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Voices of Health Equity in Chicago
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CENTER FOR COMMUNITY HEALTH EQUITY

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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.

Tuesday, March 27th 2018
Interviewed by: Amber Miller

Background: Juana Ballesteros has over 15 years of experience as a public health professional, with specific expertise in health promotion program development and evaluation, community-based planning, community engagement and outreach, development of strategic relationships and collaborative partnerships with multi-sector stakeholders, coalition building, grant writing and management, fiscal planning and oversight, strategic planning, as well as health policy analysis and development. She has a genuine interest in reversing the impact of racial and ethnic health disparities. In her current capacity with the Illinois Department of Public Health, she plans, directs and evaluates the implementation of outreach programs across the Department, creates policy on best practices for conducting effective outreach to diverse communities, as well as reviews and recommends positions on related State and Federal legislation. Juana received her Bachelor of Science in Nursing (1999) and Master in Public Health (2005), both from the University of Illinois at Chicago.

Amber: Juana, can you talk a little bit about who you are and how you got to be who you are?

Juana: So, my parents immigrated here to the US as young adults from Mexico, kind of the typical, I feel like Mexican immigrant story. I'm the oldest of three children. We were raised, and I pretty much lived my whole life in the Little Village community of Chicago, AKA Mexican capital of the Midwest. It's really interesting how I ended up in health and public health, it's pretty funny. I feel like I was put on the spot. We were in third grade and the teacher just asked all of us kids, what do you want to be when you grow up? And I had no clue. Literally someone before me mentioned a doctor and I said, "Oh, Doctor" - no clue. Never gave it a second thought, now fast forward.

Then I had some older family members that worked in healthcare and I just felt like it was something that I could do. I also knew I wanted to work in the helping field. Healthcare just seemed like a natural thing to do. So I went to nursing school at UIC and I had this whole game plan that I was going to become a pediatric nurse practitioner. Get through the Bachelor of Science and go back and then become a nurse practitioner. And while I was there, in nursing school, I took this elective course called Public Health Nursing. It just sounded so interesting to me. I thought that I could learn a lot.

I did know that in my professional capacity I did want to work in my community in a Latino serving healthcare organization, in a really grassroots kind of healthcare setting. So I took this elective course. The course almost didn't happen because it required a minimum of 10 students. Us students that were really interested in the course had to recruit, at the last minute, so we did. It wasn't easy recruiting the minimum 10 students. I actually was talking to fellow classmates and telling them "Hey, come take this course". So I was kind of organizing my fellow classmates to take this course. And the professor was this amazing woman who did real public health work in very remote areas of the world, stuff that we've already done here in the US a hundred years ago. For example, things like sanitation systems, safe drinking water or vaccination programs. She just seemed like this real super woman of a person to me and I thought I want to be her when I grow up.

She had an MPH behind her name. So I told myself, OK, I'm going to get an MPH someday. So I finished nursing school, worked in a hospital for a little bit, then ended up in my first community-based community health job at El Valor in Pilsen and South Chicago. I was there for about six, seven years doing health promotion with staff and families with young children. I did create a home visiting curriculum for pregnant women, prenatal classes and all that good stuff. I worked there full time and at

the same time I went back to school and did my MPH at UIC. So I did both Undergrad and Grad school at UIC. So it took me a little while because I went to school part-time and so that's kind of the education side of how I got here.

I spent a good 15 or so years working at different non-profits in mostly Latino-serving organizations. Like I had mentioned, I worked in Pilsen, I worked in Humboldt Park also. Interestingly enough, my time in Humboldt Park I think was the most formidable years for me as a professional. That's where I ended up as an executive director of a community based health coalition called the Greater Humboldt Park Community Wellness. The coalition came to be as the result of a lot of different factors. It was the result of the Sinai Urban Health Institute with its first community health survey, finding huge disparities in Humboldt Park. The data found by Sinai really galvanized local community leaders to do something to address those health disparities. At the same time LISC Chicago was implementing and supporting the New Communities Program. And so, communities with some support from LISC, we're able to address community level issues.

By accident, I got involved with them. Initially, I was hired as a consultant to gather some quantitative and qualitative data and do a report focused on HIV in the Latino community as well as recommend related policy and advocacy priorities. Then at the time the executive director, a consulting executive director because the organization was so new, was transitioning out of the role. She said to me, “I think you should be the executive director”. And I said, “I don't know that I could do that. You have big shoes to fill.” She said, “Don't look at it that way. I think you'd be great.”

At the time I was in transition myself. I was in the process of leaving my job at UIC, our funding was being cut. I worked on a research project looking at HIV positive pregnant women. We followed them and their infants to assess any possible effects of antiretroviral meds on their babies. She knew that I needed a job and so I said why not give it a try? So I say that was my most formidable years because I was exposed to such great minds and leaders like Steve Whitman, founder and Executive Director of the Sinai Urban Health Institute, Jose Lopez of the Puerto Rican Cultural Center, Dr. Lee Francis from Erie Family Health Center, Madeline Roman Vargas of the Humboldt Park Vocational Education, and Miguel Palacio of Association House.

These individuals were doing very innovative work at the community level and they were community leaders with such wisdom, humility, and vision. But at the same time very much challenged people to do more and really challenge the powers and were unafraid and unapologetic about discussing the historical context of injustices and racism and inequalities that lead to these huge disparities in Humboldt Park.

So to this day I consider those folks the best mentors I could have ever had. Working in Humboldt Park I grew on so many levels both professionally and personally. I underwent a lot of self-actualization about myself and my role in community health and public health. It's interesting because in my public health education, I learned what impacts people's health. For example, diet, exercise, access to health care and our social networks. I hate to say it, there wasn't a huge or big enough focus back then on all of the historical contexts and the policies and the structures that truly make the biggest impact on one’s health, the social determinants of health. I hate to say it, I kind of just learned about theories of health behaviors. For example, the theory where an individual is in the middle of a circle and there are layers of factors that impact our health. The closest layer is our personal relationships and then it's our community environment and our faith-based environment, and so on.

Amber: The Socio-Ecological Model?

Juana: Yes. Lucky for me, I learned about inequitable structures and power imbalances and their impact on health in my twenties and early thirties, and not way later on in my career.

So, I was there for about four years. I enjoyed it. I enjoyed working with so many other people, parents, several non-for-profits, church groups, FQHC's as well as academic partners who I was also very much able to challenge them to do more. I think they learned from me as well, to do more for communities and understand how to work with us in very equitable relationships and not to further perpetuate the helicopter effect but to truly engage in the CBPR model. Not the savior syndrome and expect communities to say thank you for giving us something. Rather, working together to acknowledge and build off of the community's capital and capacities.

You know, it's learning to work together, but for them not to feel like there's this kind of status between them and us and we should be grateful. Right? Thinking about how to take an asset-building approach. It's interesting, but it's not so much asset-building because in Humboldt Park there was a lot of assets and that's the other great thing I learned is not to take a deficit approach in our work, but bring an asset-based approach to our work. Communities, although from the outside, people might think "Oh, poor, Humboldt Park, poor Little Village, they have so many issues that are so daunting" you know? Oh, "they need so much help". But then you talk to folks in these communities and they don't feel like that. You learn to recognize your own implicit biases and how they are barriers to the work.

I heard that, and I saw that and I could relate. It's almost as if you say, "how dare you think that we need you." Or, "How dare you think that we are lacking in so many different things" As opposed to, "Hey, let's work together. We would love your technical assistance. We would love your guidance, your partnership, but you're not coming in here to save us. We don't need saving". You know what I'm saying?

That kind of mentality happened and was very evident, and I witnessed it all the time in working in Humboldt Park especially. I was also able to teach others who were not from community, how we wanted work with them, you know, and vice versa. So it's basically the principles of CBPR. I first learned about CBPR in grad school but I was able to practice the fundamentals of CBPR while working in Humboldt Park.

Yeah, so I did that. I did a lot of community-based, community-health work for about 15 years and then learned in my time working in Humboldt Park that ultimately what impacts people's health the most is sound policy or lack thereof. To me, sound policy is for the people and by the people. Sound policy is policy that is very much informed by the community and its development is influenced by community advocacy. So once it does become policy or law or a mandate, there's a high likelihood that it's going to be very successful and impactful, you know? Sound policy will positively impact people's lives at the same time it is reducing or completely avoiding any negative possible implications.

So at the time, that's when the ACA was rolled out and I saw how there was so much, even before it became law, there was so much negative press about it. I thought to myself – *but this is a good thing*. I thought, people are not focusing on the big picture. A lot of the negative press was focusing on the cost and how the government shouldn't be forcing people to do anything they don't want to do. So as the ACA was being rolled out, I literally saw and I knew people that were very much involved in enrolling people and doing community outreach and things like that. And I witnessed so many people now have

health insurance when they never had it ever in their life. And now they were able to have a primary care home, see a doctor for prevention, get a mammogram for the first time. Women very much in middle age when they should've had their first one years before, or colonoscopies, and people ultimately getting treatment for their diabetes, you know, things like that. And so, when I was able to witness that, I was like, “Oh my gosh, policies have a huge impact on people's health” So then I said, “OK, I think I might want to work in health policy now. But, I don't work for government and didn’t exactly focus on health policy in my studies”. So, I consulted with a couple of people that I knew were doing health policy and said. “Hey, I didn't study this. I focused my studies on community health sciences. What do you think? Am I crazy to think I could do this?” And they said, yes, you are from the community. You've been in the trenches, you've had your boots on the ground, you understand the community, you know what the issues are, and you'd be great to be able to bring voice, their voice to the government level.

Then I said, “OK, I'm going to pursue jobs in government” and ended up here I've been here for almost four years in. My title, it doesn't have “policy” in it, but I have done policy work. About a good two years ago, I spent a whole year working on community health worker policy research, analysis, and development. I managed a statewide community health worker advisory board and they put forth and proposed policies in a very robust report. So that's kind of one of the bigger policy initiatives that I've worked on. More recently, I've been working on making sure that our staff, programs, and services are culturally and linguistically competent. So developing more internal policies around that is one of the things I've been working on.

I'm also on the steering committee of our internal health equity council. So also looking internally, and I say internal because we're looking at our internal policies and practices and making sure that we definitely are doing everything as a state public health agency that we should be doing to support and positively impact health equity. For example, is our grant making impacting those populations who are most vulnerable? Are our services and programs linguistically and culturally competent?

Amber: Yeah. It's so interesting to listen how you started off in nursing all the way to a government agency. I know a few nurses that are interested into getting into community health, but they were never taught that, that wasn't a big part of their curriculum. They could take a course if they wanted to, so similar to you and what you mentioned, but they go in and they learn a little bit about population health and community health and they leave believing this is the field of nursing they want to pursue, but there's no curriculum for it in their programs.

Did you have any other classes or was there more than just one elective for you to take that was population health based in Chicago? Or was like community health or population health part of your curriculum?

Juana: Actually. So we did have a community health nurse course in nursing school. That was an elective, not a mandatory course.

I'm hoping the nursing curriculum has evolved since I graduated undergrad in 1999, making community health/public health nursing a mandatory course. At the time, our field placement for the community health nursing course was at a public elementary school in Pilsen and we case managed kids that had chronic lice, asthma, and other issues. I'm hoping that all nursing programs have evolved and include this as a mandatory and not an elective course. I think the ACA might have really led to a change in curriculums because there's so much focus on prevention and understanding the patient as a whole

person, not just their physical aspect. And a focus on that and prevention and managed care and case managing patients and keeping them out of more urgent or emergency care settings because that's so expensive. I'm hoping that has also caused a change in nursing curriculum because of everything else that has happened at the federal level. Hopefully.

Amber: I know you talked a little bit about working on like an HIV project. Is there any specific health issue you work with in particular that you've worked with the most.

Juana: That's a good question.

I've had the luxury of kind of dabbling in different things. So I mentioned diabetes and HIV. I've also dabbled in asthma, mental, behavioral health, oral health, active lifestyle, it's been great that I've had the opportunity to work on different health issues. Mostly, because of when I was the Executive Director of the health coalition in Humboldt Park, we organized our structure and work into task forces and each task force focused on a particular health issue. Each of the task forces focused on those health issues I just mentioned. It was a great and the task forces had strategies they worked on: raise awareness, leverage the community's assets, and implement collaborative projects in partnership with all of the different resources and assets that they've been able to leverage and coordinate services, thus reducing duplication of services. This model was impactful because the sum of the parts was greater than working in silos. That was the other great thing that I really enjoyed about that work was that we were able to have all of these great service providers and community folks at the same table when they otherwise probably would have never sat at the same table. Many times, I would hear the coalition members say "Oh, I didn't know you guys are doing that. Oh, we're doing this. Oh, well how do we ensure that we are working together and not duplicating efforts? And what are the gaps in services and how to we address them together?"

Amber: I think we say, "Oh yeah, let's not duplicate services or research", but it's another thing when you're actually coming together and just talking and learning what each other's doing and making sure that, again, just don't duplicate services when you're two separate organizations and you're a few blocks away and you're doing the same work. It's very powerful when you're able to coordinate your services and to identify the gaps in services and then work toward filling those gaps by leveraging other organizations who are interested in the same work.

Juana: To get back to your question, I went to grad school not really knowing what particular area or health issue I wanted to focus on like diabetes or breast cancer. I did know that I wanted to get an MPH and use my degree to do impactful work in my community. Interestingly enough, while I was in grad school, I learned about the growing disparities in HIV among the Latino community. There's no ignoring the huge impact HIV has made and continues to make in the African American community at the same time, I learned about the disparities, in particular, Latinas of childbearing age, heterosexual women. And I was like, "that's me". Those are my peers, what's going on? The data showed an upward trend in new cases in this group, and I wanted to learn more and why this was happening. It was great to learn more, understand and peel away the layers. Learning how our cultural norms and beliefs impact our risk for HIV. This is when and how HIV really peaked my interest.

And so, I did my grad school practicum at a Latino-serving HIV community based organization. My first job after grad school was in the area of HIV. That was how I ended up working at UIC where we were following pregnant women that were HIV positive. I was there for less than a year. Then they literally pulled the funding from right up under us. So I've always had a real interest in HIV and just really

understanding what are the factors that put us at risk and why do we have these risk factors, many are cultural norms and beliefs. Apart from just other things, what else puts you at risk for HIV? Like drug use and substances and how these impedes your judgement. But for me, it personal, the whole cultural aspect, especially when it comes to Latina women and how traditional gender roles, not feeling empowered in your sexual relationships and a lack of self-determination puts us at risk for HIV.

Amber: What do you think are some of the biggest obstacles when dealing with community health in Chicago or improving health equity in Chicago?

Juana: It's no secret. With everything that's been happening right in Chicago from police brutality to school closings and why certain schools are being closed and are being built and where they're being built. And so, I mean, it's no secret, you know, Chicago's a very segregated city. We have an awful history of racism, and racist policies and practices. Some people might argue, well, you know, all of that happened many, many years ago, but its effects are still here.

People make the same argument about slavery, right? The effects of slavery are still here some 200 years later. I think we need to acknowledge that we've had and continue to have unequitable policies and practices. So, it's not just acknowledging and trying to get past them, but I think it's also about being very intentional on actually empowering communities to be at the decision making tables, and I'm not necessarily saying, "Oh, we're going to help people run for office". What I am saying is that people with decision making power making sure that they are genuinely engaging with folks from disenfranchised communities and in a very genuine and organic way, listening to them. Really taking what they say in and taking that information to help inform their decision making. That's a tall order I think and it's not easy to do community engagement and do it correctly and do it well. Some think they know how to do community engagement, but they really don't.

I hate to see emails from government agencies and their "community engagement office" about community forums the day before they're held. I see that all the time. This is not true community engagement. It's show for the cameras. True community engagement requires a lot of time and effort into building very trustworthy relationships with communities and these relationships should be for the long-term.

I think one needs to be really understand how to do community engagement. One way is by implementing CBPR principles. It's a very reciprocal relationship. I really want to learn from you. I really want to take what you're telling me and your realities to help inform whatever power I have in decision making and policy development. And so, I think until we do that, I don't think that we'll see much of anything changing. I do see and believe we are going to continue to have more and more people of color running for elected offices, and that's great. But again, I think to me the simplest, easiest thing is for people who have power and policy making power to genuinely engage with communities. People in power really wanting to do what disenfranchised people tell you is best for them versus one thinking they know what is best for them.

I recently became a Chicago United for Equity (CUE) fellow. CUE came to be in response to national and local reporting of modern-day school segregation as well as school closings in Chicago as well as how new school construction fueled race and class segregation. CUE provides the mechanism for parents and other stakeholders to have a voice and have their voices heard by CPS and those in power.

CUE fellows undergo a day-long training on how to use an equity lens, by using racial equity tools, in decision making, whether it's programmatic, budgetary, policy, etc. In a nutshell, the goal of using an equity lens and using equity assessment tools is to ensure that during the decision making process we assess the possible negative implications of our decision making and ensure our decision making doesn't further disenfranchise already vulnerable communities. This approach to decision making really interested me and made sense. It forces me to look at both sides of a coin in decision making. There are good intentions with decision making. However, we don't necessarily take a step back and think about the possible negative implications of our decision making. So these tools forces you to do that. But also really focuses on engaging and empowering folks that could be impacted by decisions. I've said a lot about community engagement. It's not always done well by those in power.

Amber: From you being in this position, have you identified a good strategy or a good mechanism for engaging communities?

Juana: So, that's a really good question. I have built such great relationships with folks that they know who I am. I have colleagues that I first met 20 years ago. They know that I'm legit, I'm all about helping the community and they know that I'm a real gung ho, hardworking person. They know I'm the real deal and they trust me. They say, "She's a person with integrity, diplomatic". That reputation goes a long way. So they see me here, they know that I'm still that same person because I built my reputation and they been able to witness it.

Amber: Someone who is fresh out of college coming and working in government at their first time job… do you think they can successfully do this sort of work?

Juana: I don't think so. It's interesting because I actually had a colleague who does some community outreach and engagement, he once asked me, "Can you get the word out about this and that to your contacts? Can you just give me your contacts?" And I said no, that's not how it works. It takes time to build trust and build this community, if you are not working with people, you can't just hand over that information to somebody.

I had to kind of explain that to my colleague. I then asked him "What do you need? I can help you. You tell me what it is that you're trying to do and I'll tell you if it's going to work or not". And then, I will communicate to those folks that I think will be supportive of what it is that you need and want or whatever. Yeah, it was really interesting. Some people don't understand how this works and what this work entails.

Colleagues also know that I have an understanding of community engagement and they will turn to me and pick my brain about a strategy or whatnot. And I think that's great because they're trying. And I respect that they're trying to understand what I know and how this work is done. I know how communities want to be approached and really what their needs are and things like that. So it's been interesting to be somewhat of a bridge.

Amber: Since you've spent most of your time in Chicago and this is the Illinois Department of Public Health, do you work only within this region of the city, or are you working with people down south? Is it more difficult to work with people or do you travel all over the state?

Juana: My job doesn't require me to travel throughout the state. I've been to Springfield maybe three times since being here. That's for several reasons. We have seven regional health offices throughout the

state, so we have staff scattered throughout and so in those regional health offices we have a regional health officer and they're the eyes, ears, voice, and liaison representing the agency for their region. Which is good for me because I would hate to spend a lot of my time in a car driving to and from, and I also I think it's very helpful. Like I mentioned more recently, I have been working on internal policies around language and cultural competency. It helps to ensure that all of our staff is culturally competent on what the needs are of different cultures and folks whose English is not their first language, and what they should do if someone comes to their office that doesn't speak English and things like that.

So that's been great to work on that. I've been able to help ensure that we have those policies in place and that staff understand what they can do, and just understand their own knowledge about working with different cultures. It's interesting because a lot of what I also do is raise awareness and increase the cultural competency of staff by coordinating webinars. Webinars are practical and efficient since we have staff throughout the entire state. I've done webinars leveraging the different heritage months. So, you know, African American, Hispanic, Asian, and Native American, to raise people's awareness on racial and ethnic health disparities. One of the more interesting webinar was on implicit bias and the speaker is an expert and sought out presenter on the subject. During her webinar she showed several video clips of different scenarios where our implicit biases showed through and impacted our behaviors and responses to different people from different backgrounds. I'm embarrassed to say that I have done some of those things and had similar thoughts. Our staff had lots of questions and answers and they were very honest with their own biases. And so, we learned how to recognize our own biases and how they also come into play in the work setting. It was a great experience. It was great to be able to bring that speaker and that type of information and knowledge to our staff. Among other things, we've had webinars on refugees, maternal mortality among African American women, Latino health paradox, just to name a few.

Amber: Would you say you are you optimistic or pessimistic about the future of health equity in Chicago?

Juana: Given the results of our more recent primary elections, I'm very optimistic. I am for sure. I think what happened there is a change of shift that I feel can trickle down to other arenas, not just in a political setting. So I feel hope. I feel like there is going to be a shift. As a result of recent elections I think many minds will change. People are done with how things have been happening for so long. To me, that makes me optimistic. There were several election winners who ran on a progressive platform and agenda. That's why I'm optimistic. I feel like those individuals have a more intimate understanding of vulnerable communities and their needs and understand the importance and how to empower them.

Amber: Do you have any advice for students who may read this interview? So let's say they're just like me and they're graduating with an MPH or social field who are about to enter into the workforce?

Juana: I have the utmost respect for people who decide that this is as their life's work, versus working in corporate America, because the work is not easy and it's hard and you might not always see the fruits of your labor in the short-term or the intermediate-term, but by no means does that mean that I'm trying to dissuade you, I'm not. I don't mean to be disheartening in any way. But, I applaud you. Again, the work is not easy but definitely rewarding. I'm in it to make a difference. Trust me, you do.

So that's one thing I think with regards to career advice. I would also say jump around to as many jobs as possible, different areas. I think sometimes people think of public health and think you can only work for government or an academic institution and that's not necessarily true. I think you're entering a field that

offers so many opportunities to work in so many different type of organizations and institutions and levels and things like that. So definitely seek out those opportunities because what I have found is that people love that you have an MPH. They do because you have received such a rich multi-disciplinary, interdisciplinary education. What I have noticed, is that employers appreciate those individuals who have received this multidisciplinary and interdisciplinary education that builds your capacity to tackle an issue using a very wide lens approach. You have a wide lens and take a big picture approach when other people have a very narrow view of things and they're just focused on the here and now. Our public health education has forced us to critically think of an issue through this wide lens from different contexts.

And so you can take that expertise or knowledge of tackling issues to any setting, whether it's in breast cancer, in youth development, faith-based initiatives. So, make sure that when you're out looking for jobs that you stress that you have that ability to tackle an issue from a very wide lens. Look at things from that perspective. So make sure you know how to advocate and use it in an elevator speech.