In other words, what is the economic impact of bringing youth into the justice system based on a tobacco violation? Stating an estimated figure (if such data exists) would strengthen the argument of the proposal</p> <p>The problem statement gives an overview of criminalization of health behaviors and issues with purchase, use, and possession (PUP) laws. This seems to be the focus of the proposed policy. However, the stated aim of the policy statement is much broader: advance equity as it relates to the purchase, use, possession, sale, and distribution of all commercial tobacco products. Therefore, the scope of the problem statement needs to be aligned with the aim.</p>	
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	<p>Provide additional examples of how harms related to PUP criminalization for youth disproportionately effect BIPOC communities. (beyond Ocean City)</p> <p>Add data to document the disproportionate impact on populations. While groups are mentioned, there is no magnitude of the burden provided to make the case, especially for the purchase, use and possession law</p> <p>Add discussion related to the impact/effectiveness of current law enforcement for businesses who sell to underage tobacco purchasers, nor the impact of previous legislation (i.e. no commercials on television or in print for tobacco products) have had on this problem.</p> <p>Evidence in the problem statement is limited, few sources. The problem statement could benefit from evidence earlier in the paragraph. Problem statement mentions multiple perspectives in the potential for inequity, but the evidence and description of problems are only elaborated for Black youth/adults. Problem statement needs either</p>	
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	<p>to explicitly focus on this population, or provide more evidence / description of equity issues for other populations at risk of disparity.</p> <p>The problem statement could benefit from less jargon and more applicability statements in the beginning. A non-subject matter expert must read deep into the problem-statement paragraph before learning of the problem. A non-expert or quick-skimming policymaker/advocate could read the problem statement and think the problem is with tobacco-control laws in public. The shift from criminal/individual punishment must be up front and clear.</p> <p>The strategy of moving from criminal to civil penalties for underage tobacco purchase, use, and possession needs to be specific about whether this would be a state or national strategy and how this would address the disparity in enforcement or stigmatization.</p>	
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<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ul style="list-style-type: none"> <li>g. Is/are the proposed strategy/strategies evidence-based?</li> <li>h. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ul>	<p>Providing more real -world evidence that the best policy interventions would be raising the price of tobacco products and bans (e.g., self -service bans, flawed product bans).</p> <p>The strategies are confusing about who should enforce laws. Needs to be clearer on which policies to keep, reform/change, and the impact for each population noted</p> <p>While there is evidence for several of the strategies proposed, the evidence for two main proposed strategies is not adequate. Include evidence showing the effectiveness of: (1) eliminating youth PUP laws and (2) moving from a criminal to civil penalty structure of all tobacco laws. The evidence is overgeneralized in some instances, e.g., evidence for Black only extended to all vulnerable groups, study on people with possession of tobacco products generalized to PUP (purchase, possession, and use)</p>	

	<p>The list of evidence-based strategies is incomplete. While many of these strategies are focused on policy/institutional reform, there is no strategy for implementing these reforms. How do you assume that asking for these policy/institutional reforms will lead to their implementation?</p> <p>The evidence provided for raising prices is limited and incomplete. This is well-studied area, but here you only select a few references.</p> <p>More importantly however, is that the “total effect” of raising prices on e-cigs is absent and may mislead the reader. Consider recent work by Courtemanche 2019, which found that raising the price of e -cigs led to lower e-cig use, but individuals substituted to cigarette use. Without acknowledging this recent evidence, and finding ways to overcome this substitution effect, the policy/regulation section may be easily refuted by those with opposing viewpoints.</p> <p>Within the list of best practices are “Prosecution of offenders” (L.294) and “penalties</p>	
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	<p>for violating the law” (L.295). This seems inconsistent with your opposition to criminal enforcement. Clarification/elaboration</p> <p>The statement “There is no research indicating that effective enforcement programs require the use of law enforcement.” (Line 301) is problematic. Is there research indicating the opposite conclusion? This statement is followed by supporting sentences that overstate the conclusions of the articles cited.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ul style="list-style-type: none"> <li>i. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>k. Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>l. Were any opposing views missing?</li> </ul>	<p>The opposing argument about second -hand, third-hand smoke seems remote. Would proponents of tobacco bans be opposed to interventions that could discourage smoking?</p> <p>Address the possible “substitution” from e-cigs to cigarettes in opposing arguments.</p> <p>Improve the scientific evidence used to refute the opposing argument “increase in tobacco use in the long run due to alternate supply sources (e.g., a black market), benefits of PUP in predominantly White</p>	

	<p>communities only and demonstrated short-term reductions, lack of resources for enforcing tobacco possession policies. “</p> <p>Evidence suggests that youth of color are disproportionately cited for tobacco PUP, which ultimately increases their interactions with law enforcement” (line 413). These statements are based on one study conducted in Texas in 2000, which was based on respondent report only. The study also only looked at citations for possession-- not purchase -- so not “PUP”. It is a determinable fact how and the racial category of the individuals cited. Yet, there is no study that has looked at actual cases in this manner. By contrast, studies cited in this position paper note that PUP laws are infrequently enforced.</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS:</b></p> <p>h. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p>	<p><b>Action steps are taken from a joint statement from a consortium of public health organizations. These need to be appropriately cited and rephrased to avoid plagiarism.</b></p>	



<p>i. Focused on policy/principle, and not on specific legislation/regulation?</p> <p>j. 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> <p>k. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p> <p>*If additional action steps are needed, note whether you believe authors need to exceed the 10 page, 50 reference limits to address gaps and if so by how much.</p>	<p>Provide evidence for Value 1 step 1 (Vest enforcement authority for commercial tobacco control laws in public health or other non-police officials (e.g. civil code enforcement officers).</p> <p>More information needs to be provided on how these action steps will be implemented.</p> <p>Many of the action steps are not directly supported by the evidence or rationale documented in the proposal. It is difficult to gauge from the current steps how they relate to the evidence. It would strengthen the proposal if:</p> <p>(1) the evidence/rationale is presented in certain themes; (2) the strategies are presented under those same themes; and lastly, (3) the action steps are also presented under those same theme</p> <p>Action step to increase government oversight for tobacco sellers and seller requirements will have financial implications. This raises concern for feasibility without further information</p> <p>Add institutional reform guidance or action steps</p>	
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	that can facilitate the action steps described in the statement.	
<b>References</b>  Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?	Appropriate cite the Action Steps to prevent plagiarism  The references are properly formatted but many of them are old references (15 -20 years old) and need to be updated.  Add additional peer-reviewed evidence where appropriate.	

## C6: The Misuse of Preemptive Laws and the Impact on Public Health

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

<b>Criteria</b>	<b>Write a summary statement and include recommendations to the author.</b>	<b>Author's Response</b> <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The word "Impact" has a neutral connotation; precede, for example, with negative.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	This statement intends to replace 201511. This statement adequately updates developments since the previous statement.  Are their existing policy statements on abortion to include.  Delete L47-48. Not necessary.	
<b>Rationale for consideration</b>  Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> identified for the current year (see attachment)? IF YES, please identify the topic area. If NO, please comment whether the author	Please correct the misspelling of "Rationale."	

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?		
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> <li>Identify any relevant ethical<sup>7</sup>, equitable<sup>8</sup>, political or economic<sup>9</sup> issues.</li> </ol>	<p>You use much of the PS (on/about L74-132) to explain the topic of preemption. With general language on the sorts of preemption topics. What is missing are detailed examples of preemptive laws that have negative consequences on public health (e.g, disease and injury prevention; health equity; social determinants of health.)</p> <p>L94-102 provide Refs.</p> <p>L99-102 an example of ceiling and vacuum preemption involving PH topics would be helpful.</p> <p>Examples of ways to improve the PS:</p> <p>*L105-107 provide examples from recent history (10-15 years).          *P107-110 provide examples.          *P117: (re: policy experimentation leading to widescale adoption).          Provide examples using papers on intervention effectiveness (e.g., published in AJPH, Public Health Reports, Milbank, Cochrane Collaborative.)</p>	

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	<p>Instead of relying on broad statements from Ref. 7, provide specific examples. (An example could read something like: From [year through year] # of cities in [state] adopted [ordinance/law on A]. [B,C,D (stakeholders)] worked with state lawmakers to pass a bill in [year] that [did E].</p> <p>In the Rationale for Consideration, you mention that in Florida, more than 50 preemptive laws have been enacted since 2010. Describe some of them in the PS that are PH-relevant (and provide Refs (preferably not news articles which often disappear for readers in years ahead or fall behind paywalls.))</p> <p>You mention in the Rationale for Consideration, the topic of punitive measures against local officials. In the PS describe some of them (and provide Refs.)</p> <p>L161-L163 Provide Ref for the phrase (“in years leading up to the COVID-19 pandemic, states across the country amped up their preemptive efforts across a variety of issues”). We don’t see that topic in Ref. 7. In addition, providing state-specific examples to document the amped up efforts, and the “massive amount of preemptive” action (as stated in L57) is not well supported by what is presented in the PS. Overall, too general, with just a smattering of examples. It isn’t until P5, L145 that you provide an example.</p> <p>L153-159: Rephrase to be more precise and clear for readers. Ref for the California Code reads “assessment on groceries.” The aim of some local governments and/or</p>	
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	<p>local citizen initiatives was sugary beverages. If we are understanding correctly, the beverage industry's opposition strategy (statewide) was sophisticated. Ref. 15 suggests it was able to draw support from localities/mayors, unions, etc.</p> <p>L171-172: Elaborate on each of the topics (masks, vaccine, quarantine) mentions with numbers of states. How many are cover all infectious diseases vs. COVID-19 specific. Is there a better source that lists each of the laws? Are there some that address all three of the topics?</p> <p>L175-178: add date it became law or took effect.</p> <p>L180-181: "successfully" challenged?</p> <p>L187-190: Rephrase to include the date of the survey (2018).</p> <p>L191-195: Instead of a summary statement, provide examples.</p> <p>L208-211: Provide Ref.</p> <p>Missing from the discussion is the use of preemption to override local ordinances for protection of LGBTQ+ rights.  <a href="https://ballotpedia.org/Transgender_bathroom_access_laws_in_the_United_States">https://ballotpedia.org/Transgender bathroom access laws in the United States</a></p> <p>Consider examples from 2020-2022 when rural lawmakers in Kansas and Missouri preempted local control efforts in more urban areas. The disparate incidence rates of COVID-19 between more urban areas and rural communities empowered claims of government "overreach on individual liberties." The result was a statewide assertion of power to</p>	
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	<p>quash perceived liberal strongholds or individual authority figures preventing local efforts at control that would not be necessary in some rural communities.</p> <p>Please highlight the connection between the risk that preemption holds for the public health profession as a whole and how it influences the abilities of public health professionals to fulfill their roles of protecting the public's health.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ol style="list-style-type: none"> <li>Is/are the proposed strategy/strategies evidence-based?</li> <li>Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ol>	<p>This section is presented as a list of recommendations. It does not describe strategies being used to address the problem. It lists what actors could do instead of what has actually been done. The EBS should flow from the PS. You should examine recent APHA policy statements to see how these sections are written and how evidence is presented (and Refs provided).</p> <p>Topics/ideas for EBS:</p> <p>*Describe initiatives that are doing this and the result.</p> <p>*What organizations/disciplines are doing this research and what has been its effect? Are there examples from other legal/regulatory tactics or campaigns that have benefits from research to influence law? Could they be a model to use research to influence policymaking?</p>	

	<p>*What types of public health evidence can play a key role in proposed EBS2? Is there a case-study or policy that has been successful in using a type of evidence during the policy making process to assist with determining whether preemption will have a positive, negative or neutral impact on public health?</p> <p>*Consider whether community impact analyses could be used to temper/influence preemption efforts.</p> <p>* Documenting evidence of the harms and organizing advocacy efforts to repeal laws or request relief from Governors in the midst of a state of emergency declaration could be an added strategy.</p> <p>Additional sources that may be helpful for ideas for EBS.</p> <p>Awareness campaigns of examples of preemption could help organize various interest groups to work together.  <a href="https://lawatlas.org/datasets/preemption-project">https://lawatlas.org/datasets/preemption-project</a></p> <p>What has been the impact of awareness training program or information: such as:  <a href="https://www.changelabsolutions.org/product/preemption-public-health">https://www.changelabsolutions.org/product/preemption-public-health</a>  <a href="https://www.changelabsolutions.org/product/assessing-addressing-preemption">https://www.changelabsolutions.org/product/assessing-addressing-preemption</a></p> <p>Without the benefit of evidentiary support, it is unclear if the current proposed strategies are ethical and equitable.</p>	
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<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ul style="list-style-type: none"> <li>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>c. Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>d. Were any opposing views missing?</li> </ul>	<p>L233-234: We were unable to find the quote in the reference provided (Ref. 26)</p> <p>Additional OS: The negative impact of preemptive legislation and health outcomes is not supported by the evidence provided. At best, the described relationship could be called correlated, but it ignores all of the many other health related policies which could impact life expectancy in these communities. The practice of preemption in an effort to disempower public health happens in the context of a larger anti-science anti-government environment.</p> <p>There does not appear to be any evidence suggesting the negative impact of lost income or opportunity costs associated with missed work due to COVID-19 infection. As an example, many of policies aimed at preventing secondhand smoke have historically been blamed for lost revenue in bars and restaurants. Consider adding this as an OV and rebut (with Ref.)</p> <p>Some people/ organizations/ lawmakers prioritize other things above public safety and welfare, such as individual liberty.</p> <p>L248-251: Provide ref.</p> <p>L251-250: Provide examples descriptions of how PH campaigns have accepted preemption.</p> <p>Lines 252-258: Are the examples you provide a rebuttal to L248-249 and/or L249-251? They don't see to be.</p>	
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	L253-256: Possible causality between preemption and outcome differences. As written, without specific evidence of the connections, this is at best a correlation and does not represent causation. Is there additional evidence to support your rebuttal?	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ol style="list-style-type: none"> <li>Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>Focused on policy/principle, and not on specific legislation/regulation?</li> <li>Supported by the evidence or rationale documented in the proposal? Are the action steps evidence-based, ethical, equitable and feasible? If not, please explain?</li> <li>Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ol>	<p>Language can be made stronger and more direct in this call to action. For example, using words like should makes it vague as to whether the action must happen. The word 'advocates' is also vague as to who that is asking to take action.</p> <p>Some of the AS (e.g., 7, 8, 9) are aspirational, not action.</p> <p>The steps should also align with the evidence-based strategies above. Once those strategies have more direct evidence added, these actions steps should parallel those strategies. AS should flow from EBS described. Some examples:</p> <p>A1: is there a strategy, such as requiring a health impact assessment for legislation</p> <p>AS2 and 3: are there situations in which this has occurred that could be described in the EBS? Where has it been tried? (Use in EBS)</p> <p>AS4: examples of floor pre-emption in laws (in PH or related) (Use in EBS)</p> <p>A8: Is there an example of this being tried and successful? (Use in EBS)</p> <p>Etc. for other AS.</p>	

	<p>AS rely heavily on policymakers prioritizing PH. This may be overly optimistic, as some simply prioritize other things above PH.</p> <p>There needs to be more discussion of the situation for sexual minorities.</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>		
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>The proposal could benefit from a review by the Public Health Law Section</p>	

## C7: Advancing Health Equity Through Inclusive Democracy and Access to Voting

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The term “inclusive democracy” is not fully developed in the statement. The statement focuses more on civic engagement. Recommend revising title to: Advancing Health Equity through access to voting.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?	<p>It is not clear that these statements speak to political determinants of health, which would be a nice frame to strengthen the arguments presented in this statement: how civic health and public health are related and connected to health equity.</p> <p>Consider the relation to “Advancing Public Health Interventions to Address the Harms of the Carceral System”?</p> <p>It should be noted that LB20-04 was not adopted as an APHA policy in the year following its submission as a late breaker.</p>	

<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP</b> or requested <b>UPDATE</b> 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?</p>	<p>As previously noted, the policy statement does not reflect on a policy gap related to political determinants of health. If focused on the political determinants, you could argue that their statement completes the connection between structural racism and social determinants of health to consider the political environment, which created barriers to equity through limited access to voting.</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> <li>Identify any relevant ethical<sup>xix</sup>, equitable<sup>xx</sup>, political or economic<sup>xxi</sup> issues.</li> </ol>	<p>Please add additional content to describe the disproportionate impact on health outcomes among underserved and diverse populations.</p> <p>The problem statement does not adequately describe what exactly is meant by voting restrictions – please provide additional detail about this.</p> <p>P.4, L121-123. Please provide recent examples of ballot initiatives on public health issues or public health funding. Medicaid expansion is mentioned---was this on a ballot for voters? Is there evidence that voters think about health issues when casting their ballots?</p> <p>P.4, L124-125: Please rephrase this statement more accurately. The Census does not determine funding. The census is used to</p>	

	<p>apportion the seats in the U.S. House of Representatives.</p> <p>Provide further explanation of reasons why ID documents, address changes, and misconceptions about voting rights limit voter registration and where those disparities stem from. This may help to clarify some of the evidence-based strategies.</p> <p>The absence of political determinants of health is one noted concept missing from the problem statement. It could be interesting as evidence to consider that states where voting restrictions are in place and minority population high have those state expanded Medicaid, had higher mortality rates from COVID, or experienced outcomes that speak to health inequity. In theory, this could be done for the US in comparison to a country like New Zealand that has a higher voter turnout rate.</p> <p>The disproportionate impact on underserved populations could be tied to both policy and health outcomes to strengthen the problem statement.</p> <p>The problem is weakened by now clearly making the argument that the problem of restricted franchise is undemocratic. Perhaps, this is an obvious point and maybe it is made, but I do read this statement to make as strong of an ethical argument as could be made.</p>	
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	<p>The problem statement includes adequate scientific evidence in certain sections. Additional peer reviewed evidence is needed to support statements in the proposal. Missing from the discussion is the use of preemption to override local ordinances for protection of LGBTQ+ rights. <a href="https://ballotpedia.org/Transgender_bathroom_access_laws_in_the_United_States">https://ballotpedia.org/Transgender_bathroom_access_laws_in_the_United_States</a></p> <p>In 2020-2022, several Midwest legislatures with rural populations preempted local control efforts. The disparate incidence rates between more urban areas and rural communities empowered claims of government “overreach on individual liberties.” The result was a statewide assertion of power to quash perceived liberal strongholds or individual authority figures preventing local efforts at control that would not be necessary in some rural communities.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ol style="list-style-type: none"> <li>Is/are the proposed strategy/strategies evidence-based?</li> <li>Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> </ol>	<p>The framing of the evidence-based strategies is a bit odd. You write about social cohesion, community resilience, but it is not clear how these two factors expressed in voting impact health. This section is weak and should be firmed to describe specifically the evidence.</p> <p>The first strategy is sufficient; however, it is not clear how civic participation as a Healthy People goal would improve population-level health.</p>	

<p>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.</p>	<p>Strategy 2 should mention APHA's advocacy efforts which lend themselves to voting.</p> <p>There is a missed opportunity to connect their call for civic participation to the strategy in the policy statement, "Advancing Public Health Interventions to Address the Harms of the Carceral System" to "restor[e] voting rights to formerly and currently incarcerated people"</p> <p>The stark differences in voting in rural settings as compared to urban settings warrant a discussion of these issues in the context of recommended strategies.</p> <p>Further evidence is needed for statements such as "States that make elections more accessible....enjoy stronger public health outcomes." And again there are confounders that most likely play a role in this relationship Page 5 – "The resulting disparities in voting lead to disparities in health outcomes, for example when women gained the right to vote child mortality declined by 8-15%." Also citation #7. Content expert review recommended. - add a citation in section 7 when talking about Black, Latino, and American Indian voters experiencing longer lines, fewer polling locations etc. <a href="https://www.scientificamerican.com/article/smartphone-data-show-voters-in-black-neighborhoods-wait-longer1/">https://www.scientificamerican.com/article/smartphone-data-show-voters-in-black-neighborhoods-wait-longer1/</a> <a href="https://www.washingt">https://www.washingt</a></p>	
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	<p>onpost.com/politics/study-heavily-minority-precincts-endured-longer-wait-times-to-cast-ballots-in-2018/2019/11/04/f8433e1c-fef7-11e9-8501-2a7123a38c58_story.html  <a href="https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/">https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/</a></p> <p>Limited evidence is provided on the effectiveness of some strategies. Strategy 1: Need evidence that noting something as a national health goal improves our ability to reach the goal. Strategy 2: May consider linking to PHAB policy and advocacy measures. Need more explicit roles for public health professionals vs partners and community members. The proposal needs evidence that the proposed strategies will have an impact</p> <p>Many of the references discuss barriers that impact voting but not health</p> <p>Some references do not support the statement they're linked to:</p> <ul style="list-style-type: none"> <li>• References 14-19 do not support statement they're linked to</li> <li>• Reference for lines 199-206 does not state that civic participation/voting can reduce health disparities; no discussion of how to ensure equity with strategies; lines 287-88 re Medicaid enrollment linked to voter registration – HIPAA concerns and distrust of government; line 408 action step not discussed in policy;</li> </ul>	
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	line 416-7 – concern that elected officials may have vested interest not to increase engagement.	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ul style="list-style-type: none"> <li>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>c. Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>d. Were any opposing views missing?</li> </ul>	<p>The wrong opposing perspective is highlighted. The point to be made is that political partisanship and a limited electorate does not harm population-level health but helps it. One could argue that conservative efforts to limit access to voting and advocate for policies to restrict abortion are all life affirming issue. This is counter to the point that the restricted electorate harms population-level health.</p> <p>There is a need for more evidence in this section; only two references are provided, in the rebuttal.</p> <p>Page 11, Lines 347-353: The statement about voting methods and political conflict seems confusing. It does not provide evidence for the point about non-partisan organizations successfully engaging on these issues.</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p>	Consider action step to enact federal laws to protect voting, enacting provisions of the	

<p>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p> <p>b. Focused on policy/principle, and not on specific legislation/regulation?</p> <p>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?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p> <p>*</p>	<p>Voting Rights Act, passing the John Lewis Act, etc.</p> <p>Actions steps are broad. Add an action step focused at the local level with county voting commissions. Advocating for example that these elections be non-partisan just as one would hope the election or appointment of the county health department director would be non-partisan. This is the level of intervention that would reasonably impact civic participation in voting.</p> <p>To the point of being culturally responsive, it is not clear that these action steps engage populations. Where is the community empowerment and support of organizers? Address work groups have been doing through the country to register voters, fight restrict laws, etc. To not mention Black Voters Matter and the consider the work of LaTosha Brown and others is a huge oversight. Add work from organization such as this or the NAACP as the action that centers communities.</p> <p>Provide evidence in support of the action steps.</p> <p>Page 13, Line 408 and Lines 412-415: Not previously addressed in the Problem Statement or Evidence-based Strategies</p> <p>Page 13: Lines 416-417: Are government agencies and elected officials best positioned to “reassess, revise and evaluate” civic participation</p>	
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	<p>policies? Some have a vested interest in low civic engagement.</p> <p>Not clear how the action steps for strategy 2 are culturally responsive to under-represented and underserved populations addressed in the policy. Needs more information than just “promote participation on community advisory boards, town halls, public meetings, ....”</p> <p>Consider the need for intermediary steps for these action steps to be taken. What do you suggest needs to be done in order for the proposed actions in each of the strategies to take place? For example, what actions can to be done to support HHS to reinstate civic participation in HP2030.</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>Dawes and Williams are cited (reference 28), which makes the lack of focus on political determinants of health as a framing perspective for this policy statement unusual. Please revisit.</p>	
<p><b>Social justice and human rights metrics</b></p> <p>Does the proposal <b>primarily</b> focus on an issue of human rights and social justice? If no, proceed no further. If yes, see below:</p> <p>a. Does <u>International Human Rights Law</u> [<a href="http://www.asil.org/erg">http://www.asil.org/erg</a></p>	<p>This is a missed opportunity. You do not tie voting to human rights and social justice (add Black Voters Matter active during COVID to support Black communities being vaccinated and getting access to services which could make the argument that voting rights are not only human rights but also center public health).</p>	

<p>/?page=ihr] support this issue?</p> <p>b. Is the proposal consistent with the <u>Universal Declaration of Human Rights</u> [<a href="http://www.un.org/en/documents/udhr/">http://www.un.org/en/documents/udhr/</a>]?</p> <p>c. Is the proposal consistent with the <u>WHO Commission on Social Determinants of Health</u> (CSDH) [<a href="http://www.who.int/social_determinants/thecommission/en/">http://www.who.int/social_determinants/thecommission/en/</a>]?</p> <p>d. Is the proposal consistent with guidance (if any) from APHA constituent groups on the topic, specifically, the <u>International Human rights Committee</u> and the <u>Ethics Section</u>?</p>		
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## D1: Defining Public Health Leadership to Achieve Health Equity: Merging Collective, Adaptive and Emergent Models

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The title of the policy statement seems disconnected from the theme of the statement, which is the need for more inclusivity and community engagement in public health leadership. Please reframe title to include the specific role and relationship of collective leadership in achieving specific improvements in health equity goals.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	Other related APHA Policy Statements include the following: <ul style="list-style-type: none"> <li>• APHA Policy Statement 20189: Achieving Health Equity in the United States</li> <li>• APHA Policy Statement 200412: Support for Community Based Participatory Research in Public Health</li> </ul>	

	<ul style="list-style-type: none"> <li>• APHA Policy Statement 20091: Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities</li> <li>• APHA Policy Statement 20005: Effective Interventions for Reducing Racial and Ethnic Disparities in Health</li> </ul>	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>The proposed policy statement does not address an identified policy gap or requested update. It is unclear why an APHA policy is the appropriate means for calling for a new leadership model.</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <p>a. Are there important facts that are missing from the problem statement? If so, describe them.</p>	<p>There is a need for a clearer articulation of the actual problem. Recommend problem statement be developed according to policy statement author guidelines. Many of the action steps were vague and/or left readers with questions about how these recommendations would be operationalized and could consider additional policy action steps.</p>	

<p>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.?</p> <p>c. Identify any relevant ethical<sup>xxii</sup>, equitable<sup>xxiii</sup>, political or economic<sup>xxiv</sup> issues.</p>	<p>The problem statement contains some valuable concepts about leadership but is somewhat disjointed in relating issues of COVID-19 and other public health issues, public health leadership, structural racism, health inequities and systemic change. It is not clear how leadership can be implemented other than by collective action but this is also not clearly articulated.</p> <p>Key evidence is missing to support statements made in the proposed policy statement. Additional information is needed to describe the extent of the lack of diversity in PH leadership, i.e. racial, ethnic, sexual and gender demographics of the current PH workforce.</p> <p>Greater clarity of the actual problem is needed. The background shifts in focus and makes it difficult to assess the actual problem of public health leadership.</p> <p>Page 4, lines 118-125. Consider relocating these statements to the evidence- based strategies section of the proposal.</p> <p>It seems that merging three leadership theories in a policy statement seems to go beyond the scope of a policy statement to recommending a new framework of leadership. It may be more feasible to focus on collective leadership and focus the problem statement on why a specific area of public health</p>	
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	<p>work requires adoption of this model of leadership.</p> <p>The relationship between leadership models in public health and the lack of progress on health equity goals to achieve health equity is also not clear enough. While it is possible or likely that hierarchical leadership negatively impacts the goals of the policy, there is no clear research evidence that links them. Please consider defining more clearly what is meant by leadership in public health. Is the focus on leadership in governmental public health (local, state, federal) department levels? Research program or intervention levels? Academic public health? All of these areas could be challenged in their current leadership models, but it's questionable whether an APHA policy statement could address leadership gaps in all of these areas or that an APHA policy is the appropriate means for calling for a new leadership model.</p>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <p>a. Is/are the proposed strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies,</p>	<p>The proposal does not sufficiently describe what evidence-based strategies are being proposed to address the problem.</p> <p>Lines 137-143 offer a recommendation versus an evidence-based strategy with demonstrated success and appropriate citations. For each evidence-based strategy, you need to relate it back to how said proposed has</p>	

<p>ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>demonstrated success in addressing the problem.</p> <p>Re-structure the evidence-based strategies section to strategies that are likely to have a measurable impact. See: <a href="https://journals.lww.com/jphmp/Citation/2020/07000/Understanding_the_Dynamics_of_Diversity_in_the.19.aspx">https://journals.lww.com/jphmp/Citation/2020/07000/Understanding_the_Dynamics_of_Diversity_in_the.19.aspx</a></p> <p>Please describe the success of the various types of public health leadership through evidence-based science.</p> <p>Statements showing the relationship between public health leadership and health equity need to be strengthened.</p> <p>There is description of models of leadership and community participatory research but no in-depth discussion on research and initiatives that show the relationship between leadership and outcomes that relate to decreasing health inequities.</p> <p>See detailed comments regarding strategies from the Medical Care Section:</p> <ul style="list-style-type: none"> <li>• There's a strong focus on ethical and equitable leadership but the reviewers found gaps in the evidence provided AND in the available evidence needed to support a call for the proposed model. Also the proposed policy is not necessarily a reasonable call.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• The strategies mentioned in this section are not presented using evidence-based arguments.</li> <li>• Rethink if it is a good idea to present different leadership approaches (collective, emergent, etc.) as strategies to solve a problem. If the problem is the lack of collective leadership, it'd be better to focus on strategies to implement this novel approach that could be seen as non-feasible. For example, a strategy would be to urge researchers to demonstrate the effectiveness of this leadership approach, urge HR departments to modify their job descriptions to be more conducive to collective leadership, etc.</li> <li>• The study of leadership in general is fraught with styles/models/aspirations that are promoted without a clear idea of their effectiveness and outcomes. However, there is a relatively large literature on the effects of leadership styles (just to use one term of many in the leadership literature) on many organizational outcomes or their effect on specific interventions. For example: O'Donovan, et al. (2021) reviewed the impact of leadership behaviors on team performance while Markle-Reid, et al. (2017) documented the effect of collective leadership on a specific intervention.</li> </ul> <p>Review:</p>	
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	<ul style="list-style-type: none"> <li>• Markle-Reid, M., Dykeman, C., Ploeg, J., Stradiotto, C. K., Andrews, A., Bonomo, S., Orr-Shaw, S., Salker, N., &amp; Kelly Stradiotto, C. (2017). Collaborative leadership and the implementation of community-based fall prevention initiatives: a multiple case study of public health practice within community groups. <i>BMC Health Services Research</i>, 17, 1–12. <a href="https://doi-org.ezproxy.uis.edu/10.1186/s12913-017-2089-3">https://doi-org.ezproxy.uis.edu/10.1186/s12913-017-2089-3</a></li> <li>• O'Donovan, R., Rogers, L., Khurshid, Z., De Brún, A., Nicholson, E., O'Shea, M., Ward, M., &amp; McAuliffe, E. (2021). A systematic review exploring the impact of focal leader behaviours on health care team performance. <i>Journal of Nursing Management (John Wiley &amp; Sons, Inc.)</i>, 29(6), 1420–1443. <a href="https://doi-org.ezproxy.uis.edu/10.1111/jonm.13403">https://doi-org.ezproxy.uis.edu/10.1111/jonm.13403</a></li> <li>• Please also consider adding other ways to support and lift up communities' voices beyond mere inclusion to advocate for representation at all levels.</li> <li>• The proposal would benefit from making</li> </ul>	
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	<p>specific reference to evidence regarding community health workers and their potential as a core part of the leadership needed to advance health equity.</p> <p>Recommend consideration of another strategy regarding the need for additional public health investments in order to build and sustain these leadership models, to ensure salaries are adequate to incentivize more interest from non-traditional leaders/community members with lived experience to work in local public health, and to expand community-based, long-term partnerships.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ul style="list-style-type: none"> <li>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>b. Is the proposed approach</li> </ul>	<p>Opposing arguments are not well-described. The statement discusses “the importance of community-based investments in public health and community infrastructure” lines 241-22, which does not present an opposing argument.</p> <p>This section would benefit from additional emphasis on alternative models of collective leadership and potential positive outcomes, also reasons why the advocated leadership model(s) have not been used in public health, and the possible obstacles/problems of this/these model(s).</p>	

<p>justified in comparison to opposing/alternative strategies (i.e. is it more cost effective, better equipped to address inequities, more expansive in reach etc.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable?</p> <p>d. Were any opposing views missing?</p>	<p>Refutation of a few key opposing positions are included; however, please address additional opposing views to be more fully considered and discussed in Section X. These include concerns regarding: time, cost, effort, bureaucratic and systemic resistance to change, and other challenges that may present in moving from current, widely accepted, and widely practiced models of leadership to public health systems that effectively and meaningfully incorporate models proposed. The Action Steps included in Section XII provide a number of steps for which it may be easy to identify possible opposing views to be addressed.</p> <p>Additional evidence based science is needed to refute the opposing arguments presented</p> <p>Alternative views are presented (e.g., top-down leadership, crisis-response cycles), but further discussion is needed about why these views are inadequate (not just that the model/framework being presented is better).</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <p>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</p> <p>b. Focused on policy/principle, and</p>	<p>Action steps are too broad and need refining. Action steps should include specific measures in leadership development related to decreasing health inequities.</p> <p>There is not a clear logical flow from the leadership model</p>	

<p>not on specific legislation/regulation ?</p> <p>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?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>strategies to the action steps provided.</p> <p>Include more details in the hiring practices such as including salaries in job postings, giving not only the alternative qualification but also weight to lived experience</p> <p>Consider inserting “value” in bullet on line 262.</p> <p>Include mentorships, social medicine residencies, and expanding opportunities for people with lived experience to enter public health and community health domains. (see also Drs Oni and Uche Blackstock). Line 290 – “multi-do” may not be a well-known term. Typo?</p> <p>Consider calling for collaborations between public health, healthcare and community groups: housing programs, correctional health, reentry programs that support communities overrepresented in the criminal legal system based on where they live. Cross reference policy 202117 – Advancing Public Health Interventions to Address the Harms of the Carceral System.</p> <p>Lines 62-72 do not add to the overall premise of the proposal. Lines 62-64 read like a commentary and are not a factually supported with evidence. Lines 65-68 fail to contextualize the thesis of lack of diversity in public health leadership. You do not address</p>	
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	<p>other significant external factors i.e., lack of political leadership from the highest level of public office, or the of systemic racism that contributed to mistrust in science and government.</p> <p>See action steps comments from</p> <ul style="list-style-type: none"> <li>• The introduction including proposal of a new definition of public health leadership is not specific to the proposed leadership models being proposed in Strategies and throughout. The language in that definition refers to improving health, not leading an organization / system / human workforce.</li> <li>• Suggest the last sentence of the intro paragraph begin “In addition to this,” or start a new paragraph for this phrase of APHA recommendations to other groups. Minor edit “...that enable(s) equitable improvements...” (line 256).</li> <li>• There is a big picture concern with some of the action steps. For example, the removal of clinical qualifications. Although leaders can build their careers from any public health role, deleting clinical qualifications (perhaps you just need to be more specific about this term)</li> </ul>	
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	<p>from job requirements may not be feasible as there are sometimes minimum clinical/medical licensure requirements for specified duties.</p> <ul style="list-style-type: none"> <li>• The first section is headed with “State and Local Governments” but the steps seem to apply to governmental agencies, or especially just public health agencies/departments and not legislative or judicial branches (i.e. no calls for policy).</li> <li>• The first action step under State and Local Gov’ts may present a barrier to entry for those without leadership training, as currently worded. Suggest “Provide comprehensive leadership training...” instead.</li> <li>• Part 2 of 2<sup>nd</sup> bullet should be divided into two steps, with the new step beginning “Require demonstrated experience with community engagement”. Suggest a preference for this experience over “requirement” AND/OR with demonstrated capacity for engagement as an alternative.</li> <li>• 4<sup>th</sup> bullet “Evaluate public health</li> </ul>	
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	<p>departments”: This needs to be more clearly worded. Who evaluates the PH depts? State evals local government agencies, self-evaluations? Reported to whom?</p> <ul style="list-style-type: none"> <li>• 5<sup>th</sup> bullet “Integrate community-based...” appears to belong in the next section under PH agencies and Program Implementation Teams</li> <li>• The first step of the PHA and Program Implementation Teams section (“Acknowledge...”) focuses on an important issue but it seems out of place in this specific list of action steps which is insufficiently supported by Strategies section.</li> <li>• There are similar concerns with the last bullet point “Identify the role...” This is a good idea but it is not supported by Strategies section and does not seem to flow naturally from the scope of this proposal.</li> </ul> <p>P8, L259-260: Leadership training is important. What is your view on when the requirement is to be completed? Post-hire? Or in order to be considered for a leadership position? Given the lack of leadership training, it</p>	
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	<p>should be the former. Also, should the requirement extend only to “publicly appointed” positions. There are so many in leadership positions that need training. This approach would help to facilitate change rather than just requiring it of new hires.</p> <p>Minor format change recommendations:</p> <ul style="list-style-type: none"> <li>• Use numbers instead of bullets for action steps.</li> <li>• Please consider restricting statements (such as 3<sup>rd</sup> &amp; 5<sup>th</sup> bullets) to the Action Steps. Extra wording like “to ensure rapid integration of knowledge and practice” belongs in the Strategies section supported with citations that demonstrate evidence for this impact (regardless it’s not an action but an outcome). Same with “that serve to earn the trust of communities”; this is editorial not action – perhaps reword to say “Integrate...with the explicit aim of earning the trust of communities...” to make it actionable.</li> </ul>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>Reference 31 should be re-formatted.</p>	

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## D2: Ensuring Access to Affordable Medications

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	The title should indicate the focus on prescription medications. Proposed: Ensuring Equitable Access to Affordable Prescription Medications	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	200611 – This PS references universal accessibility of contraceptives. While this isn't explicitly discussed in the proposed PS, this could easily be incorporated. 200613, 20031 – These PS are clearly related and should be referenced in the proposed PS. Specifically, they should be referenced and updated during the discussions of the use of cost-effectiveness.	

<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>Closely review each of the related PSs and consider which of these becomes redundant with the proposed PS. Currently the proposed statement is equal parts new and redundant. Lines 47-48 should be updated. More current data are available from IQVIA, which utilizes data from OECD reports. Lines 48-49 need a citation for the 2.5 times claim.</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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</li> </ol>	<p>The problem statement is concise but would benefit from some additional content. Revise problem statement with supporting evidence from peer-reviewed literature</p> <p>Include more information on how additional populations are impacted by unaffordable drug prices and/or explaining why information on incarcerated and undocumented people were chosen to be highlighted. The disproportionate impact of drug affordability could be amplified in the problem statement as well.</p> <p>To further strengthen this statement, add details on drug utilization programs, more clear data on proposed policy changes (e.g., describing where these policies have been successful elsewhere) and shifting some of</p>	

<p>disparity, persons with certain sexual identity and orientation, etc.?</p> <p>c. Identify any relevant ethical<sup>xxv</sup>, equitable<sup>xxvi</sup>, political or economic<sup>xxvii</sup> issues.</p>	<p>the explanatory information to the problem statement.</p> <p>Lines 66-69 are unclear, and seems to be incomplete. The Problem Statement does not discuss the phenomena of abandonment and cost-related non-adherence, as it should. These concepts are especially relevant to the discussion of the public health effects of expensive medications.</p> <p>Also missing from the Problem Statement and other relevant sections are a discussion of the power of the lobbying organizations which play a significant role in policymaking in the US and abroad. On the international front the lobbying wings of the pharmaceutical industry have a significant influence on the World Trade Organization policy process through the TRIPS agreement. The lobbying by these groups within the WTO influences global access and costs of medications. Healthcare represents the largest sector by financial investment in the United States political lobby. Within the healthcare lobby the pharmaceutical industry is the largest investor, spending \$354 million in 2021 alone (<a href="https://www.opensecrets.org/federal-lobbying/sectors/summary?cycle=2021&amp;id=H">https://www.opensecrets.org/federal-lobbying/sectors/summary?cycle=2021&amp;id=H</a>).</p> <p>The CHW Section called for additional discussion Interpersonal, institutional, and systemic racism in the problem statement, indicating that the disproportionately negative</p>	
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	impacts that high prescription drug prices have on Black, Indigenous, and People of Color are not adequately discussed. Similar comments were provided by the CoA.	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ul style="list-style-type: none"> <li>a. Is/are the proposed strategy/strategies evidence-based?</li> <li>b. Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ul>	<p>There are plenty of theoretically logical policy and strategic suggestions made here, but the measurement of their impact on other areas is not presented well. There is not enough evidence after implementation in the proposal to suggest these are the best, evidence-based options. The inclusion of those in the criminal justice system is confusing. There is no mention of this prior to page 8. Why choose this population and not another? Finally, the entry of generics is not universally placing downward pressure on pricing. In some cases, for limited application medications, investment companies buy patents and arbitrarily set prices at astronomically high levels because they too have no competitors.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p>	<p>The magnitude of profits in the pharmaceutical industry are not mentioned. There should be some context for these margins which are amongst the highest in any industry. More could be done to</p>	



<p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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.)?</p> <p>c. Are alternative viewpoints, ethical, equitable and reasonable ?</p> <p>d. Were any opposing views missing?</p>	<p>examine the influence of TRIPS in the World trade Organization.</p> <p>Explain, with supporting evidence, why a national formulary will be a better approach and provide any supporting evidence.</p>	
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<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation?</li> <li>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?</li> <li>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ul> <p>*If additional action steps are needed, note whether you believe authors need to exceed the 10 page, 50 reference limits to address gaps and if so by how much.</p>	<p>Action step 2a is not feasible. The time it would take to measure these outcomes for most medications would be the lifetime of those who need them. Mortality is measured already in clinical trials and is a required endpoint defined as serious adverse event.</p> <p>The call to expand affordable drug insurance to all Americans specifically mentions only incarcerated individuals and the undocumented population. Please add a discussion of other marginalized populations who are impacted by high drug costs.</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-</p>	<p>Lines 70-71 report drug expenditures in 2018. More recent data is available to update this to at least 2020. Reference: <a href="https://www.iqvia.com/insights/t">https://www.iqvia.com/insights/t</a></p>	

to-date, and peer-reviewed? Are there no more than 50 references?	<p><a href="https://www.he-qvia-institute.com/reports/drug-expenditure-dynamics-1995-2021-appendices">he-qvia-institute/reports/drug-expenditure-dynamics-1995-2021-appendices</a></p> <p>This reference can also provide meaningful and relevant evidence in other areas of the proposed PS.</p> <p>For References use full PDF links as many were not accessible with the provided link. Example below:</p> <p>Ref 26:  <a href="https://www.annfammed.org/content/annalsfm/16/3/211.full.pdf">https://www.annfammed.org/content/annalsfm/16/3/211.full.pdf</a></p>	
<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>Consult with the Occupational Health and Safety Section for an additional review.</p>	

## D3: Falls Prevention in Adults Aged 65+

### Spring Assessment: Negative

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

<b>Criteria</b>	<b>Write a summary statement and include recommendations to the author.</b>	<b>Author's Response</b> <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b> Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	Consider revising the title, such as "An Integrated Approach to Fall Prevention in Adult over 65 years"	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	Review existing APHA policies and determine which are related to your proposed policy and list them. For example, the following are ones to consider:  A Call to Improve Patient and Public Health Outcomes of Diabetes through an Enhanced Integrated Care Approach (2021). No. 20215 Prevention of Lower Extremity Amputations due to Non-traumatic Loss of Sensation and Loss of Circulation (2021). No. 20212 Coordinated Nationwide Approaches to Promote Eye Health and Reduce Vision Impairment (2019). No. 20191 Policy statements re: insurance/access to comprehensive healthcare (e.g., may refer to specialty care):	

	<p>Supporting the Updated National Physical Activity Plan (2017). No.20172</p> <p>Related policies addressing similar problems from 2020 could added: 202011 &amp; 202013</p>	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	<p>Please consider that the Rationale for Consideration is not included in the final adopted policy that is posted on the APHA website. Therefore, information in this section that describes the problem should be presented instead in the PS.</p> <p>Based on what is stated in this section, the section largely describes a problem related to the CDC initiative called STEADI. You indicate (1) STEADI needs to be improved, stating there are “gaps in its implementation and content,” and (2) that all healthcare providers (not just primary care and gerontologists) need to be involved in fall prevention with adults over age 65. PS, however, does not focus on these topics. Instead, the PS largely presents info on the risk factors for falls.</p> <p>P3, L79-88 is a description of STEADI which is the strategy being promoted. This kind of description belongs in the Problem Statement (PS) or Evidence -based Strategies (EBS). One approach could be describing it and then indicating how it could be improved/enhanced (P7, L211 -225).</p> <p>Alternatively, after risk factor information about falls (P4, L96 -P8, L251) add a secondary problem about STEADI being a good tool, but</p>	

	<p>not used as widely as you think is warranted.</p> <p>P3, L76-77: The statement does not align with references provided. The reference does not mention falls.</p>	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ul style="list-style-type: none"> <li>a. Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>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.?</li> <li>c. Identify any relevant ethical<sup>10</sup>, equitable<sup>11</sup>, political or economic<sup>12</sup> issues.</li> </ul>	<p>PS fails to include the critical role of nurses in conducting fall risk assessments. Nurses/home health care nurses are most often the first point of contact with patients. Fall risk assessments fall under their responsibilities and they conduct them diligently. Nurses/home health care nurses also have ongoing engagement with patients and their families.</p> <p>There are dozens of different risk assessment tools and you don't provide data to support position that STEADI is best (and the problem is that other assessment tools are inadequate.)</p> <p>Is STEADI superior to other fall risk assessment tools?</p> <p>Suggest adding a definition of your term "community setting" to better contextualize this policy.</p> <p>PS discusses the problem with falls, not the inadequate implementation of STEADI.</p>	

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	<p>PS should include the costs of assessments and where is it conducted and by what providers.</p> <p>What data is available to demonstrate that people 65 and older are not being evaluated with some sort of fall risk assessment tool? Fall risk assessment tools are plentiful and are often utilized in acute and primary care settings by providers, nurses, and physical/occupational therapists. Fall risk assessment, for example, is part of the “Welcome to Medicare” visit for new Part B recipients. Also part of the visit for health systems who are a part of the Age Friendly initiative which involves the 4M’s (what matters, mentation, medicine, mobility). Even those health agencies outside of the Age Friendly initiative commonly evaluate mentation, medications, and mobility at primary care appointments.</p> <p>The proposed policy asserts that STEADI works but it is underutilized. The statement appears to argue a well-known point that falls among older adults are a problem. It seems that STEADI is not the problem and you state it is a good framework. What evidence exists that supports the statement “it is underutilized”? Is the issue that healthcare providers should use STEADI, OR is the issue that healthcare providers should use some validated fall risk assessment tool, and, if the score warrants intervention(s), is it you’re your</p>	
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	<p>content from P8, L268 through P10, L313 (in EBS) should be implemented?</p> <p>To what extent are fall risk assessment tools incorporated (or not) in electronic health records (EHR).</p> <p>P4, L106: replace “Centers for Medicare &amp; Medicaid (CMS)” with “taxpayers” or contributes to healthcare costs.”</p> <p>P4, L107: after non -fatal falls, ADD “among older adults”</p> <p>P4, L114 -118: Provide reference(s) for this information</p> <p>P5, L140: Cite from original research (described in the meta-analysis)</p> <p>P5, L145: Is there a checklist to reference?.</p> <p>P5, L148: Delete ref 18 (APHA policy). Use Ref. 19 or another source</p> <p>P5, L157: should there be a “therefore” between “diabetes and identifying</p> <p>P5, L159-163: Be more explicit if you are saying that an added benefit of referral for a podiatric examination (besides fall risk assessment) is early detection of diabetes.</p> <p>P5, L165: Is there a reference for prevalence of gait disorders among</p>	
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	<p>age 65/+? (Ref. 22 with names of gait disorders is not needed.)</p> <p>P6, L175: Is the problem that product labeling on gabapentin (and other drugs) is not adequate? Is this a topic for the FDA to address (i.e., an Action Step)?</p> <p>P6, L186 -187: Reference for this statement? Recognized by whom? Consider moving this line to EBS where you can elaborate on the evidence</p> <p>P6, L197-199: Does referral to PT after amputation of toe(s) not typically happen? (Data/evidence to support this assertion.)</p> <p>P7, L 213 -218: This is the first instance you describe something you want to see changed in STEADI.</p> <p>P6/P7 (Vision Impairment): Consider addressing the obstacles that people with Medicare Part A do not have vision care coverage, as well as people who are uninsured or underinsured (e.g., co - pays). For Medicare Part B, vision care specialists may not be accessible.</p> <p>Very important to recognize (and acknowledge) the limitations on Medicare enrollees in their inability to pay for eye exams and subsequent treatment recommendations. (Kaiser Family Foundation likely has data about Medicare enrollees by coverage options (e.g., A-only, Medigap, Medicare Advantage)</p>	
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	<p>Additional risk factor for falls: Low back pain. Review the following papers additional potential sources of evidence:</p> <p>*Bell T, Pope C, Fazeli P, Crowe M, Ball K. The Association of Persistent Low Back Pain with Older Adult Falls and Collisions: A Longitudinal Analysis. J Appl Gerontology. 2021</p> <p>*Yousef Soliman, Richard Meyer, and Neil Baum. Falls in the Elderly Secondary to Urinary Symptoms. REV UROL.</p> <p>New meds like Reequip for restless leg syndrome show the need for updating medications over time.</p> <p>Could shorten the section on medications since this topic largely falls to the primary care and geriatrics physicians. The APHA policies adopted in 2021 on diabetes and amputations covers a lot of this information and should be noted in Relationship to Existing Policies. As a result, the information about ophthalmology, metabolic disorders, and amputations could be relatively shorter.</p> <p>PS could include comparison of the costs of multiple yearly referrals to the cost/savings of avoided trauma from falls.</p> <p>Recommend including/expanding cost/benefits of fall risk assessments.</p>	
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<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p> <ol style="list-style-type: none"> <li>Is/are the proposed strategy/strategies evidence-based?</li> <li>Is/are the proposed strategy/strategies, ethical, equitable and reasonable? If not, describe why not.</li> <li>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.</li> </ol>	<p>Overall, this section needs to be developed with more detailed ideas and rationale. The aim should be to connect each strategy to an issue in the problem statement AND to an action step (AS) recommended at the end. Problems identified should each yield an EBS and AS should be supported by evidence previously presented.</p> <p>EBS section is inadequate due to lack of consideration of nurses/home health nurses that have ongoing engagement with patient. Most risk factor assessments (home safety, meds, frailty, etc) are done/would need to be done by home health care nurses.</p> <p>These strategies focus on CDC STEADI algorithm. You focus on how different health care providers can implement/be involved in these strategies, but this section could be strengthened by speaking to how public health professionals can also support these strategies. Create more of a connection to public health professionals beyond the fact that these are strategies recommended by CDC. For example, what role do health departments have in addressing/helping to reduce the risk of falls in the community (e.g., campaigns/awareness training on risk factors (safety assessment, physical activity for older adults)?</p> <p>Provide evidence that STEADI is the most effective fall risk assessment tool. Consider focusing on the components of the effective tools,</p>	
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	<p>instead of focusing on STEADI. Are the items on P8, L267 through P10, L313 the essential components of a fall risk assessment tool?</p> <p>Mandating a single assessment tool, when other valid and reliable tools are available, does not seem a prudent use of CMS resources, health professional education program resources, etc.</p> <p>The peer-reviewed and consensus (including CDC publications) evidence on STEADI has not been fully incorporated. It would be helpful to give the reader more information about STEADI, emphasizing, for example, its comprehensive approach and providing research evidence specific to STEADI.</p> <p>We suggest summarizing the prevention strategies at the end of line 267 to orient the reader to the subsequent paragraphs on physical activity, home safety assessments, foot examinations and visual exams.</p> <p>Consider the following source of information for the sentence ending on line 83. (Sarmiento K, Lee R. STEADI: CDC's approach to make older adult fall prevention part of every primary care practice. J Safety Res. 2017Dec; 63:105 -109.)</p> <p>Include evidence supporting the need for greater implementation of STEADI. For example, Vincenzo et al found only 25% of PTs used STEADI despite 50% having knowledge of STEADI. (Vincenzo JL, Schrod LA,</p>	
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	<p>Hergott C, et al. Physical Therapists and Physical Therapist Assistants' Knowledge and Use of the STEADI for Falls Risk Screening of Older Adults in Physical Therapy Practice in the United States. <i>Int J Environ Res Public Health</i>. 2022 Jan 26;19(3):1354.)</p> <p>Here are studies assessing the effectiveness of STEADI: Crow RS, Lohman MC, Pidgeon D, et al. Frailty Versus Stopping Elderly Accidents, Deaths and Injuries Initiative Fall Risk Score: Ability to Predict Future Falls. <i>J Am Geriatr Soc</i>. 2018 Mar;66(3):577 - 583.</p> <p>Johnston YA, Bergen G, Bauer M, Pet al. Implementation of the Stopping Elderly Accidents, Deaths, and Injuries Initiative in Primary Care: An Outcome Evaluation. <i>Gerontologist</i>. 2019 Nov 16;59(6):1182 -1191.</p> <p>Karlsson L, Doe K, Gerry M, et al. Outcomes of a Physical Therapist - Led, Statewide, Community-Based Fall Risk Screening. <i>J Geriatr Phys Ther</i>. 2020 Oct/Dec;43(4):185 - 193. doi: 10.1519/JPT.0000000000000228. PMID: 30883528.</p> <p>Lohman MC, Crow RS, D iMilia PR, et al. Operationalisation and validation of the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) fall risk algorithm in a nationally representative sample. <i>J Epidemiol Community Health</i>. 2017 Dec;71(12):1191 - 1197.</p>	
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	<p>Other Evidence-based strategies (EBS) solutions may include quality improvement strategies, re-evaluating STEADI cut -off scores, and incorporating STEADI into health sciences education. Possible source of information on these topics:</p> <p>Tricco AC, Thomas SM, Veroniki AA, et al. Quality improvement strategies to prevent falls in older adults: a systematic review and network meta - analysis. Age Ageing. 2019 May 1;48(3):337 -346.</p> <p>Provided some evidence on ways proposed to reduce falls: being physically active, having a home safety assessment, regular foot and eye exams. You do not describe strategies or best practice programs to facilitate/encourage these interventions for people aged 65 and older.</p> <p>Are there examples of fall prevention programs being reimbursed and/or part of value-based care that incorporates fall prevention?</p> <p>Are there insurance programs or best practice examples from the Veterans Administration with respect to full coverage of podiatry and/or vision care?</p> <p>P8, L253: Need a Ref. to support statement: Over 90% of adults aged 65 and over report...provider annually</p> <p>P8, L257 - 261: Is the STEADI tool designed to be used by all these</p>	
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	<p>different healthcare disciplines? Is that why you prefer it?</p> <p>Who is responsible for providing referrals and are these referrals cost-prohibitive (uninsured/copay)?</p> <p>P8, L258: Do you mean “dieticians” instead of nutritionists?</p> <p>P8, L259: (Chiropractic Health Section suggests adding chiropractors to the list of health care professionals. (For support they recommend:</p> <p>Hawk C, Pfeffer MT, Strunk R, Ramcharan M, Uhl N. Feasibility study of short -term effects of chiropractic manipulation on older adults with impaired balance. J Chiropr Med. 2007 Dec;6(4):121-31.</p> <p>Holt KR, Haavik H, Lee AC, Murphy B, Elley CR. Effectiveness of Chiropractic Care to Improve Sensorimotor Function Associated with Falls Risk in Older People: A Randomized Controlled Trial. J Manipulative Physiol Ther. 2016 May;39(4):267 -78.</p> <p>Dougherty PE, Hawk C, Weiner DK, Gleberzon B, Andrew K, Killinger L. The role of chiropractic care in older adults. Chiropr Man Therap. 2012 Feb 21;20(1):3.</p> <p>Consider adding / expanding on EBS about the link between depression and falls among the elderly which is mentioned in the PS. No strategies presented that address this bidirectional relationship. For</p>	
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	<p>example, mental healthcare providers could serve as another touch point for fall screening, and mental health resources need to be provided to those who are deemed high risk for falls.</p> <p>The following citations may not be needed and would make room for the new sources recommended elsewhere. (E.g., Remove #10 and replace #11 with the more recent 2019 reference. Don't include #12 if this information is in the updated #11 reference. Line 134: Should this be citation #13 #14 or #42?; Line 109: Common knowledge, #8 unnecessary.</p> <p>Line 138. Consider combining the first two sentences and only using reference #16.</p> <p>Exercise section could be expanded to further explain what is needed, such as resistance training as a safe option. Line 276: "resistance training did not show the same effect with some participants reporting injuries." We encourage examining additional research as strength and power exercises have been found to reduce frailty. It is important that those over the age of 65 are properly trained and educated on power and resistance exercises to prevent injury, while decreasing their risk for frailty. See:</p> <p>*Angulo J, El Assar M, Álvarez-Bustos A, Rodríguez-Mañas L. Physical activity and exercise: Strategies to manage frailty. Redox Biol. 2020 Aug; 35:101513. doi:</p>	
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	<p>10.1016/j.redox.2020.101513. Epub 2020 Mar 20. PMID: 32234291; PMCID: PMC7284931. Sentence on tai chi is weak and reference could possibly be updated (good only for low risk? – 2012 ref))  <a href="https://www.health.harvard.edu/staying-healthy/the-health-benefits-of-tai-chi">https://www.health.harvard.edu/staying-healthy/the-health-benefits-of-tai-chi</a></p> <p>Other potential sources of evidence:</p> <p>*National Institutes of Health; National Center for complementary and Integrative Health  <a href="https://www.nccih.nih.gov/health/tai-chi-and-qi-gong-in-depth">https://www.nccih.nih.gov/health/tai-chi-and-qi-gong-in-depth</a></p> <p>*Mayo Clinic  <a href="https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/tai-chi/art-20045184">https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/tai-chi/art-20045184</a></p> <p>Strategies describing electronic health record modification/ integration recommendations should be added, and evidence described.</p> <p>Review and support any additional tools and resources to be included in the fall risk assessment recommendations or similar grant funded research initiatives to support inter-professional need for health care work force GWEP initiatives, homecare workers training, community health workers role in fall risk.</p> <p>Are there technological advancements with telehealth and mobile applications that are being deployed and evidence of</p>	
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	<p>effectiveness with respect to fall prevention?</p> <p>What programs/example of referrals to community programs when insurance doesn't cover/pay for fall prevention interventions.</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <ul style="list-style-type: none"> <li>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</li> <li>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.)?</li> <li>c. Are alternative viewpoints, ethical, equitable and reasonable?</li> <li>d. Were any opposing views missing?</li> </ul>	<p>This section is not well developed.</p> <p>Structure this section with brief description of Opposing View (OV) and then a rebuttal. For example, something like this: One argument against using the 12 - item STEADI tool is it adds X amount of time to a patient encounter. (Rebuttal could be: When time constraints pose a challenge, there is a 5 -item and a 3-item version of STEADI.)</p> <p>Include concerns about promoting one specific tool (STEADI) and rebut (if your position is that STEADI is the gold standard/most effective.)</p> <p>Need more information about resources needed by all parties involved (healthcare providers, patients and payors sources) which could make the EBS infeasible.</p> <p>P10, L314 to 328: In statement about falls among people with dementia and the need to ask a caregiver who is knowledgeable about their history, rather than asking the patient with dementia (could lead to inaccurate information.)</p>	

	<p>P10, L323-325: Unclear; further explanation needed followed by response/rebuttal.</p> <p>P10, L325 -326: State the opposing view more clearly; and respond/rebut.</p> <p>P10, L327 - 328: Unclear. Is this OV that healthcare providers are not reimbursed for doing fall risk assessments? If so, does this belong in PS or EBS, rather than as an OV? In EBS, for example, provide examples of the business case.</p> <p>Add data/evidence on cost - effectiveness of fall risk assessment (to support rebuttal of opposing argument(s)).</p> <p>Acknowledge somewhere in policy statement that provider's referrals to specialists must consider their scope of practice and recognition that specialty care may be cost prohibitive depending on the senior's insurance coverage and/or specialty care in their community (e.g., rural areas, providers who do not accept certain types of insurance)</p> <p>Consider adding OV that the time required to make referrals, when patients' insurance/ability to pay/co-pays is a barrier for some (many?) patients to actually be able receive specialty care in their community and/or that specialty care is not available (no providers) in their community?</p>	
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<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <ul style="list-style-type: none"> <li>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or implement a specific strategy)?</li> <li>b. Focused on policy/principle, and not on specific legislation/regulation ?</li> <li>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?</li> <li>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</li> </ul>	<p>There are AS on topics that are not addressed in PS or EBS. AS need to link to PS and EBS. Remove or link.</p> <p>AS can be re-organized, possibly combined, around insurance coverage for exercise. E.g., Medicare should cover more than one body part for physical therapy at the same time.</p> <p>Consider adding AS about referrals to community programs for those without insurance/funds.</p> <p>Action Steps on P10, L337 -338; P11, L356 -358 and 369-370 are internally directed (i.e. directed at APHA). Revise or delete.</p> <p>Address the equity issues for some AS such as the cost of accessing care; insurance gaps.</p> <p>P10, L331-336: Neither PS nor EBS mention role of CEU's and requirements for state licenses for healthcare providers.</p> <p>P11, L339-341: There is no coverage under Medicare Part A for eye exams and out -of-pocket costs are high. (Even reading glasses are cost prohibitive.) How do you make it feasible for many seniors who are uninsured or only have Medicare Part A?</p> <p>P11, L345 - 347: Not mentioned in PS or EBS. In addition, what does "increase access" mean? What programs at fed, state, local level</p>	
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	<p>does this work? Is there funding for it, or is funding needed?</p> <p>P11, L348-350 &amp; L363-365: Neither PS or EBS describe the role of health insurers as an obstacle or facilitator of care. (Some insurance plans for seniors do pay for exercise classes at community activity centers. Do they address or not address the topics you mention?)</p> <p>P9, L285 -289: You note that home assessments for fall risks conducted by occupational therapists (OT) are more effective than by a non- OT. Are there examples of interventions that facilitate or overcome obstacles to implementation? (e.g. initiatives of Am OT Assoc? insurance coverage?</p> <p>P11, L342 -344 &amp; L367-368: Combine and modify to something like: CDC to collaborate with public health and other stakeholders to review every [# of year] the framework for prevention of falls among people 65 years and over.</p> <p>P11, L351-353: Are the calls on CMS? HRSA? CDC? to conduct outreach to healthcare facilities, especially those with emergency departments, to....</p> <p>Related matter, sshould discharge instructions “recommend” to the patient rather than “obtain”? (To acknowledge that some patients don’t have insurance coverage (or adequate insurance). Vision care not necessary covered by insurance.</p>	
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	<p>P12, L371-375. The role of the FDA and NIH are not addressed in the PS or EBS. If they already “assess the potential impact” on the age 65/+ population is that an EBS to point to? And call for more of it? Or is it a gap in FDA’s evaluation of drugs? If a warning label already says a drug may put someone at risk of a fall, is there something else you want FDA to do?</p> <p>P11, L361--362: Comes out of the blue.... (not mentioned in PS or AS)</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>Many references are incomplete citations. (Makes it difficult for reviewers to assess the evidence.)</p> <p>Some references are not AMA style, including: 1,2,3,10,11, 15, 18, 19, 21, 24, 33, 34, 35, 36, 37, 38, 39....)</p> <p>Are Ref. 9 and 11 the same document?</p>	

## D4: Expanding Medicaid Coverage for Birthing People to One-Year Postpartum

### Spring Assessment: Conditional

Note to Authors: In the table you may see acronyms which refer to sections of the proposed policy. Problem Statement (PS); Evidence-based Strategies (EBS); Opposing Views (OV); Action Steps (AS); and References (Ref).

Criteria	Write a summary statement and include recommendations to the author.	Author's Response <i>This includes, but is not limited to, references to page numbers and line numbers to ensure that the changes are clear to the JPC reviewer</i>
<b>Title</b>  Does the <b>TITLE</b> accurately reflect the problem statement, recommendations, and/or action steps?	Consider changing the title to make it about “extended” rather than “expanded” Medicaid. Expanded sounds like it is for either coverage of additional services or for additional people. What the statement describes sounds like a combination of “extended” and possibly expanded.  Recommend removing “for Birthing People” from title.	
<b>Relationship to existing APHA policy statements</b>  Is there an existing APHA policy statement that covers this issue? What is the <b>RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS?</b> (Please identify the related existing policy statements by number and note if the proposal updates the science of the older policy statements?)	No existing APHA policy statement covers this particular issue. It complements 200318, 20004, 201113, 201114, 200714, 20153, 20192, 20203. There is a question, though, about how it relates to recently passed statements related to universal health insurance coverage (20219). Please clarify how it relates to that (20219) policy statement and explain that a late breaker on this topic was passed at the 2021 annual meeting and explain that this is an update to that statement	

	that is now going through the regular policy review process.	
<p><b>Rationale for consideration</b></p> <p>Does the proposed policy statement address a <b>POLICY GAP or requested UPDATE</b> 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?</p>	Rewrite the rationale to be more evidence-based, data-informed, and concise. Remove the multiple references to this being a “late-breaker”	
<p><b>Problem Statement</b></p> <p>Does the <b>PROBLEM STATEMENT</b> adequately describe the extent of the problem?</p> <ol style="list-style-type: none"> <li>Are there important facts that are missing from the problem statement? If so, describe them.</li> <li>Document any disproportionate</li> </ol>	<p>There are important facts missing from the problem statement. Additional information regarding the specific facts about the timing of maternal morbidity/mortality in the postpartum period and how that relates to the one-year recommendation (as opposed to 3 months, 6 months, or two years). Add facts about how incentives work, whether additional Medicaid insurance coverage actually increases quality of care or use of health services in the postpartum period.</p>	



<p>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.?</p> <p>c. Identify any relevant ethical<sup>xxviii</sup>, equitable<sup>xxix</sup>, political or economic<sup>xxx</sup> issues.</p>	<p>Adding any evidence to indicate that the critical period is 61 to 365 days – either epidemiologically or health insurance wise, e.g. are other coverages available for women after 60 days?</p> <p>Fully describe the political and economic issues regarding the costs to states of expanding this coverage and whether any of these costs will be offset by cost benefits, or how cost effective this policy will be in terms of reducing maternal morbidity/mortality in general and among birthing people of color in particular.</p> <p>Carefully review and edit to make sure every large statement has a citation.</p> <p>Describe the logic about why extending Medicaid coverage to one year will solve the problem of people not going to their postpartum visit, given how few people with Medicaid insurance through 90 days go to their postpartum visits now.</p> <p>Describe the logic about how expanding this coverage to a year will address low quality postpartum care and also how it will address structural racism.</p> <p>Adding a clearer description of how structural racism contributes to the variability in the risk of pregnancy-related death (around line 140).</p> <p>Consider:</p> <ul style="list-style-type: none"> <li>• Lines 205 – 214 describe the American Rescue Plan Act and</li> </ul>	
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	<p>the corresponding State Plan Amendment. You discuss how effective April 1, states can expand coverage by adopting this amendment to their Medicaid program. Reword this section and/or adding any necessary updates since April 1<sup>st</sup> has now passed.</p> <ul style="list-style-type: none"> <li>• Adding information about how social determinants of health (beyond race/ethnicity) impact maternal mortality rates and adding suggestions to plug women into necessary resources beyond clinical care that could lower their maternal mortality risk, and note whether these can these resources be provided through Medicaid?</li> <li>• Adding information about the impact on the children and families who have to deal with the effects of the mortality and morbidity of birthing people. For example, there seems to be ample research suggesting a negative effect of postpartum depression in child development, e.g. Slomian, J., Honvo, G.,</li> </ul>	
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	<p>Emonts, P., Reginster, J. Y., &amp; Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. <i>Women's health</i>(London,England),15, 1745506519844044</p> <ul style="list-style-type: none"> <li>• Adding information about maternal morbidity &amp; mortality among rural pregnant and birthing people and strategies that may be especially relevant for them.</li> <li>• Adding a stronger argument including more direct language about cost savings for one-year coverage, as well as more references to the cost section</li> <li>• Adding a clearer description of how structural racism contributes to the variability in the risk of pregnancy-related death.</li> </ul> <p>Below are suggested areas where language needs to be clarified:</p> <ul style="list-style-type: none"> <li>- P4, L121-122- citation?</li> <li>- P4, L126-135- everything tied to reference 2?</li> <li>- P4, L134-135- reference to HP2020, what about HP2030?</li> <li>- Update the Medicaid data to be the most recent</li> </ul>	
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	<p>rather than from 2018-2019</p> <ul style="list-style-type: none"> <li>- Percentages are hard to understand without a sample size, please add.</li> <li>• Adding definition of churn on line 191.</li> <li>• Recommend editing to make clear that this is no longer a late breaker policy statement.</li> <li>• Recommend using consistent language for race and ground sentences in person-first language, whites is not appropriate, but white persons is.</li> <li>• On line 161, recommend using language used in the survey itself re: ethnicity, e.g. Hispanic rather than Latinx, as these are not interchangeable.</li> <li>• Clarify that the language re: “Federal limit of 60 days”, e.g. line 176, as this makes it sound absolute, as though there’s a ban on states using their own dollars to pay for coverage beyond 60 days, which many states do.</li> </ul>	
<p><b>Evidence-based Strategies to Address the Problem</b></p> <p>Does the proposal describe what <b>STRATEGY/STRATEGIES</b> is/are being <b>PROPOSED TO ADDRESS</b> the problem?</p>	<p>There is some confusion as to whether the proposed strategies are/should be about services in the full postpartum year that could be funded by extended Medicaid coverage and the effectiveness of these services or whether the strategies should be about strategies for getting states</p>	

<p>a. Is/are the proposed strategy/strategies evidence-based?</p> <p>b. Is/are the proposed strategy/strategies , ethical, equitable and reasonable? If not, describe why not.</p> <p>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.</p>	<p>to adopt this extended Medicaid or whether it should be about strategies for extended Medicaid to translate into more use of these services. Address each of these as you redraft your proposal – 1) strategies for getting states to adopt extended Medicaid and 2) how extended Medicaid can improve: quality of services, service utilization, and outcome.</p> <p>The section should highlight how you envision extended coverage to look in a practical sense and consider: Does extended coverage mean people who have given birth are encouraged to go to health care visits beyond the recommended 12 weeks post-delivery? and What could or should one ultimately do with extended coverage?</p> <p>Provide evidence and specific arguments to describe what difference in extending Medicaid to 1 year postpartum from 6 weeks would have on health outcomes.</p> <p>Please also address why they recommend 1 year rather than 3 months, 6 months, 18 months, 2 years, etc. What is the evidence or rationale for this 1 year timeframe?</p> <p>Ensure that all of the services they list are services that are currently covered (or not) by Medicaid; right now, some seem like Title X services and MCH services, so it isn't really clear whether extending Medicaid would provide more coverage for these services in particular.</p>	
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	<p>Including strategies to get states to adopt this extended coverage would be reasonable. Recommend adding additional information to help assess whether these are equitable and ethical – specifically adding information about whether the time period and additional services covered by extended Medicaid make a difference in health services utilization, quality of health services, and are the services that would reduce the racial inequities in maternal morbidity and mortality.</p> <p>Redraft this section to focus on strategies for policy adoption, the new services that extended Medicaid would cover, and how the services would fill a need. Pay special attention to how this extended Medicaid will affect service quality, service utilization, and maternal outcomes.</p> <p>Address equity and anti-racism throughout this section rather than adding it on in a separate paragraph. Also clarify how the piece around anti-racist, unbiased service delivery fits in in terms of evidence-based strategies and how this policy statement will get there. Is there a way to incentivize training in and actual improvement in the anti-racist unbiased service delivery? What does the evidence say about how to incentivize this?</p> <p>Please note whether the 12 month coverage is for FULL Medicaid coverage for postpartum women, or for the much more restricted pregnancy-related coverage (summary and line 208).<a href="https://www.kff.org/policy-">https://www.kff.org/policy-</a></p>	
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	<p>watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/</p> <p>Clarify that Medicaid postpartum extension is different from full Medicaid expansion (line 106)</p>	
<p><b>Opposing Arguments/Evidence</b></p> <p>Does the proposal include <b>OPPOSING OR ALTERNATIVE VIEW POINTS</b>?</p> <p>a. Does it adequately refute the opposing/alternative viewpoints presented using evidence? If not, please explain.</p> <p>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</p>	<p>The proposal does not adequately refute the opposing/alternative viewpoints using evidence. Recommend adding cost estimates, cost-benefit analyses, and/or cost-effectiveness analyses --- both overall and with reducing inequities as a goal.</p> <p>In addition, add more details to justify why extended Medicaid for 1 year rather than expanded Medicaid to cover more people or more services are more important or more politically feasible.</p> <p>Address the opportunity cost question – i.e., why is this strategy more likely to achieve equitable improvements in maternal morbidity/mortality than other possible strategies.</p> <p>One member section reviewing raised questions about whether the State Plan Amendments section is accurate. Additional review by a health care financing policy expert is needed.</p> <p>Add an opposing view about whether extending Medicaid actually addresses racial inequities in service utilization/outcomes and what, in particular, might be needed for this to occur.</p> <p>Additionally, the alternative strategies need further explanation to help the reader</p>	

<p>in reach etc.)?</p> <p>c. Are alternative viewpoints , ethical, equitable and reasonable ?</p> <p>d. Were any opposing views missing?</p>	<p>under the arguments being proposed in this section.</p> <p>For refutation of opposing arguments-it may be a good idea to see how different medical associations forecast the effect of the proposed extension among health care providers. For example, would the extension change their billing, coding practices, volume of patients, unbalance their payer mix, etc.? These associations are likely to be in favor but the reviewers / readers are not 100% sure based on current argumentation.</p> <p>Adding additional opposing arguments, i.e. cost (that some state legislatures question the long-term nature of the federal matches e.g. "the feds could change their mind at any moment and stop paying the match"); being opposed to Medicaid in general.</p> <p>Adding additional opposing arguments, i.e. cost (that some state legislatures question the long-term nature of the federal matches e.g. "the feds could change their mind at any moment and stop paying the match"); being opposed to Medicaid in general.</p>	
<p><b>Action Steps</b></p> <p>Are the <b>ACTION STEPS</b>:</p> <p>a. Externally-directed (i.e., directs an external entity, NOT APHA, to promote or</p>	<p>Action steps are not supported by the evidence or rationale in the proposal. Revise the strategies section to provide evidence that the action steps outlined will be likely to contribute to improvements in use of health care and public health services outlined, to the quality of those services, and ideally to</p>	



<p>implement a specific strategy)?</p> <p>b. Focused on policy/principle, and not on specific legislation/regulation?</p> <p>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?</p> <p>d. Culturally responsive to the under-represented and underserved populations being addressed, if appropriate? If not, describe why not.</p>	<p>improvements in maternal mortality and morbidity. Not all statements in the action steps are well-described and are out of context – e.g., the reimbursement rate piece.</p> <p>The proposed action steps are not realistic or specific in many cases. For example, who are “all states”? who are “healthcare leaders”? Additionally, what are the suggested vehicles for getting these action steps done?</p> <p>Identify action steps that will make the services being paid for by this extended Medicaid anti-racist and high quality. Add additional language to the 4<sup>th</sup> bullet regarding culturally relevant and anti-racist services. As of now, these are not included. Evidence regarding possible tradeoffs or unintended consequences of these action steps, as well as how they affect structurally vulnerable people should be described.</p> <p>Revise the action step related to incentivizing evidence-based care, given that many women don’t attend postpartum visits or breastfeed for a year. It is unclear that extending Medicaid eligibility for a year will address this.</p> <p>The last 3 action steps need to be better established and supported with additional evidence in the strategies section. Establish the policy/programmatic levers to motivate change, cover full preventive services, remove cost sharing, and open reimbursement to all types of providers from Medicaid.</p>	
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	<p>It is not clear from the proposal whether all of the action steps are financially and legally feasible. Revise the policy statement to explain whether the action steps are financially and legally feasible, and possible objections to this feasibility should be added to the opposing viewpoints section.</p> <p>The action steps are not explicitly culturally responsive to underrepresented and underserved populations. Add language to the 4<sup>th</sup> bullet regarding culturally relevant and anti-racist services.</p> <p>Integrate considerations for anti-racist and unbiased service delivery models into the final bullet</p> <p>Revise the action steps per CHPPD questions &amp; recommendations. Specifically, consider: Why only call for national Medicaid postpartum coverage for one year? Why ask for states to adopt the option, if it's made mandatory by Congress?</p>	
<p><b>References</b></p> <p>Are the <b>REFERENCES</b> connected to the text? Are references complete, up-to-date, and peer-reviewed? Are there no more than 50 references?</p>	<p>References mostly are not peer-reviewed. Instead, they are websites and statements from other professional associations. Add more peer-reviewed articles instead of websites and professional association statements. As the evidence-based strategies and opposing arguments sections are revised, there will be considerable opportunity to add peer reviewed articles instead.</p>	

<p><b>Additional review</b></p> <p>Does this proposal require <b>ADDITIONAL REVIEW</b> from additional APHA components or external experts? If so, please identify reviewers (individuals and/or organization):</p>	<p>Please consult with an expert who understands the State Plan Amendments and who understands more about health care financing and Medicaid should review this, particularly the alternative strategies section. One option is the organization NHELP.</p>	
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