"The more that I engage in community research, the more I question our own biases in academia."

Jeni Hebert-Beirne, PhD
Assistant Professor
School of Public Health
University of Illinois Chicago

Voices of Health Equity in Chicago
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CENTER FOR COMMUNITY HEALTH EQUITY

DePaul University Rush University

Center for Community Health Equity
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Voices of Health Equity in Chicago
Our *Voices of Health Equity* project collects the stories of people who have made health equity a central concern in their work. We are interviewing academics, clinicians, public health advocates, community organizers, and others to better understand how different disciplines and professions could work together to eliminate avoidable, unnecessary and unfair health disparities.

Thursday June 29th, 2017
Interview by Celie Joblin and Sarah Wozniak

Background: Dr. Hebert-Beirne is an Assistant Professor in the School of Public Health at the University of Illinois Chicago. Her research interests include Community-based Participatory Research (CBPR), community health equity assessment, social determinants of health, community-based qualitative and mixed methods and women's and adolescent female pelvic and sexual health. She teaches Community Health Assessment and Determinants of Health to graduate students in the School of Public Health at UIC.

Celie Joblin: Could you just tell us a little bit about who you are and the work you do?

Jeni Hebert-Beirne: I am an assistant professor in the division of community health sciences in the School of Public Health at UIC. I am a community based participatory researcher so that means I engage in research in partnership with community residents or community organizations representing community residents. And I really strive to engage in this kind of transformative research that addresses issues of equity and power. I came to CBPR from working in practice for several years, so I was at the Chicago Department of Public Health for 10 years doing health planning and community health assessments and had a bunch of babies and found my way back to academia. What I do here, I engage in several different kinds of research but it all has this common thread of really striving to be community scholarship, so community informed, community-driven, and really kind of pushing against these ideas that academia or science or research is all-knowing. You know I'm moving away from this even hypothesis testing at the academic level and then we do this very top-down kinds of research on people so, and this is very much an ongoing lesson about how to do this well because it's very, very, very hard we're pushing against these structural inequities in terms of power.

So I do research in Chicago neighborhoods, building off relationships I gained as a city resident for a trillion years and then working at the health department. I do a lot of work in Little Village, in North Lawndale, I've worked really all over the City of Chicago. We just got a new grant to do some work in Southeast Chicago so I'm really excited about that because this is an area that experiences enormous inequities, particularly environmental exposures, hazards, so that would kind of be a new topic area for me, but again the common thread is this - how do we do research in partnership with people who are experiencing or exposed to particular phenomena.

Sarah Wozniak: And did you know that you wanted to go into this when growing up or when you were in high school or college did you ever see yourself working on issues like these in Chicago?

Jeni: I think so. I remember being in high school and the AIDS epidemic was really unfolding, and not even really understanding much about it but wanting to kind of be a part of that stopping of an epidemic. I grew up in a family that's a real math and science family and several of my siblings went on to med school, and so I think I've always had this health focus but I'm not one who is headed to med school for a million reasons! And so I think so. I went to Boston College and I studied sociology and I actually came to Chicago right after college and started a job working with runaway youth, so I was the Youth Crisis Interventionist and realized, like really quickly how awful I was at that job in particular. How unsuited I was too. You know, I had the expertise of having been a youth, but outside of that I really didn't have the experience or the insight to deal with these really complicated issues that drive youth to run away. So I figured out really quickly that while I wanted to be in this field, I wanted to address issues that were at the roots of these problems. You know and I thank everyone who does case management,

but it was like I want to be way upstream to try and prevent the conditions that lead the youth to run away.

Celie: So what does health equity mean to you?

Jeni: ...You know, I think that this move to really talk about health equity and commit to health equity is huge for public health. This has been such a phenomenal shift because like the easy answer to the question is well it's about fair opportunity to be healthy. It's about really attending to the conditions in which people live and their opportunities to be healthy and a real recognition that there are structural reasons why people have differential opportunities to be healthy. But just even laying that out, it's like, you know we have this exercise. I did mention that I'm a teacher and I love to teach so that's actually very much a part of who I am, but when we teach about this stuff you know, we kind of play around with this "But Why" exercise. But why are there differential conditions and opportunities to be healthy, but why, but why? And you really get back to these kind of these dark reasons why, which is that the way that we have decided to organize as a government, as a society, is so imbalanced in terms of power that really we have structures that advantage some over others, and they advantage those who are making the decisions over others.

So, I think in public health this idea that we moved away from just recognizing health disparities and trying to work on behaviors in order to reduce the gap of health disparities across people who are in different social groups to health equity has like dramatically changed just where we even are positioned in public health. So if you think about the upstream downstream analogy, you know we've been talking about the fact that public health has been doing a lot of this downstream work, and for sure, I mean, that's me. Like I graduated with a degree in public health from this institution. Actually I got my Masters here and then I went and worked at the health department for 10 years, and then I can't even remember what happened that got me back here, and I had three babies while I was working on my PhD. And like, I was trained as a behaviorist, like how to do health education, health promotion. You know and if only we could get people to eat better and exercise and get a vaccine, and it feels so foolish to me now understanding how people's opportunities to engage in healthy behaviors are rooted in really what their social position is and what determines their social position? Well those are these structural drivers, and what are those structural drivers? Well they're really these interlocking systems that, like I said, advantage some over others and oppress some over others.

I took a job in Milwaukee at the Center for Health Equity there, because I was like this is what, this is where we need to be. … Like you need this model that sits apart from government, that involves academia but also community, you know that engages a diverse stakeholder group and that's what Milwaukee was doing, it was actually what was the Wisconsin Center for Health Equity. And I was like, I want to learn about this, I want to be a part of this, and I wanted, you know, to see that here in Chicago. So I think that a lot of what is happening is a part of this movement to really claim not only health equity as our focus, but you know how do we then as collaborators across the city really have a strategic plan to address these issues of health equity because they are so complicated and so hard to talk about, and so hard to measure.

It's really easy to measure smoking behavior, or you know, wearing a condom for sexual intercourse. Actually neither of those things are very easy to change but they are easier to measure than structural racism, right? Institutionalized racism. And even our measures for racism tend to be at the individual level, which again is progress but not really like but how do we change those systems so that they are more equitable.

Celie: So you've talked a little bit about, and your article touches on it as well, about how academic community relationships are so vital to the work that you do. Do you think that that is kind of universally applicable or do you think that that's just specifically beneficial in Chicago with the dynamic communities that we have? Or a little bit of both?

Jeni: I think it's universal. I mean I think it's really an important topic for us to think about how do we transform the way that academic institutions engage in health equity research. So both from how do we train students who are getting their Masters and PhDs in public health and also how do we engage in research. So I have a couple of grants that... I do this work on community health equity, so in Chicago neighborhoods, mostly using community health assessment approaches, like this paper describes, you know trying to really challenge this idea of whose community and whose data and whose expertise. But I've been able to kind of apply that to research I have in topics that you would think this wouldn't apply. So for example, I work on a big grant from the NIH to look at women and girls' bladder health, which you would think is very different then these issues of community health equity, but I find similarities over and over and over again. There's a lot of structural reasons why women and girls' bladder health is actually receiving no attention. You know we've got funding for men's bladder health and Viagra, and all sorts of sexual health. So there's this massive gender inequity, but, actually I could spend 45 minutes just talking about this study, and I won't because, we're really trying to think about how would you, how would you build a research agenda for women and girls' bladder health that attended these issues of equity, and part of it is flipping these ideas that researchers, clinicians know stuff (laughs). Like let's really challenge what do they know and how do they know.

It's this idea that in academia and science, in research, we tend to reproduce our own knowledge. So we spend a lot of time building on each other's work. And that presumes that that first scholar in that area kind of got it right, and I think that the more that I engage in community research, the more I question our own biases in academia. And particularly if we haven't experienced the phenomena of interest, you know we bring preconceived notions to our hypothesis generation. So I think it's huge, and I have to say in this NIH study I have been talking about, we are engaged in participatory research and qualitative research, which I think is really part of just changing the agenda too. We are doing some pre-hypothesis generating engagement to understand these phenomena. What I have been really impressed with is the NIH has been very warm to this idea of you know, rethinking research and really engaging in more research that is transformative and that's what this paper is trying to get at is. We've done a lot of with language around building the capacity of community members to be researchers and that's important, but it's as important to transform researchers to be community partners. And I think that's where we don't have a lot of experience. We're not trained how to do that and have to learn on the job, and it's incredibly humbling because it is challenging your own issues of privilege and identity and really, you know, humbling yourself to be led, and that can be hard for people with advanced degrees who have been trained to lead. I think for a health equity agenda, I think that these kinds of community engaged scholarship and participatory research is, just what has to happen.

And if you think about it, I don't know if you're familiar with the World Health Organization's framework for structural determinants of health. One of the key messages from that framework that I don't think is talked about enough is that in order to address issues of health equity, we actually have to transform power, not just in those interlocking systems that oppress, but the power of people who are oppressed or the power of people who are most disadvantaged to engage in health planning in research. You know? I think that this word 'power' has this negative association because it oppresses but it's also making sure we create systems so that people can be empowered. I actually hate that word

[empowered], but that is kind of what we mean. Empowered to control their own destiny in respect to health, you know, and to be civically engaged to inform policy. So it feels hugely important to me, like I have this really critical lense now when I see this kind of top-down research that's spending lots and lots of money to either regurgitate what we already know, or maybe discern some nuances in a particular health issue, where *exactly* the health disparities really are. You know, where *are* these health disparities when it's like, no we know how health disparities are socially produced. That money really needs to be shifted upstream, to how do we intervene upstream to reduce that gap in health disparities.

Sarah: And so going back to the article, you talk about how researchers are sometimes viewed as "the outsider." And we, being MPH students and even in our undergrad, our professors always talked about this. How sometimes if you go into a community, the community will view you as an outsider, like you don't understand all of the problems that are happening and what they are experiencing. With this idea, the article also talked about different levels, the concept of expertise and what it is to be an expert in relation to lived experience.

Jeni: I think that what these spaces [Tranformative Communication Spaces] do is they provide an opportunity for everyone's expertise to be validated. And it allows the community member whose expertise is their own health in their own community to be on the same table as my dorky academic expertise in you know, health theory. Maybe even not, maybe even not the same level, right? Like I bring some theoretical frameworks to a problem that someone knows really intuitively. So I think it is trying to level the playing field or create an environment in which we can all equitably engage together.

That said, this is incredibly difficult. I think that in the same say that you know, post, you know the disastrous election results, we're in this new space of really having to face these issues of privilege and power and prestige and equity in these painful ways. I mean I think that, I do a lot of, I've been doing this research a long time and, I don't know if you know Vivian Chavez's work, she wrote a paper on the dance of race and privilege in community research and one of the analogies she uses is that if you are really going to commit to this kind of research, you're in a constant dance with stakeholders. So those stakeholders are students, and my research students are equal partners to community residents, to faculty, to funders. But in that dance, you will step on toes and your feet will get stepped on. We don't know those boundaries so I think that it is a very difficult process, and yet the potential for the results to be transformative and to be sustained are worth the dance. You know, even if it can be, it can be really hard. We've really had some experiences lately where we've just hit spaces that are very uncomfortable. You know like, really even challenging, you know [and I think] why, why am I so committed to this research? And we talk through how did I come to this space and other people about how did they come to this space. And we really came, you know I had a privileged path to this space, for sure. So there are things that I won't really understand but I'm always trying to figure out, despite that knowledge gap, what can I do or what can I learn?

Celie: So how have you had to kind of adapt from one community to the next? How easy or smooth of a shift was it to take it from Little Village to North Lawndale?

Jeni: Now we are expanding to Southeast Chicago and I've been thinking a lot about this because yeah, these things aren't replicable. I would really like to say, "Here's the recipe" but I think that, we've just widened our focus from Little Village, where we've done most of our work to North Lawndale. North Lawndale has been like an important, important, important partner of UIC for a long time. I mean, they're our neighbors. So even though I think we've had a lot of opportunity to build trust in the neighborhood, I think that in adapting these models of participatory research in a lot of ways, we start

from phase 1 again and really these conversations about, so what are our expectations as a research group and how are we going to get there. Despite, I think our best efforts at even laying those things out and trying to create a smooth path, it's just not smooth. We actually really want to engage in community-driven research. It's hard.

We have this new grant from NIOSH, the National Institutes of Occupational Safety and Health to look at work as a social determinant of health in North and South Lawndale, and this has been a huge opportunity for us because we've been doing a lot of this work in an underfunded capacity and now we have money, and so we're like so excited to actually be able to build up this infrastructure that was really, we like to say we kind of duct taped together these small pots of money and we leveraged all of our volunteerism and all these students get involved because it's an incredibly important learning opportunity. But when we finally had money, we were then paying people around the table. Well that really changes things, like when you move from "I'm here just because I want to be here" to "I'm going to pay", there is some natural, "How much are you getting paid?" You know? And that makes sense, right? And how much am I getting paid to be at the table, and are we all getting paid the same amount? We are not. So I think that we've had to, we actually in our study just stopped a couple weeks ago and said, "Let's stop and let's regroup." How can this really be community driven? So we just kind of keep asking those questions. Can it really be community driven? For these federal grants, NIH or NIOSH, CDC, they come to the academic institution, and then we subcontract out. And so there's already this power imbalance of who wrote the grant, who has the money, who's executing the subcontracts. Within that context trying to create an equitable research partnership is really hard.

So I think the short answer to your question is like it's kind of constant reflection and constant adaptation to make sure it's working well. You know, I've used the word humbling before but like, it's being prepared to be humbled at any point to like "It's not working," you know? I think that what is healthy in our partnerships is that we do try to be authentic. We really, really want this to work. So I think that with that genuine sense of why we're here, that's what keeps us going, but that doesn't mean that every time we stop isn't difficult. North Lawndale is an extraordinary place because the community is very protective of who's driving and who's in charge, as they should be after years and years of really chronic disinvestment from the City of Chicago. And so that is a situation in which even when we got the funding we had to think about is this funding structured such that we remain the outsiders who are allies to this work but not driving because it is completely not appropriate for us to drive in either community area but North Lawndale is a little bit more cautious about who's driving.

Celie: And is that because the city has messed them over or do you think it's for other reasons?

Jeni: I think it's both city disinvestment and I also think it's academic institutions that have come in. You know we use this helicopter analogy with community based participatory research, which is that you know a lot of research institutions helicopter into communities and take data and then they helicopter out and publish in fancy journals and they present at conferences and the data never, the community never even heard the findings, you know that the research wasn't designed to advantage the community. The flip side of that CBPR is collected by community residents, community residents help interpret the findings and the findings lead to interventions that matter or social change that matters. I really hate this word intervention too because of what it kind of implies but that the findings and the process of research should lead to social change around these issues that we're interested in.

I've talked a lot about my privilege of being able to teach students and we need to transform our public health workforce, I've had a couple colleagues push back on the work force because it is kind of this

capitalistic idea that we produce these workers and then you go out and work, but I can't come up with a better word right now. You know our public health practitioners or public health researchers that we want to transform their own capacity to engage as equitable partners to work upstream, to really be able to identify issues that compromise health equity and take action, and similarly, this is much harder, but we want to engage community residents to be a part of that process. I think what's really hard about that is that systems are in place to make it harder for people who are, who live in high hardship areas to civically engage, to work as a research partner. So the overall goal is basically that we have public health practitioners and researchers who are more suited to health equity research and that we have community members who are interested, willing, skilled in being able to step in as community researchers.

And wait there's something else I wanted to say about that. I think that this, the overall idea is really to address these issues of trust and we say that all over in the paper but it is like when as a representative of an academic institution I bring all of this baggage to the table and it's real baggage right? I mean we've really, really harmed communities in order to advantage ourselves; more papers, more money, more privilege. So this idea of any steps that we can take to try to build trust, to try to build, you know position institutions and you know I think both DePaul and UIC are good examples of this. I mean UIC as the public institution where our students come from a lot of these communities, we need to be that trusted partner, our money needs to be invested in these communities. DePaul with a more of a social mission, more of a religiously oriented social mission, similarly, you know I mean needs to rethink how do we behave, how to we act, what are those funding streams look like, what are issues of IRB. We think through every kind of step of like what should we look like so that we can be part of this more transformative process?

...

Our health departments, our local departments, state departments, are tied to government in these ways that make it really difficult to talk about upstream factors, right? And so I am actually really impressed with the way that Healthy Chicago 2.0 was able to name structural determinants of health inequities in ways we've never seen before. Talking about racism, talking about xenophobia, talking about heterosexism, I mean this is just progress, period. And I think that the health department, I'm a very close partner of theirs, because I think that when you're working in that setting where you, you're not only resource poor because of you're city government but you're also restricted in political ways, it's really hard because public health basically is a political agenda. I mean like we pretend like it's not, but it is, so when you come from a place, whether you're either tied to an academic institution or city government you're really, your opportunity for advocacy and action are kind of limited by the context in which you work. ...I've seen engagement [by the health department] like I've never seen before too and I know I've sat at community meetings where, when they're rolling out their action teams, where community members are like I want on that team. That really used to be the reverse, it used to be like "Please come to the town hall meeting," so I think this is probably kind of this natural evolution but I think we're seeing more community members represent community organizations and say, "How do I get at the table?" rather than the reverse.

Celie: I mean for me personally, like having that as a resource has been so helpful in school, you know? Because we're just starting off our work in Chicago...

Jeni: I'm glad for you to say that, you know I well I have it right here (reaches for Health Chicago 2.0.) I like to age myself and talk about, well the health department used to produce these community health

profiles and lots of people who you're interviewing will probably remember this because when they were produced, they were of course produced in hard copy, it was like a binder and then you scrambled to get them because new data! It was just like "Oh my gosh!" Then of course you would actually do the analysis yourself and say, "Look at this, South Chicago is kind of different than Englewood, kind of different than Albany Park," and the fact that it's at our fingertips? Extraordinary! And the fact that the other amazing thing Healthy Chicago did, and of course we have a long way to go, but I'm a glass half full person. You know, the fact that some of the, the indices, the metrics that they use are rooted in issues of health equity is awesome. Childhood Opportunity Index, the Hardship Index, I mean I think that Nick and Sheri and the whole team, you know brought this health equity frame in ways in which we haven't seen before. In the past we saw "Hey look at these health outcomes, they're different from each other, look at that! They're different by race or class," but this is, the conditions in which people live and the opportunities to be healthy are different across the City of Chicago so forget about the health outcomes, I mean that's totally where I am. I have to give a talk on health behaviors coming up and I'm like, I'm so done with health behaviors, right? But if, we've invested... if you think about that Frieden pyramid, we've done all this work at the top of the pyramid, and what we've done is we've actually increased health disparities you know? We've advantaged those who are advantaged to do better.

Celie: You kind of touched on this for North Lawndale and Little Village, but I guess as larger Chicago in general, what do you think the biggest obstacle that the city as a whole faces when it comes to addressing health equity?

Jeni: I mean it's hard, it's our segregation generally. Yeah, the biggest obstacle really is how, is our history of racial and class segregation. We've participated in an *On the Table*, Chicago Community Trust does this *On the Table Event*, which I always think is awesome because it's basically providing people who don't usually come to the table together to talk. I remember a couple times in a row these people would ask this question "What can we do?" and some of the answers are creating more opportunities like this, like talking and listening, you know? One of our methods in this paper are the production of these Listening Events. You know, this really came from a kindly community partner saying, "academics need to learn how to listen, just shut up and listen!" (All laugh) Listening is so powerful, the process of listening so important. I just think we need more and more opportunities to listen to each other and I think to recognize and name our privileges and from where do we come to the table because that is important to recognize and it gets in the way if it's not recognized. I do feel like the solutions to addressing health equity in Chicago are solidarity and working together in unity and that's really hard because we've basically been structured and are used to these segregated, both communities and disciplines and academic institutions, so it's really breaking away from that, which is hard.

Sarah: In "Partner development praxis", you brought up the point that community based research isn't held to the same scientific standards compared to other research. As I read that it was very interesting because I took a step back and I was thinking about it and reading through this I could see that and I was wondering why do you think this is?

Jeni- Hmmm. You know when we set about to write this paper, and this is like version 200 (laughs) it was very difficult to even figure out what is it that we wanted to contribute. One of the things that we were struck with was when we're trying to learn from previous CBPR there wasn't a lot of detail and that struck us as pretty interesting because any other kinds of research, like the gold standard randomized clinical trial, there's such detail in the steps and the processes and we felt like that was actually sloppy for CBPR to not have the same kinds of processes. I think that we say Ed Trickett who used to be at UIC and he left but he had this really healthy skepticism of CBPR that, you know, this is this transformative

research paradigm that if done sloppy actually just reproduces the same kinds of inequities between academia and community. I think that it's a really good question that you're asking because CBPR is seen as this, maybe this hybrid practice-research or kind of a light version [of research], and so academic journals don't require the same kind of detail. When we were trying to learn from other academic journals we were like "Where's the-How'd you do this?" It was just kind of fluff and so we we're like we really want to spell this out so people can learn from it but also take this seriously, this is not easy. There's a lot of risk of really messing up in big ways that actually them compromise the trust of your academic institution and we wanted to really hold CBPR to the same standards as other kind of research (RCTs).

Celie: It's definitely a form of research that I feel like we've encountered a lot less in school…

Jeni: You know, academic institutions are set up such that this is a much harder path. An academic researcher who wants to come in and sit in on someone else's grant and then analyze their data succeeds easily. Because it's really is the replication of knowledge that is valued. The replication of that knowledge leads to a ton of manuscripts and that leads to recognition of the academic institution in the world of academia. The more grants the better, the more manuscripts the better, and I'm going through my promotion processes, and this will be great to see in writing because I'm super fussy about this (all laugh). It's like trying to fit me into these processes, yeah, I have grants and I have manuscripts but the manuscript is the least transformative dissemination output of research. I mean, who reads academic journals except this privileged elite group of people? And we produce this and we share it in the name of knowledge generation, how can we produce more knowledge? But in CBPR the outcomes are actually social transformation (not exclusively new knowledge generation), so the outputs are totally different (but are measured only one way in our academic promotion processes).

Actually I claim these outputs of these transformative communication spaces, the creation of spaces, the hiring of community members as an instructor in the classroom, that's transformative, but there's no place in my promotion processes to really name that or count it… although I'm shoving it in there. Even if I could get it in, it's not counted in the same way that a manuscript is counted. I think it's super interesting. It's why we're not positioned well for this transformative research. Most academic institutions want that scientist, that researcher, that brings in a lot of money and spits out a lot of papers, you know? That is kind of our business in academia. So for us to bend - and we just do a lot of pushing and bending around here with everything - how we spend money, who's hired, who's at the table, and that is a more difficult kind of research path. I think that academic institutions see less value in it, just because of what they count as valued. But I agree with you, I think that a lot of-but this is definitely changing - I think that there's a lot of people who are claiming this space. They are definitely claiming this after they get through promotion and tenure (not before) because they can.

But there are some of us who are actually pushing through these promotions and tenure because in order for this kind of research to be more prevalent. Our promotion and tenure processes similarly need to transform. They need to count things differently, and they are. There's lots of academic institutions, not ours (all laugh), but ours will, right? They are but slowly as they're looking at other academic institutions because there are these outputs that are valuable for the academic institution, they're just not readily recognizable.

Celie- Especially with a public health school, you know? You would think that that would be more prominent, but I guess not (laughs).

Sarah- Yeah!

Jeni- That's the sort of thing you miss in an interview, someone being like "Yeah!", right? Or in a transcript.

Celie: So one of the things that the article talked about was the qualitative think tanks. Is that something that you found across the board that is a thing, or do you feel like that was special to the transformative communication spaces? How do you see that working in your research?

Jeni: So we've definitely developed them in Little Village, in our Community Health Assessment, and now we've adapted it to our, what we call our Greater Lawndale Healthy Project. We right now are doing participatory qualitative data analysis think tanks but using the audio files rather than the verbatim transcripts. We're launching, like we have a meeting today where we're really launching these, but if you think about what you're going to do with these interviews (the one we are conducting) with even the thematic analysis, looking for patterns, we're going to do that but by listening and kind of real time memoing and discussing. From our memoing we'll develop codes, then we'll go back to the audio file and look for the patterns. So same thing but it actually, audio files are more accessible than written transcript and to be honest, if I took thirty pages of written transcript and gave it to community members and was like "Okay, let's go through this now," no, what it actually does is identifies that I am more comfortable with thirty pages of text. So I would have more confidence and a community partner might not come with this same kind of love for textual data.

Celie: Since the majority of these Transformative Communication Spaces have taken place in Little Village and North Lawndale, where do you see the health of those communities going in ten years, twenty years? And then after that about Chicago in general?

Jeni: Hmm. I think that one of the things that I've seen in North Lawndale, as this outsider, ally, and partner, is a lot of commitment to solidarity across the communities and a lot of push back that these communities, while contiguous, they're very different in terms of race and ethnicity, and income and employment, and documentation status. So while the structural drivers that produce health inequities in these communities are the same, they kind of have these different social processes. One of the things we've been hearing in our Greater Lawndale project is this aversion to, even looking at our data by community area, because that reproduces some stereotypes about residents in this community that isn't true, because that really isn't how people experience health.

We do this really interesting concept mapping project where we're trying to identify how residents in these areas experience work and residents in these areas. What we know about how people work in these communities is that these are neighborhoods in which there's a high percentage of people engaged in what we call "Precarious work" and that can be precarious because you're exposed to hazards or can be precarious because it's not stable employment, there's issues of exploitation with work. There are issues of not being able to work because of documentation status, or former incarceration experiences. As we're looking at these data, our ultimate goal is being able to name these upstream factors, but we've hired community researchers from both of these communities to engage with our research team and there's this real push back to looking at the data at the community level and they want to look at the Greater Lawndale.

This is a great example of the true transformative nature of participatory research because my head wouldn't have gone there and it's also pushing back on some of this institutionalized discrimination that

we might not even name. I think in community areas because I always have, seventy-seven community areas in my head, I know them really well, I know the data, and for community residents to say like "Stop," it's not as if those boundaries (community area boundaries) are a physical boundary. There's ton of moving back and forth with the needs of these communities and we're experiencing the same structural drivers of inequity. So that has been such an important learning experience with these neighborhoods working together, Little Village is particularly resource rich in terms of organizations and residents really taking action on health and North Lawndale similarly. A lot of North Lawndale community coordinating councils are doing amazing work at this broad level on issues of health and wellness.

Your question was kind of where are we going in terms of health, you know glass half full, I think in a very positive direction. That said I think it's so hard to even talk about this change in our presidential administration and the impact that it has, it's just so hard because it needs to be said but it's also very painful to admit. If Little Village residents were experiencing stress and fear associated with documentation status before this election, it's a whole new world. To be honest, we're working on a manuscript where we did focus groups and interviews with residents in Little Village on issues of community health broadly and we really stopped and looked at our data, and actually one of our community partners has been very articulate in like, let's be careful how we even present findings in Little Village because people are feel very fearful and protective and we wouldn't want our research to at all to increase stress or fear. So that's messed up. Then North Lawndale too, fear from the roots of which might be slightly different but you know this administration is just hostile to people who have historically been disenfranchised.

Sarah: It's really hard too because how you're saying public health is inherently tied to government, so it's like you go into communities like these and you want to be like "No we want to help," but they see you're tied to government. It's just a really hard situation to change.

Jeni: Yeah. Research funding, it really does make a difference on issues of health equity and our research funding is going to be cut. Just no doubt, we're all just holding our breath. You know, how much, how bad? This is an administration that doesn't value science and knowledge!

Sarah- Yeah, just alternative facts.

Jeni- Alternative facts! So this is where my glass half full is really compromised because we just have to be real. I think overall Chicago as a whole is definitely headed in a positive direction, I'm really impressed with what DePaul is doing, what the Health Department is doing, I think we're really doing some important things here at UIC, but our sociopolitical context? So threatening to our work.

Celie- Okay so last question. Do you have any advice for other new students who are just entering the field and interested in public health? Or just beginning their careers?

Jeni- Yes! I would say like "Welcome to the greatest field on Earth!" I do feel that because we are tied so much politically, this is a discipline, a field, research area, in which we can see enormous growth. We need to really commit to this frame of healthy equity. We need to transform or advance or rethink our research questions, who's asking the questions, who's collecting the data, who's interpreting the findings, and then how are the findings disseminated and implemented? We have huge opportunities with dissemination and implementation science that we haven't really had before. I think it's an extraordinary time to be entering public health. I loved it when I entered in 1992, it was such a better

home for me than case management and the fact that we've continued to move upstream and had to actually continually enhance our own capacity to move upstream, you know? Most of your instructors weren't really trained in some of these things, so we're actively having to learn this as we go along. It's a very dynamic field to be in right now and I think the more that we recognize these interlocking systems that oppress people, the more we recognizably need to work with these stakeholders of these other systems, which again make us increasingly important.

Public health needs to work with education, needs to work with legal, needs to work with human services. So I think it's an extraordinary time and maybe these challenges are actually like, no progress without a struggle, right? Maybe these challenges will actually just enhance our capacity to make the change that we know needs to happen.