Lisa: Hi, I'm Lisa Hernandez

Lizzy: And I'm Lizzy Ghedi-Ehrlich.

Lisa: And we are your hosts for Scholar Strategy Network's No Jargon. Every other week, we will discuss an American policy problem with one of the nation's top researchers, without jargon.

Lizzy: You know, it's a sign of the times that so much has been happening in politics and policy and our lives that here we are at this time of year, that maybe in a less crowded world, we would all be remembering that six years ago was the start of what would become the COVID-19 pandemic. I honestly have to say life has been so fast and furious, I kind of didn't even think about it.

Lisa: In my head, COVID was maybe two years ago at most. And I mean, I know it's still a thing. I'm not saying that the *was* is definitive here, but you know, the beginning of it all was absolutely two years ago and you cannot convince me otherwise. So, it's mind boggling to be thinking about six years since then.

Lizzy: For me, I think one of the things that I have noticed that has changed for me is that before the pandemic truly came to town, so even like kind of the end of 2019, when if you had say a mom who was more invested in conspiratorial type or histrionic news items, that mom might have started saying to you, I think a deadly virus is about to shut down the world.

And I remember really being like, that doesn't sound like how this works. That doesn't sound like what happens in America. That doesn't sound like what happens when all of our countries work together on these kinds of like public health things. Like it sounds like we're having another conversation about Ebola here or something. Like, something that is real and that harms people but isn't gonna actually change the entire course of world history. I was wrong, I guess, is the one thing I wanna say about that.

Lisa: You know what? We are all wrong sometimes, and I think all of us were perplexed at the enormous event that was coming our way, in a way that we were like, no, I refuse to believe that is actually going to happen to us.

Lizzy: The difference is now I know that is possible and that is how it can go, and I've seen the incredible amount of interrelated effort it takes on like multiple ends on detection, on communication, on the actual science that has to be put into very rapidly coming up to solutions on the communications issues in the public health sphere that, ooh boy, that, we are, we are not super great at that, it turns out. So, yeah, it's different now. That is one of the things that is different now.

Lisa: Absolutely. And of course a lot of it you mentioned mom looking at news from. Other sides of the world. And that really, leads me to really think about what global health communication looks like. And I was really, really glad that we got to talk to an expert in global health about the COVID of it all.

So for this episode, I spoke with Joseph Harris, associate professor of sociology at Boston University, incoming chair of the section on the sociology of Development of the American Sociological Association, and immediate past vice chair of the International Studies Association's global health section. He studies how politics and power shape healthcare access and infectious disease risk response, both in the United States and around the world, and hosts the Global Health Politics Podcast. Here's our conversation.

Lisa: Professor Harris, welcome to No Jargon.

Joseph: It is such a pleasure to be here. Thanks so much.

Lisa: Well, we are gonna dive right in and talk about a really hard time I'm sure we can all remember. In March 2020, the World Health Organization officially declared COVID-19 a global health emergency. We're now approaching the six-year anniversary – Oh my goodness, time flies – of that moment when much of the world shut down. Looking back as someone who studies global health. What stands out to you the most from that time?

Joseph: Yeah, I mean, it's a hard time, and one that we all really remember. And I'd just like to say first, we are still living through the pandemic. Millions of people have been affected by long COVID, our children, our elderly, adults also, continue to regularly get COVID. These have implications for our health, even though we've gotten out of the hard part, and so we're in a much better place than we were then six years ago. But, what can we learn from that time? Very sadly, I'd say we learned a lot about the limits of global solidarity, but also the lack of solidarity in the US.

And while we're very fortunate to have developed new vaccines in record time with Operation Warp Speed, there were really no real serious measures put in place to ensure equitable access to those new technologies. Rich countries, many of them where some of the leading vaccine manufacturers are located, were able to sign contracts very quickly with those vaccine manufacturers, and this led to really vast inequality around the globe in terms of who gets access to the best treatment. Some parts of the world went without vaccines for years. And still to this day, some people have not had COVID vaccines.

We set up a vaccine initiative called COVAX. But this was a charity-based effort that aimed to get vaccines to countries that signed up. But it came after those procurement fulfillments that richer countries had with the top vaccine manufacturers.

And so I think the pandemic really revealed something about the importance of intellectual property. And how having a monopoly on critical recipes for people's good health, in this case, things like the MRNA vaccine and the lack of willingness to share that can lead people not to have access to critical technologies that they need. And this led to essentially a lot of people dying, not just inequality and access, but a lot of people dying. And also there were outright efforts to stifle the generic manufacturing of vaccines. And so, despite the efforts of organizations like the WHO working with countries, people who were trying to pioneer generic technologies in places like South Africa, we saw real limits to global solidarity.

Now, in the US, I think the pandemic exposed the limits of solidarity in our own nation. People's individual attitudes towards vaccines and masks really trumped all

kinds of social concerns. And those who were concerned obviously wore masks and maybe even got the best kinds of masks, the N95 and KN95 that they could. Other people went without.

And to me this is a real lost opportunity, because we did see vulnerable people in particular pay the price, and the ultimate price. Why didn't we see public service announcements at that time about how wearing a mask not only protects your grandmother who you love, but also your beloved neighbor. Or someone you don't know who's a mom of a child. Why weren't there more serious efforts to get vaccines and masks into the hands of the most vulnerable? To me, this is a real failure.

I love to share in my classes this graphic that shows the degree of protection one has if you are not wearing a mask, and somebody else is not wearing a mask, versus a cloth mask, versus a KN95. And the difference is stark. But, this difference also reflects people's access to information, people's access to resources, and those who were on the front lines, as you know, quote, essential workers, ended up being much more vulnerable and much less in terms of access to those lifesaving technologies.

Lisa: Talking about sort of that start of the pandemic before the vaccines were here. When we first got that global health emergency, sort of panic entry level point into the policy actions or maybe individual actions that people were taking. Did you expect it to be different than how things turned out? Did you feel like the US was prepared for a global health pandemic?

Joseph: No, not at all.

Lisa: Okay [laughter].

Joseph: I mean, as someone who studies the politics of infectious disease response, it was very clear early on to me that we weren't ready. It was late January, and I remember in my classes, suddenly a lot of people, more than normal, were sick. It offered some idea to me that something out of the ordinary was going on. And this was before we thought COVID had really hit the ground here in the

US. And of course, with the fullness of time, we realized, oh, it was actually probably here much sooner than we realized. And of course that ended up being the case.

And so, it was clear to me that local institutions, employers, the US government were not prepared. And this ultimately was a problem because you wanna get ahead of this thing, you wanna get people the protections that we do have, like masks, you wanna enable people to work from home if they can.

For a lot of people who don't know infectious diseases, this was like drinking out of a fire hose. They were running around without a real sense of what to do.

Lisa: You mentioned masks and people's decisions to either mask or not. In your research or within your expertise and personal experience here, why do you think people in the United States were so averse to masks?

Joseph: Yeah. Well, I think we have become a very polarized society.in America. I think that there are powerful, political and economic interests that underlie the different major parties in this country. And I think that there's a lot of mistrust, both of government institutions, but also, particularly among some vulnerable communities. In health systems, we have legacies of mistrust that are for good reason.

If you look back, decades ago, the Tuskegee experiments here in the US that led to a lot of Black people being infected by STDs that they were not aware of, to see how that disease develops if left untreated. And this led to people dying. And so, of course, there's going to be mistrust among some communities, for good reason. We have the legacies of slavery, for crying out loud. And we have this sort of situation where people are dying in the streets these days, and words like diversity, equity, and inclusion have become bad words. So, I think that is a current that is just undeniably there in our world here in America, and I think we have particular challenges around reaching populations that have rightfully felt mistrust.

And then you have people who have become skeptics, or their skepticism has been cultivated. And, it's not always for good reason. And you also have, basically,

Americans who haven't experienced things like an iron lung or know what polio does when it affects people. Or with the current outbreak of measles, what measles can do, kids can die. And I think, sadly, that forgotten history or that unexperienced history is leading history to repeat itself.

Lisa: You mentioned that sort of erosion of trust in medical and health institutions over the last years, decades. I'm wondering if you have any advice or recommendations on what these institutions can do in order to build trust again? I know that we definitely have seen a lot of anti-vaccine sentiments. You mentioned polio, measles, and things like that. What do you think people can do in order to have sort of medical data and real facts around these health measures be front and center in conversations around these diseases that can be controlled?

Joseph: Yeah, this is a great question. And I'd say, first we need to start investing in public health again. We have been underinvesting in public health for decades at the local level, at the state level. Currently, the CDC – which has long been a real leading institution globally for protection of public health, not only in the US but in supporting efforts abroad – many of its resources and people are being dismantled. And so I think we have to build back the capacities that we've lost.

I think then we owe it to have those public service announcements, to develop relationships with the community so that public health becomes something that people care about. That we see our neighbors and other people in society as people we should care about. Because ultimately, thinking about others isn't only something that's good because it might feed some kind of altruistic sense that we have, but it's good for our own health and our own security, and ensuring that other people are fed or have healthcare that they need, have the kinds of conditions that prevent disease ultimately secures our own health. Our fates are intertwined.

Lisa: And speaking of fates being intertwined here, you've mentioned global health, how people need to feel more connected to communities outside of their immediate surroundings, even in the United States looking at other countries that maybe don't have the same level of access to healthcare and money in order to gain access to those tools that are needed in order to prepare or fight back against like these diseases. I wanna talk to you a little bit about what the pandemic revealed the

most, in your opinion, about the need for our health system to be in touch with the rest of the world, or essentially how the US depends on global cooperation.

Joseph: I think that, sadly, global cooperation wasn't at the front and center of a lot of our concerns. It was about ensuring vaccines for our own population. Obviously, we've seen different, very different kinds of policies from the Trump and Biden administrations as they toggled back and forth and I think those are meaningful differences.

We made the decision recently to withdraw from the WHO. This is a problem because it not only cedes leadership in areas where we've traditionally been a leader in global health and development. The dismantling of USAID encourages the spread of disease, which will just bring these problems home to roost.

And so I think that it's important that we recenter our focus and remember that our own health is really dependent on the health of others. And, it makes sense to have access to health information about outbreaks by virtue of being a WHO member and to cut ourselves off from that because we think it might score political points with our constituency, is ultimately going to harm the health of that constituency.

I would maybe just say our capacity to respond to future pandemics has never been weaker. You know, with the disinvestment in public health, the destruction of the CDC, the withdrawal from the WHO, we're in a real tough spot right now.

Lisa: And you have spent a year studying healthcare in other countries and how they manage health crises. You've studied the passage of universal healthcare in Thailand. So I wanna talk to you about essentially what it's like studying these non-Western countries. What has it taught you about blind spots in the US system?

Joseph: I have written several articles and op-eds. I love to write op-eds and have written one for the Washington Post about how resource-constrained countries are committing to universal health coverage. Another one for US News & World Report about the lessons we can learn from Thailand about healthcare. Our US healthcare system is exceptional. And when I say exceptional, I don't mean that in a good way. For many of us who do have the privilege of having good health

insurance, we have access to a lot of great care. However, even those people who are fortunate enough to have that have tremendous problems, such as denials, delays of service. Miranda Yaver has a new book coming out called *Coverage Denied*, which I recommend, that's gonna get at this.

These problems have been so great that we've seen one vigilante take justice into their own hands, quite wrongly, and target a health insurance executive. But I think that underscores the stakes. People are dying and Congress has let these subsidies for the Affordable Care Act that allow people to get access to care lapse.

But we are a peculiar country. We are one of only two countries in the world to allow direct-to-consumer advertising by pharma. You hear, “ask your doctor” all the time. We have a system that's very fragmented in terms of health insurance. We have Medicare and Medicaid for elderly and for the poor. But in many southern states, men aren't covered.

Private insurance that we depend on largely through our employers serves two masters. Their mission is, on the one hand, to cover the healthcare needs you have, but also their mission is to serve shareholders. And that's fundamentally a conflict of interest. You know, who wins at the end of the day?

Other countries finance and organize healthcare very differently. So Thailand, for example, that I've studied for over 15 years, has really invested in public health infrastructure over decades. Building district health centers, community hospitals, really targeting rural outlying areas to make sure everyone has access to the care that they need. It has put in place a universal health coverage system, and it did that in 2001, 2002, which was at a time when they were a low- and middle-income country.

And we don't normally think of universal healthcare as something that low- and middle-income countries can do, and yet they did it. And along with a number of other countries like Rwanda, Ghana, Turkey, and Mexico really provided proof that countries at a lower level of socioeconomic development could do this. This was a stringent feasibility test and they passed. And no country does this perfectly, but Thailand covers everyone at a fraction of the cost that we do. Their benefits are

very inclusive, from cancer to treatment for mental health conditions, to heart surgery to dialysis.

And it's not just Thailand. Brazil is another country I study, and they, like Thailand, have a very outward-focused, community-based health system. In Thailand, village health volunteers go out and do important work, from contact tracing during pandemics to promoting health and disease prevention. And in Brazil, they do the same, and they're there in the communities regularly. Doctors, nurses, public health officials. And what this means is that when you face a pandemic, you are epidemic-ready. You can get a real-time epidemiological picture of how a disease is spreading because you have that system in place.

We have no such community health worker system nationally in the US. We have some states that are doing well, and some states where there's no policy at all. And so this is something that could pay dividends. And even countries like the UK, which is known for having universal health coverage, the National Health Service, they're learning from Brazil about what you can do to get in the community and improve health, beyond just having a reactive one where people come to their primary care doctor.

Lisa: I know that in your book Achieving Access, you really look at access to health services and AIDS treatment in Brazil specifically, we're speaking of pandemics. I'd like for you to share a little bit about the management of AIDS and HIV in Brazil. What can the US learn from the treatment services that are offered there or have been offered there?

Joseph: If it's okay, I'll sort of sketch out for your listeners sort of what the book is about. So it's called *Achieving Access, Professional Movements, and the Politics of Health Universalism*. It's published by Cornell Press. And, we have this idea that democratization empowers the masses. And this has been shown in study after study in political science and sociology, and that's quite right. There's a lot of evidence for that.

But what I get at in this comparative study of the politics of universal healthcare and AIDS treatment in Thailand, Brazil, and South Africa, is paradoxically, there is

another takeaway. Democratization can also empower elites, and that is well-situated elites, when countries are transitioning into democracy, who can through their networks, through their expertise, and through their privilege positions in government, promote the institutionalization of these really expansive and sometimes expensive policies, to the good of citizens at a time when they themselves don't need these policies. And so this is an interesting idea because we often don't think of elites as acting in the best interests of people. We see that in our own country, I think right now. But there are cases in which they do.

And so, I train our attention on what's called professional movements. These movements of health professionals, in the domain of healthcare led by doctors; in the domain of AIDS treatment, which is at the intersection of intellectual property and human rights, mainly lawyers, and also legally trained economists and pharmacists, who really try to promote these policies and outmaneuver some of the broader professional associations that are apart. Because often, even though doctors are guided by the Hippocratic Oath to do no harm, when you are facing a reform that stands to limit your autonomy or decrease your revenue, sometimes there's opposition to change. And so it's a story of how these doctors and legal movements managed to overcome that opposition.

And I think that what we can learn really is that if these small groups are strategic in their deployment of legal expertise, if they're strategic in using things like demonstration projects or pilot projects to demonstrate success and feasibility of projects, and put those projects in place, you can really bind the hands of politicians who would just as soon jettison these policies once they're in office and not fulfill them. And so I think that there's a lot that we can learn both in the domain of healthcare and in the domain of AIDS treatment, you know, their countries from these cases.

Lisa: A lot of what you're mentioning, especially as it comes to, I'm losing the word here, but patent comes to mind, especially when it's a vaccine. So, pretty much ownership over certain medications, over tools, and things that we can use in order to protect ourselves and safeguard our health is owned by a lot of corporations. Do you have any recommendations for these health experts? You mentioned doctors coming together and sort of organizing themselves in other

countries. Do you see anything like that happening in the United States? I know that we're in sort of an anti-science mode over the last couple of years, but is it something that is feasible in the United States to have experts come together and sort of fight back against the greed that has really taken root within our healthcare system here?

Joseph: Yeah, I mean, you underscore that it's a really strange time to be working in global public health right now. There's a lot of lessons to be learned from not only experts in public health and leaders, but also social movements and organizations that have come together collectively and used collective action to make demands and to produce social change. And so I'm actually writing a book with a political scientist, Rick Doner from Emory, about how to navigate the politics of public health, drawing on different cases from around the world. And, you know, it's a particularly important time to understand that.

And the lessons, for example, we can learn from The AIDS Coalition to Unleash Power (ACT UP) in their efforts to try to destigmatize the disease of AIDS in the 1980s and their efforts to try to bring the Food and Drug Administration to the table to make access to experimental drugs easier for AIDS patients who are dying and would otherwise die without them.

If your choices are between not having access to drugs or trying an experimental one and you know you're gonna die, you're going to wanna have those drugs. And so, these groups forced real changes to the way that science was conducted and tried to work with scientists and others to get funding to flow into AIDS treatment. And when the AIDS cocktail was announced in 1996, which turned essentially this fatal illness into a chronic disease, you know, the battle wasn't won. The cost of that cocktail just to keep you alive was still over $10,000 a year.

And so there were efforts to name and shame. Drug companies and governments allowed the status quo to continue and organizations like Doctors Without Borders, which had won the Nobel Prize. Paul Farmer's Partners in Health, ACT UP, and others played incredibly important roles in drawing attention in really invisible ways to those issues. Doing things like staging die-ins or delivering the ashes of fallen comrades to the White House lawn.

And so I think that we can learn from those tactics. We're seeing them again in the fight for insulin. We're seeing them again in the fight for mRNA vaccines for Covid and other applications.

So we're trying to learn from cases around the world, not just social movements, but also, for example, why Surgeon Generals Luther Terry and C. Everett Koop were so effective in reducing smoking. And Dr. Mona Hanna-Attisha, and how she was able to get the attention of the world around about the lead contamination and high lead levels of kids in Flint, Michigan. And was able to effectively, albeit slowly, change the story there. And so, we want people to become more cognizant of the political context in which they operate, to understand how, when, and under what conditions they can make change, and different ways to do that.

Lisa: Well, I certainly look forward to learning more about your new book and essentially getting some tools under my belt as far as health messaging that hopefully works in the long run in order to impact people's healthcare options. And I wanna take a moment before we wrap up for you to tell us about the Global Health Politics Workshop and the Global Health Politics podcast that you've worked on.

Joseph: Sure. Thanks so much for asking about that. So, I direct and founded at Boston University the Global Health Politics Workshop. This has been a workshop that is now in its fourth year. We are kind of a training space for graduate students. But it's not just for scholars. This is a space where people in government, where members of non-governmental organizations like Partners in Health that work just down the street, come to learn about cutting-edge issues in global health politics. And it's a hybrid workshop. We have people attend both in person -- you get cookies and tea and all of that stuff when we come in person -- but people from around the world are part of these conversations. And that's something I've been really proud of. We have about 50 people or more attending per session. And at a time when DEI is under attack, in our first three years, 17 of our 25 events highlighted the work of people of color; 19 to 25 events gave platforms to female scholars, including practitioners.

We took on big issues like anti-blackness and global health. Is it possible to shift power in global health? And the problem that comes from unaccountable big philanthropy. So lots of important issues and this led me to create the Global Health Politics Podcast to fill a niche out there in the podcast landscape that really needed to center issues of politics. Because you can have the best technical ideas about how to optimize public health, but as we've seen, unless you address the politics of why a policy isn't getting through, why different people are not taking up a vaccine or wearing masks, you're not gonna really get anywhere.

It concerned me that in schools of public health, you really have very few political scientists hired or political sociologists hired. You get great training in epidemiology and biostatistics, but comparatively little, if any training on the politics of health policy, maybe a course in the policy process.

And so in the Global Health Politics Podcast, we have really intimate one-of-a-kind conversations with emerging and leading voices in global health from around the world. These are sometimes scholars. Sometimes they're activists, sometimes they're policy makers, sometimes they're authors. And this month if you go to the podcast, which is available on Apple Podcasts, on Spotify, on Amazon, and other leading platforms, you'll find my conversation with New York Times bestselling author, John Green, who we may know, more, sort of famously for his works like, *The Fault in Our Stars*, and also *Paper Towns*, but who is also on the board of Partners in Health and who has been a real advocate for TB control. And his new book, *Everything is Tuberculosis*, is what we talked about. But I've talked with Tim Schwab, a really critically renowned author, about his book, *The Bill Gates Problem*; Themrise Kahn about the issue of white saviorism in international development; and global health leader Madhu Pai about global health inequality. And he's been really outspoken on these issues. But I think our probably most well-known episode was dealing with the dismantling of USAID and the consequences for global health.

And there we interviewed not only high-level policy makers who had worked in USAID, but also people who have been involved in understanding the impacts of that dismantling. And it was a truly sobering conversation. So, I hope your listeners will join us next month, we're going to be speaking with the shadow representative

for the District of Columbia, Oye Owolewa. He's going to be talking about his experience in that role just as the district was being occupied. And the challenges that he has faced and the issues he's fought for in that role. So it should be a great conversation.

Lisa: Absolutely. I look forward to our listeners tuning in and continuing to learn more about global health, past and current issues and how they can best prepare us for our future here. So I really appreciate the work that you are doing, helping inform folks on health matters, global health matters at that, and for coming on No Jargon. Really love talking to you today. So thank you so much for joining us.

Joseph: Well, I want to thank you for the work you do and the Scholar Strategy Network more broadly. I think the work you're doing, helping to translate research findings into packages that the public and policymakers can more easily consume is just so critical today.

Lisa: Well, let's keep on informing everyday people and all the politicians about why health is so important. So thanks again. And thanks for listening. For more on Professor Harris's work, check out our show notes at scholars.org/no jargon. No Jargon is the podcast of the Scholar Strategy Network, a nationwide organization that connects journalists, policymakers, and civic leaders with America's top researchers to improve policy and strengthen democracy. The producers of our show are Wendy Chow and Dominic Doemer. Our audio engineer is Peter Linnane. If you liked the show, please subscribe and rate us on Apple Podcasts or wherever you get your shows. You can give us feedback on X, formerly known as Twitter, @NoJargonPodcast or at our email address nojargon@scholars.org.