The Orphaned Elephant

... and other stuff we ignore

Orbiting the Giant Hairball by Gordon MacKenzie is a cautionary tale about creativity within a major corporation, Hallmark, the nation’s largest producer of greeting cards. This non-traditionally sized book (5”x7”) combines line drawings, prints, scribbles, and handwritten and typeset text to share an amazing story of creative chutzpah in an entertaining, provocative, and insightful way. This issue of UAB Public Health is a homage to MacKenzie’s book in style, format, content, and hopefully, creative entertainment.

Universities produce thousands of magazines each year to showcase the achievements of their schools or colleges, to explore in-depth one or two timely topics, and highlight alums and donors. For UAB Public Health, we wanted to move away from this coffee-table format — beautiful, highly professional, and occasionally read — to a format reminiscent of the old cardboard-backed composition book, like MacKenzie’s book. We chose this small size so that it can easily fit in a backpack or purse, and we have filled it with a number of short vignettes about public health issues often overshadowed by the sexy, readily-sponsored topics like diabetes, hypertension, obesity, dementia, and genetics. We chose these orphan, often overlooked public health issues — our elephant in the room — to highlight the richness of our profession — academic and practice. And an original drawing done by a student or faculty member accompanies some of these vignettes.

As Tom Hanks memorably said in the film Forrest Gump, “Life is like a box of chocolates. You never know what you’re gonna get.” We hope UAB Public Health is sampled again and again, and stimulates thoughtful discussion about some of the complex and challenging issues facing public health. We also hope you will enjoy and be fascinated by this different approach to a college magazine — indeed, we hope you will add your scribbles and notes in the margins of our composition book.

Max Michael, MD
Dean, UAB School of Public Health
LGBT MYTHS

by Nancy Dorman-Hickson

Sex is much more complicated than Masters and Johnson ever dreamed. Much has changed. People living with HIV who take their medicine now live normal lifespans. The marriage equality ruling passed. Olympic decathlon winner Bruce Jenner became Caitlyn, transgender celebrity. Being LGBT is the new normal — except when it isn’t.

“Some people cannot say ‘gay.’ They think they’re saying something dirty. You have to teach people how to use the words.” ~ Bob Burns

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“People who are HIV-positive and who take their medicine as prescribed now live a normal lifespan. Magic Johnson [diagnosed in 1991] has said publicly he now has an undetectable viral load.” ~ Charles Collins

“Transgender persons are more likely to be victims of physical assault and murder. They are more likely to contract sexually-transmitted diseases. They are more likely to be involved in substance abuse.” ~ Charles Collins
When you’re sold for sex — a prostitute — you get beaten when you don’t meet your nightly quota. My face doesn’t bruise anymore. I have been beaten so much that it caused structural damage to my mouth. This scar on my eye is from being hit by a guy wearing a National Championship ring. The scar on my neck is from a switchblade. I’ve had guns placed at my head and triggers pulled. I’ve been raped by inanimate objects. I was too afraid to leave.

After a dozen years of being sold on the streets, I finally got up the nerve to get out. I earned an undergraduate degree in social work at the University of Alabama and went on to earn Master’s degrees in both Public Health and Public Administration. I never saw myself as a victim. It took years of healing for me to come to terms with the truth: I never chose that life. I was not free to leave. None of us were.

On July 3, 2010, as part of my graduate research project, I founded The WellHouse, a nonprofit organization in Birmingham offering shelter and programs to women and girls who have been trafficked or sexually exploited. Today, there are two WellHouse houses that support 24 women and girls. My job is to tell the public what they don’t want to hear: There are women on our streets being exploited. It affects the entire community. Communicable diseases contribute to this health burden, including tuberculosis, sexually-transmitted infections, and skin infestations, as well as non-communicable diseases such as asthma, dental disease, and malnutrition.

Mental health is perhaps the most important co-morbidity among survivors of trafficking. The emotional scars — post-traumatic stress disorder, depression, anxiety, substance abuse, cognitive disorders, Stockholm syndrome — can last a lifetime.

We need to raise awareness of human trafficking in our communities. We need to save women and girls imprisoned in this horrific life. And we need more programs to help these victims survive. It’s time we take the blinders off and recognize human trafficking as a public health issue.

SOURCE FOR DEFINITIONS: Polaris, an organization that works on all forms of human trafficking and serves victims of slavery and human trafficking.
A group of inmates at the William E. Donaldson Correctional Facility — an Alabama State maximum-security prison — are writing eight 15-minute audio dramas on the health issues they face behind bars. Devised and supervised by Connie Kohler, DrPH, UAB professor emerita, the audio programs use characters and scenarios from prison life to educate inmates about the choices they have and the situations that arise, from nutrition to tattoos, which will affect their health.

“They want to present a realistic picture of people struggling with the same issues we all do, only having a harder time due to the restrictions under which they live,” Kohler says.

“They want to present a realistic picture of people struggling with the same issues we all do, only having a harder time due to the restrictions under which they live,” Kohler says.

“Good example is, if the system would provide fresh fruit instead of sweets and refined carbs for inmates to purchase, they could enact the healthy choices they may want to make.”

When the final scripts get approval, the dramas will be recorded by the inmates and played in the prison chapel to those interested or ideally broadcast on the local radio station accessible to the prison population. The ultimate hope by the inmates is to share this series with the public via podcasts on the web.

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**Scene:** Two guards talking: Officer Dorothy Martin & Officer Johnson.

**Martin:** If you’re so scared of catching something in here, Johnson, maybe you ought to back off on getting so physical with the inmates.

**Johnson:** Then he shouldn’t have been running his mouth when I told him to keep quiet! And you need to think about doing your job — which is PRISON GUARD AND NOT NURSEMAID!

**Martin:** Do you even know how many of these guys have asthma? Or staph infections? Or TB? Or AIDS?

**Johnson:** It ain’t my job to know! I don’t know and I don’t care.

**Martin:** Maybe that’s the whole problem, right there. If you don’t care, you can’t notice. You can’t respond. And that makes you a health risk.

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**Scene:** Two inmates talking: Jimmy “Hardcore” Gunn (50, boss of the block) & Johnny H (19, new to prison).

**Gunn:** Kid, I see you over there looking at all of Ron’s tattoos. Don’t tell me he’s trying to get you all tatted up.

**Jimmy H:** Don’t see where it’s your business, Hardcore.

**Gunn:** I guess you don’t know what diseases you can get from doing a tattoo the way they do in here — sticking you with the same needle they use on everybody else. That’s asking for a dose of Hep C.

**Jimmy H:** The hell’s “Hep C”?

**Gunn:** Hepatitis Type C. It gets in your blood and eats up your liver. And maybe you don’t know it, but you can’t live without your liver.

**Jimmy H:** I ain’t stupid; I know you can’t—

**Gunn:** And you can get all kinds of other stuff. Man, you can get HIV from a dirty needle.

**Jimmy H (SCOFFING):** You telling me dudes get AIDS from a prison tattoo?
We thought we had it right.

PUBLIC HEALTH DISCOVERIES 

1. Pellagra is genetic
2. Foul air causes malaria
3. Added sugars in the food supply have adverse health consequences
4. Coffee drinking linked to pancreatic cancer
5. Teeth should be brushed from side-to-side
6. Teeth should be brushed up-and-down
7. Place babies on their stomachs to sleep
8. Add 0.7 to 1.2 mg of fluoride per liter of drinking water
9. Eating breakfast reduces weight
10. A low-salt diet benefits health
11. Scary public health messaging works better
12. Vitamin E supplements help prevent prostate cancer
13. Mentoring
14. Peptic ulcer disease is caused by stress
15. Eggs are unhealthy due to the cholesterol in the yolk
16. HRT
17. Low-fat diets work
18. MS—brain drainage problem
19. Botulism as treatment for depression
20. Evidence-based public health

Try, try again

MOVIN' ON
A Dying Shame

By Nancy Dorman-Hickson

Stigma kills. “Stigma causes people to feel shame, guilt, blame,” says Janet Turan, PhD, MPH. It’s a label that can produce disgust, fear, and, in some cases, violence or homelessness.

When it comes to HIV, stigma perpetuates the disease and prolongs the suffering. “Faced with these negative attitudes and consequences, a lot of times people are afraid to go to the HIV clinic,” says the researcher in the Department of Health Care Organization and Policy at the UAB School of Public Health.

Turan’s research involving pregnant women living with HIV in rural Kenya studied how they’re affected by stigma and discrimination.

Pregnant women in that country who test positive for HIV can “get thrown out of their homes, rejected or beaten by their husbands,” Turan says. “Their communities often shun them too.” Stigma and discrimination “are barriers for getting women tested for HIV.” Many decline medical assistance of any kind to avoid that testing.

To overcome these obstacles, Turan and her colleagues in Kenya have begun testing couples in the privacy of their homes. Then they help the couple talk about the findings with each other and give them support.

More recently, Turan’s research has considered the effects of stigma and discrimination among healthcare professionals working with people living with HIV in Alabama. She and others hold workshops to help healthcare providers understand how stigma affects clients and to urge them to discontinue such biased practices as privacy violations, physical avoidance of HIV clients, and exhibiting judgmental attitudes.

In the workshop, every person living with HIV is paired with a healthcare worker. For people living with HIV, the workshops are “empowering. They get to actually do something to fight back against stigma,” Turan says.

Each of them shares stories of how they’ve experienced stigma or discrimination. “Getting them to interact changes the way people see the issue,” she explains.

In a survey of Alabama and Mississippi health workers, “We still find about one-third of people saying that people who are infected with HIV are irresponsible or practice immoral behavior,” she says, which stops people from being tested or seeking treatment.

Turan says public health can help eradicate stigma and discrimination “by implementing strategies that spread tolerance and acceptance.” Minimizing stigma and discrimination will help people get diagnosed and treated, and that, in turn, will help slow the spread of this ongoing public health menace.

“THERE’S NO WAY TO TALK ABOUT YOU LIKE A DOG.”

— RESEARCH PARTICIPANT

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A typical neighborhood in a typical city.

But something sinister is afoot...

It’s like there's nothing solid. He's just everywhere.

We can't win this way.

Back at their Secret PH Headquarters, our heroes have switched on their Mighty Brain machine.......

I'm getting blips from UAB School of Public Health.

UAB had a problem-solving competition among students. The focus was our old foe Urban Blight.

It's a 1-2-3 punch from all sides. Let's put it into action...

You ready to blow the stink out of this neighborhood?

Step #1: Beautification

Blight's gone, but what will keep him out of this lot?

Step #2: Business Development

They're building a playground & coffeeshop here.

People are regaining hope. Those UAB students are on to something.

Step #3: Residential Revitalization

Looks like we ran Urban Blight out of this neighborhood.

Nhabited Prof Anthony Hood Bluff Hills

Nhabited is kicking Urban Blight out of their own neighborhood.

Habited is Kicking Urban Blight Out of Their Own Neighborhood.

Next time: Public Health vs the scourge of war.
When asked what would surprise public health professionals about armed conflict, Chris Murray, MD, DPhil, a global expert in health economics with the University of Washington, said, “The relatively small number of direct battle deaths.” Despite the number of armed conflicts worldwide, the total battle-death count in 5-year periods has been trending down since Korea and Vietnam.

The battlefield and its consequences have changed. Armies now hunt insurgents in caves, villages, and city streets. More small unit fighting. Better armor. Drones. All of these equate to safer soldiers. But vulnerable civilians are more impacted.

“1 in 6 children worldwide lives in an area of armed conflict, and civilians are more likely to die than soldiers as a result of the conflict.”

As armed conflicts pass through and often return again, communities are stripped of resources.

“106 of Nicaragua’s 450 health units became inoperable because contras stole medicines or placed landmines under clinic walls.”

The countries must handle the consequences to their citizens for longer than the war’s actual duration.

“20 years after Cambodia’s decade’s-long war, 1/5 of the country’s disability burden still results from that armed conflict.”

And nearby countries face sudden influxes from those fleeing the conflicts.

“In 2013, the number of refugees (60 million) reached its highest point since World War II. That’s one in every 122 people worldwide.”

When it comes to public health’s role in armed conflict, Murray says, “The most vital need is to figure out where we think conflicts will likely occur and devise strategies to mitigate some of the harm, such as creating faster response time to avoid outbreaks.”

The military might dig wells, build hospitals, fix sewers, and more. MEDCAP (Medical Civil Action Program), run by the Civil Affairs Department, can be called in to facilitate medical care, such as vaccination protocols. VETCAP may come in to treat livestock.

“The challenge is that while you do all this with the local community, you’re working defensive and offensive actions.”

One example of a community reaping notable benefits from armed conflict came in 2011-2012 in the Zhari district of the Kandahar Province in Afghanistan. Upon arrival, the 2nd Battalion, 87th Infantry, evaluated what the population needed to stabilize them and garner their support.

“Water, electrical, schooling, and security were nonexistent. The Taliban had wiped it clean and marginalized them and turned them to its will.”

When the U.S. Army left, Zhari had clean water, sewers, roads, bridges, the only hospital within six hours, and nine schools where 1,400 children attended regularly, including girls. Because they had trained police officers and medical personnel, the citizens were invested, staffed, and could — and did — stand on their own.

“You can’t force healthcare on people that aren’t ready for it.”

Austin says what’s most needed from public health in armed conflicts is “more professionals nested with the state department and ground tactical maneuvers.” The best healthcare attempts need to come into these arenas with some element of national power — military, diplomatic, information, economic — to access the information and resources necessary to determine what is possible in that area. “Because once the Army departs, public health professionals need to know they will be working with the local government,” he says. “And the reality is that a lot of those countries may not want your help.”

By Jane Ehrhardt


* Lieutenant Colonel Austin is not speaking on behalf of the U.S. military. His statements are a reflection of his own experiences.
HIV Patients Find Help at Health Service Center

By Nancy Dorman-Hickson

Birmingham, Ala. — "People say I make them tired because I have so much energy," Gloria Howard says and laughs. She is the chief operating officer of Birmingham-based Alethia House, which annually helps nearly 3,000 people with HIV prevention, homelessness, employment training, substance abuse prevention and treatment, and more.

"I get to do lots of service. The biggest challenge is figuring out ways to help all the people who came through our door," she says. "We have more need than we have beds."

Besides her work, Howard volunteers after hours with a service sorority. Why does she give to others virtually 24/7? "People would have called me an 'at-risk' child," she says of her childhood in Selma. "My mom was part of this thing they called 'the great migration.' African-American women would go up north and work and then send money back home. I was actually reared by my great-grandmother. We were very poor. People could have looked at us and said, 'Oh, that poor, pitiful child.' But nobody did that."

Instead, her community taught her responsibility and concern for others, the same philosophy reinforced at Alethia House.

Howard says the work is about "knocking down barriers" for people. "We want people to get the idea that they are part of the world and that they have a responsibility to help this world be the best place it can be."

Howard gets emotional when she talks about receiving graduation invitations from children who were born to troubled mothers while they were getting help from Alethia House.

She deflects praise: "It's not about me."
CASE STUDY

1. TYPE OF CASE
End of Life

2. DOCUMENTER
Jennifer Walker-Journey

3. SUBJECT NAME
Alice Farris

4. AGE
72

5. SEX
F

6. CARETAKER
Marti Farris Carty - daughter

7. SUMMARY (synopsis of the original situation)

Alice was 72 and in good health when she developed a nagging cough and was diagnosed with stage 4 small cell lung cancer with distant metastases. She had only months to live. Since Alice lived alone, her four children agreed that she would move in with her daughter, Marti Farris Carty.

8. BACKGROUND (subject’s situation)

Alice began a rigorous round of chemotherapy. She had beaten aggressive breast cancer 13 years earlier and believed she could beat cancer again.

However, Alice declined quickly and treatment failed to slow the progression of her disease. Two and a half months after diagnosis, new scans showed cancer had invaded 90 percent of her liver. The family — apart from Alice — was told the situation was grim.

“The doctors said, at best, they could give us a two-week warning,” Marti recalls. “We were at the very end.”

Alice was never told by her doctors that her death was imminent. “I was wondering if the doctor or oncologist were ever going to say to her, enough is enough,” Marti says.

The doctors did not. Alice kept fighting. Her children refused hospice, trusting they could provide sufficient care with the support of home healthcare. But within days, Marti realized the care her mother needed was beyond her capabilities. It was time to call hospice.

Death was a word no one in the family had wanted to speak. Nor had the doctors (though no one knows why). The day hospice started treating Alice was the day she learned she was dying. “She just went into a faraway look when I told her hospice was coming,” Marti says.

Alice had a will and also shared with the family a listing of bank account numbers and life insurance policy information. She also had written what dress she wanted to be buried in, what songs she wanted sung at her funeral, and the people she wanted as pallbearers. But she did not have documents to express her wishes regarding medical care at the end of her life.

A week after hospice nurses began treating Alice, she passed away. “Looking back, I would have done a lot differently,” Marti says.

9. PROBLEM (cont’d)

The highest concentration of Medicare spending occurs in the last 30 days of life. Patients are often subjected to needless treatments and hospital admissions — events that diminish quality of life.

Caregivers are also affected by the burden of caregiving. Studies show that many caregivers of family members — especially elderly spouses married for decades — experience an increase in morbidity six months to a year after losing a loved one.

People are reluctant to call hospice because they don’t want to face the inevitability of their loved one dying. By the time they do call, it is often too late for the patient and their family to plan and prepare for death, Tucker says.

10. SOLUTION (options for solving the public health issue)

The goal for end-of-life care is providing quality life for the patient and ensuring her wishes for treatment — or lack of treatment — are respected. Public health advocates want the discussion of mortality to come long before a person is facing death. This means having an advanced directive document that legally outlines the medical care a person would want if she becomes too sick or injured to express her wishes.

An advance directive includes a durable power of attorney and a living will. A durable power of attorney is a legal document that legally outlines the medical care a person would want if she becomes too sick or injured to express her wishes.

Increasing the low rate of completion of advance directives in the United States needs to become a priority for public health advocates.

11. CONCLUSION (potential outcomes)

More than 60 percent of people aged 18 years and older want their end-of-life wishes respected; however, only about a third have completed advance directives, according to a study published in the American Journal of Public Health. About a quarter of those without advance directive forms say they did not know about them. Others say they believe they are too young or healthy to bother with the paperwork, or are concerned about the cost, complexity, or time required to complete the forms.

Increasing the low rate of completion of advance directives in the United States needs to become part of the public health agenda,” the authors write. “The prime reason to do this is humanitarian — empowering individuals and families to be actively involved in care decisions at a critical time. In addition, reducing needless or unwanted end-of-life care expenses would allow those funds to be diverted to other pressing public health needs.”

Filed with UAB School of Public Health 2015
MLK had a dream.
Selma marched.
Obama won.
So why do people still die because of the color of their skin?

#blacklivesmatter
Brystin N. Arnold
Junior, Public Health major

Subria Spencer
Senior, Public Health major

@PublicHealth is Colorblind

Brystin Arnold @UABArnold Sep 19
#Discrimination is a hard issue to tackle. You can create policy and law to prevent discrimination in the public sector of society, but you can’t change personal beliefs with just that. There has to be #willingness from both parties to change, and an effort to unite and educate.

Brystin Arnold @UABArnold Sep 23
#PublicHealth sees the big picture, but this problem contains smaller issues that need to be resolved.

Brystin Arnold @UABArnold Sep 30
My life matters because I was put on this earth for a reason.

Brystin Arnold @UABArnold Oct 9
Why do we #discriminate against certain groups of people?

Brystin Arnold @UABArnold Oct 9
Is what I am doing or thinking adding to #discrimination?

Subria Spencer @PublicHealthSubria Sep 23
My life matters. No explanation as to why is needed. The fact that a hashtag, #blacklivesmatter, had to even be created is a problem.

Subria Spencer @PublicHealthSubria Sep 29
We — black individuals — are forced to prove our worth and why our lives matter each and every day. #Why

Subria Spencer @PublicHealthSubria Oct 1
My life matters because I am a human being. Our lives matter because we are human beings. The end.

Subria Spencer @PublicHealthSubria Oct 3
#BlackLivesMatter — the topic, the movement, the journey — has not been widely discussed in #PublicHealth

Subria Spencer @PublicHealthSubria Oct 9
The common phrase is “all lives matter.”

Subria Spencer @PublicHealthSubria Oct 11
All humans, especially black humans, have an undeniable ability to be and become more powerful individuals who can truly #MakeADifference in the world if given something as simple as affordable access to a clinic with more than adequate quality of care.
Who is my public health hero? Lois Gibbs. Since 1977, she has worked to require the government to force cleanup of hazardous waste sites. Beginning in her own neighborhood near Niagara Falls, New York, having no experience in community activism, she formed a grassroots group to keep media attention on the toxic waste that lay just beneath the ground in this area. Her continued public battles with local, state, and federal governments eventually led to former President Carter’s signing of CERCLA, known as Superfund, a multi-billion dollar Act that funds cleanup of some of the most toxic waste sites in the country.

If I were given an unlimited budget to conduct any research project, I would offer free genomic sequencing to anyone in the world. This will empower everyone to enjoy the breakthroughs of precision medicine. Genetic epidemiologists could recruit people with certain phenotypes so that they can identify novel genetic factors for phenotypic variability. Once a large number of people, say 10 million, were sampled, we could infer almost the totality of genetic information of humanity — we are a single, very large family anyway. This will not only reveal the population history of mankind, but also reveal connections between any two persons. I believe this could help bring about world peace, because it is less likely for family members to fight.

If I could solve one of the world’s public health problems, I would pick obesity. This issue affects so many people, especially in the U.S., and any improvement would likely have substantial chronic disease implications (e.g., lower rates of heart disease, stroke, diabetes, and even certain cancers). Solving obesity would be particularly satisfying, as it is such a complicated public health problem. We have to eat to live and physical activity has been engineered out of our daily lives. There are so many individual, interpersonal, community, environment, and policy-level factors involved.
“Accidental discharge of firearms in Alabama and Tennessee can probably be interpreted at face value. I think the literature is pretty clear that the rate of accidental gun deaths is proportional to the rate of gun ownership.”

– Francis P. Boscoe, PhD, Research Scientist, New York State Cancer Registry

“There is the existence of a so-called Southern Subculture of Violence. The Southern region of the United States — and to a lesser degree the West — has always had the highest rate of homicide. Always.”

– John J. Sloan III, Professor and Chair, UAB Department of Justice Services

“Empirical data seem to support this notion that Southerners have a set of cultural values that says you resolve conflict by pulling out your gun and shooting. The ease at which weapons can be procured means that everyone has a gun. And that it’s OK to use those weapons to resolve conflict.”

– John J. Sloan III, Professor and Chair, UAB Department of Justice Services
Who's our up-and-coming brain trust?

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