## [**TRANSCRIPTION**](https://podcast.agiledata.io/e/agilebi-2-adopting-the-agilebi-way/)

**Keisha Bentley-Edwards:** So when we're talking about systemic racism, most times we think about individual slights or harms that people may cause when we talk about racism, but that's more on the individual level. But systemic racism, or sometimes it's called structural racism or institutionalized racism. We're talking about policies, practices, and norms. And these can be in a health system, a school, or state, local politics, national politics, as well as what these norms are the ways that we're used to doing things that can cause harm based off of race, or ethnicity, or they also can provide benefits to people based off of race and ethnicity. And I think that's the part that folks don't always think about how racism causes harm, but it causes harm by providing benefits to someone else.

**Paul Anthony Robbins:** I kind of wanted to jump in on that as well. Because I think as we're thinking about these things, people often think of racism as like an act that you intentionally perpetrate and that sort of thing. And what we would suggest is that there are times where systems and systemic racism are intentional, and people are really going out of their way to make sure that people from certain groups don't get certain advantages and some people do get advantages. And in other instances, it's not really intentional, but what we see are outcomes that work just as well or just as poorly as if it was intentional. And I think that that's something to factor in as well with systemic racism.

**Keisha Bentley-Edwards:** Exactly. And thinking about the norms. And I'm glad you brought that up, is that it's what we think is acceptable or the ways that things that we're used to it being, and when we feel like there's a time to intervene, and do something about it or not, based off of race and who things affect. And I think that's a big part of what this book chapter is about. And the book overall is about is when we decide to help and when we decide to let things just let's see how things work out. Oh, I realized I didn't define social determinants of health. So when we're talking about social determinants of health, we're talking about all the different things that can affect you from the individual level. So the behaviors, and what are the things that you interact with in your everyday life, all the way to the policies that can affect your life. So whether or not you might be on state social services, or local services, all these different things that can affect your life and your health that may not necessarily be biological. So when we're talking about social determinants is really fitting when we're talking about racial differences. Because we're talking about race as a social construct, we're not talking about race as a biological construct. And if you understand that race is something that we put on that society has put on you, you can understand how social determinants can have desperate or differing impacts on people based off of race, because society interacts with black people, white people, Latino’s, and Native Americans and Asian Americans differently.

**Paul Anthony Robbins:** I'm with Keisha on that. And I'd also like to add that the social factors are known for consistently predicting health outcomes when they're considered social determinants of health. So those may be positive or negative outcomes. But one other thing is, typically, we're talking about, especially with regards to help something that's a preventable difference, or something that we can do something about. And oftentimes, it comes down to what Keisha was talking about earlier which is, have we accepted this difference as being normal? Or is it something that we believe can be intervened upon, and we believe that policies are something could be done differently to make it not look the way that it is? And so when you're encountering social determinants of health, you don't want to come at them from the perspective that these things are just gonna happen. Like you should expect them.

**Madeleine Braksick:** I think that's a great point. And it seems that social determinants of health haven't always been considered. Historically, we've taken a biological approach. But when we only approach that one dimension, we're missing out on a lot.

**Keisha Bentley-Edwards:** Absolutely. So much of what we think about as far as science and our health, you can understand how healthcare practices and policies and even your provider interaction can influence your health outcomes. If you think about the fact that when you look at diseases and conditions that we already have as a really good standard of care for that where you find big disparities and outcomes like cardiovascular disease, asthma, even things like treatable cancer in children and young adults. You will find greater mortality rates for African Americans than you do for white people. And these are talking about treatable conditions. Same thing when it comes to maternal death, 60% of maternal death is preventable. And that's where you find those disparities things that we know how to treat. And that's usually a sign that there's systemic racism, because if the system finds these death rates acceptable, then the system is allowing it to occur, which really set up. It set up a perfect storm for COVID to come in and really exasperate these disparities because these health conditions diabetes, heart disease, asthma, these were conditions where you already had stark disparities. And then COVID comes in, and it just attacks these vulnerabilities in individuals, but also in the systems and supports that are supposed to be in place so that folks don't fall through the cracks.

**Madeleine Braksick:** To your point about these pre-existing conditions, we've been talking about kind of buzzwords and myths surrounding this pandemic. And pre-existing conditions is something that we have heard on and on people are at higher risk for hospitalization for death for much more severe consequences if they can track COVID-19 and have pre-existing conditions. What can you tell us? I mean, this chapter starts out talking about. Historically, how African Americans are predisposed to pre-existing conditions at a disproportionate rate. So can you speak to us kind of how this chapter opens and having that discussion?

**Paul Anthony Robbins:** I think it's really more about how the society in general exposes people, black people in particular to these preexisting conditions. And so what we're looking at and what we're thinking of is like, if there are things that are related to having worse COVID health outcomes, or worse COVID outcomes, and we see a population of people who have higher prevalence of these things that that will predict more severe COVID outcomes. Why would anyone expect there to be a scenario in which we're all in this together? Or why would you come at this and say, ***“Well, we're all at equal risk. And we all have to do things, because this is going to affect us all the same”.*** And I think at first how the pandemic was viewed. And I don't blame people for thinking that from the beginning. But as it continued, and as we started learning more about how demographic characteristics and people's life circumstances and all were contributing to worse outcomes, there were still a ton of people making the argument that we're all in this together and making it seem like the risk was going to be similar, despite so much evidence that black people have a lot of the conditions that Keisha was describing earlier, that put them at higher risk.

**Madeleine Braksick:** I think you spoke to not just the pre-existing conditions, but we talked about high risk age groups, can you speak a little more about what you were kind of revealing about high risk age groups in terms of the initial risk, and also even with vaccination?

**Keisha Bentley-Edwards:** There were a lot of miscommunications. And some of it is, when it came to COVID, the health profession, public health people, they were doing what we would call, they were building the plane while they were flying it when it came to the response to COVID. Unfortunately, there were not they weren't using lessons learned from prior pandemics globally, as well as other issues that have occurred in the US. So you have this conflict that's going on. Where if you look at the raw numbers, old people, older adults, rather, were at a much higher risk of death, they still are at a much higher risk of death. But what you find is that when you start disaggregating the data, which means when you divide the data and compare older white people, black people, Latinos, Asian Americans, Native Americans, and as well as the younger age groups, what you found is that the risk for death is definitely higher for black people who are over the age of 65 or 70. But it's not it the risk was still really high for those who were in their 20s and 30s and 40s and 50s. And it was actually pretty level. And then it was a big jump, but that risk that you would see for that under 60 group for black people was very close to what you find for white people over the age of 65. And that's where messaging comes into play, and getting back into the vaccine. If I tell you that older adults are most at risk for death, and severe morbidity or illness, I would think that I don't really need to get the vaccine, because you spent the last year telling me that older folks are at the biggest risk people with pre-existing conditions. But the common public doesn't always understand what a pre-existing condition is. Some folks in that age group don't know that they're diabetic, or even when they're talking about obesity, they think that we're talking about people who have morbid obesity, and not those that are just at that lower level of obesity. So that risk is over emphasized on one group. And then when you tell people to vaccinate, ***“Well, why am I going to vaccinate, or something that I'm not even really at risk for?”***

**Paul Anthony Robbins:** It goes back to the pre-existing conditions that we're just talking about that. If black people have a higher prevalence of this, and then also if they have a higher prevalence of these pre-existing conditions, that put them at greater risk at an earlier age, than their risk is going to be much greater than what they're being told So as they're following, what the health messaging is, is they're doing what the government and what doctors and whoever also telling them to do, their risk isn't being mitigated to the same degree. Because those who are in the younger categories aren't really feeling like they're at risk, even though the data would show them. Actually, if you are black, and you're 60, or 65, even your outcomes are starting to look closer and closer to the general population, or to white people who are in their mid-70s. So I'm not gonna say that black people are 10 years older, or something like that.

**Keisha Bentley-Edwards:** Some people will talk about the weathering. So you can talk about the weathering of black women. I make the argument that sometimes due to stress, we age from the inside out. And so black people have this reputation of looking younger than they are. But if you look at our bodies, it's not, we just moisturize. Well, stay out of the sun do the things we're supposed to do. But when you look at our health outcomes, it would suggest people who are much older than they are. And then also the other aspect, when it came to the vaccine rollout, people of color in this country skew younger than white people like the average ages. So if you take a state like Maryland, who held on to the 75, and older for a long time, and when you look at the death rate for black people, it's 70. So if you have this as a priority group for the vaccine is at 75. And we know that the typical age of death for black people is before the age of 70, you're missing out on a lot of black people who could get vaccinated. So when we talk about how the systems can also support disparities, if you only assume that older populations are the most vulnerable, but don't look at some of these younger folks, and not just death, and hospitalization, we're talking about severe illness long COVID, a disabling disease for a lot of people. So a lot of things were done to undermine the seriousness of this disease, for people and a lot of different groups. And this is even for children, we find an undermining of, **“Yes, there is a much lower risk of death”**. But there's just not enough known when it comes to long term effects on the heart and on the brain. That we're just really starting to discover with this disease that we why would we want to expose children to it, just because they're not going to die doesn't mean that they won't be affected by it. And it doesn't mean that their caretakers and providers, teachers don't have to worry about these risks. So there were all these people who are affected that were saying, ***“They're not at risk as if they're not around others who may be more at risk”.***

**Madeleine Braksick:** I found the piece about the priority age group recommendations, especially striking because like you said, the CDC initially recommended a high priority group that extended beyond the life expectancy of black Americans. And these are things that a lot of people don't know, but I just found that particularly striking in this chapter and so much of the narrative was around COVID, we have been so heavily dependent on healthcare messaging on what the media is telling us things are changing every day. So much of our self-awareness of our risk level does come from what we're hearing from the outside. So y'all kind of make this recommendation. How can we change the healthcare messaging moving forward? How can we?

**Keisha Bentley-Edwards:** Well, we need to get messages from health care and health experts, public health experts specifically. Unfortunately, a lot of the health messages that we received either came from politicians, or they were filtered by politicians. So that even if it was coming from a health expert, it had to be approved politically, which made this a political disease instead of a public health crisis, which is what it was. And so we didn't learn our lessons from the HIV epidemic. And we're still not learning even from COVID. I mean, there were some things that were done well, as far as community engagement, and really connecting with churches and organizations and even developing whole new coalitions. That was excellent. We need to keep an eye out, especially in partnerships when it comes to large academic medicine, health systems, but we've dropped a lot of balls.

**Madeleine Braksick:** These political factors that you're speaking to, I'm assuming would fall under the social determinants of health?

**Keisha Bentley-Edwards:** Absolutely.

**Madeleine Braksick:** So another kind of big message that has been a part, especially at the beginning of the pandemic was this idea of stay at home. And how stay at home, Paul, if we're all in this together, might look the same for everyone. But as you both have pointed out, it doesn't. Can you speak a little bit about that?

**Paul Anthony Robbins:** It was interesting to get the messaging that people should stay at home where they're safer at home. And one of the things that that we're not taking into account is that some people's homes aren't really the safest place for them to be. And I don't mean that from, I'm not talking about like violence, or all of these sorts of things. I'm talking about with regards to a disease that is able to be passed along through the air. You're talking about multi generation families at times living together, or people living in situations where they're kind of stacked on each other to varying degrees. And what you find in those situations is that those people are going to be at risk, and you're telling them to kind of be there and just be around each other, and to not go anywhere, and that sort of thing, you're kind of setting them up to interact with others who might have COVID and to contract it. It also kind of ignores the fact that there are a ton of people who didn't just have the option to stay at home and to isolate and be away from other people. And so while I recognize that, that's just one of the messages that they were sending out there, it's very important to recognize, again, going back to this idea that we're all in this together, or that we're really not that for some people, you weren't going to have the choice to stay at home. And so them saying, if you just stay at home, everybody will be safe isn't really a thing for you. And so I have a pretty large family. And there are lots of differences in income, there are lots of differences in jobs and that sort of thing. And so it was kind of interesting to think about those of us like me, who could just be **“Alright, I'll take my computer and do all my research at my apartment, and I'll be fine”.** And then I had other family members who were maybe out for a week and had to go back and others who their job never stopped. There was so much variability. And so coming out with a consistent message that if you stay at home, you'll be safe that wasn't entirely true.

**Keisha Bentley-Edwards:** Well, unless you were considered an essential worker. But unless you're a physician, or maybe a nurse, an essential worker was also a disposable worker. So we saw that in the Death Race, when we looked at it by looked at the research it showed by career, who was at risk you have the line cooks, so not the chefs, but the cooks at the restaurants when we were doing all this takeout and delivery, those grocery store workers had a high rate of death. And obviously hospitals also had a high rate of death but not as much for physicians as it was like people who are direct care providers, but who are having long term contact with patients. This devastated folks who this has been devastating for a lot of families when we talk about go back to talking about children and the reports of how many children have lost a parent or grandparents, or some caretaker, those numbers are incredibly high. And we know that those numbers are much higher for black and Latino children, Pacific Islanders, that those Native Americans, those numbers aren't incredibly high. So, even as we talk about jobs folks, we lost over a million people. Like, and I don't know, if the gravity of that, I think we really stopped and thought about it when it was 100,000 people. But when it hit over a million, it seemed to not really mean a lot to folks. And the fact that most people know, at least one person who has either was severely hospitalized or died, really isn't understood or appreciated for the tragedy that it is in such a short time period. It's only two years.

**Madeleine Braksick:** Essential workers, we think of frontline workers. And there's the image of the frontline workers who are medical providers, or teachers, or a certain grouping of workers. And we also have essential workers, and there's overlap there. But in the chapter, you spoke to people who didn't have access to testing during the working hours, and if they took time to get tested, there's a risk. Quarantine is mandatory, but does your job actually allocate time for you to quarantine and return to your job?

**Keisha Bentley-Edwards:** And anytime of that.

**Madeleine Braksick:** And paid time, there are so many jobs out there with such restrictive time off and paid time off especially.

**Paul Anthony Robbins:** I spent a lot of time thinking about that. And I told you I have different family members who have different experiences than me. And so just from talking to them, and trying to make recommendations for them, that they do all the things that I'm doing, while also not understanding that they absolutely can't. It took me some time to really process all of what was going on, because I'm just like, **“Hey, my dad works in a factory”**. I'm like, **“Hey, Dad, why don't you just do this? Why don't you go get tested?”** And I'm not thinking at the time, if he goes and gets testing, he not getting some of his hourly wages, and I'm starting to think about that. And also like seeing some of the stories coming in about like the meatpacking plants, and these sorts of things where people are stacked on each other literally in these lands where there's a conveyor belt, and people are dying, and they're not able to report the symptoms that they have, because they don't want to miss work from being sick, especially if it's just going to go away, or if they think it might not be that severe, or even if they do think it might be severe, but they know their family has to eat, especially during a time like this. There were a lot of threats to these sorts of essential workers early on, they put policies in place later to try to do protections to make sure people had places to live to make sure people were getting these checks that were supposed to help them pay rent and these sorts of thing. But it took a long time for that to hit and people were really struggling.

**Keisha Bentley-Edwards:** And then it went away. When people said, ***“Oh, I could take a breath now”,*** especially people who had multiple children, they're like, ***“Oh, I can take a breath. And then it went away”.***

**Paul Anthony Robbins:** And it's all gone now. And they're making it seem like bringing those things back are not really possible. And there are still people who we're going to keep seeing these same surges. Because this sort of environment, we have not figured out how to address it properly. And we do not incentivize these people to do anything other than sacrifice their health, for the sake of all of us having convenient lives where we can get our things delivered, where we can get whatever we want, without supply chain issues, as quickly as we want it and that sort of thing. And I think that part of the reason that maybe we haven't done much about it is that so many of us benefit from the type of work these people are doing that we have a hard time looking at ourselves and trying to do something to make these people's lives better and to really treat them as the essential workers that they are.

**Keisha Bentley-Edwards:** Well, I think a big difference is that the people who make decisions, they're not necessarily engaging outside of a service provider, someone who's providing a service, they're not truly engaging with folks who actually have to deal with the consequences of these policies. So you have to talk to you, you have to go your family reunion. So you have to be able to talk to your cousins, and so you see the consequences. You feel it. I have family members who have died or who have been severely hospitalized. And it's not just COVID it's all the things appointments that people could not make the surgeries that had to be rescheduled and rescheduled. Again, all these conditions that at maybe COVID, or maybe COVID adjacent or just affected by COVID, because the system is so overloaded, all these things are impacted. For a year people can have funerals, like just like really thinking about that, even there's so much of our day to day life that was affected, and how we not only could not take care of our family members, and I think a lot of the people who made those decisions, really and truly did not feel affected by it outside of, that's a shame. It's one thing when it's somewhat of an academic exercise of ***“I'm reading the paper, and I'm seeing this. What a shame this is happening to all those people, compared to you having to deal with a grieving family member, or seeing a family member or yourself struggling to deal with these issues and still try to work”.*** Because even the folks who stayed at home, there was pressure to still produce, to still produce as if nothing else was going on. So there's a lot of early on in the pandemic, there was a push to reimagine a post COVID world, and a push to disrupt systems. But unfortunately, the systems that were happening before COVID effectiveness, were working for a lot of people. And those folks are very invested in returning to business as usual. And we're hoping with our chapter in the book, that we can tell folks that that's not acceptable and it's time to go a different way. And that's really how I look at it.

**Paul Anthony Robbins:** I also feel like I saw a really cool TEDx talk on that. I was just surfing the web, and there it was.

**Keisha Bentley-Edwards:** So it may have been me. So I had to slip Paul, a few dollars for his promotion of my TEDx talk about, what looks like normal on an ordinary day. And the way I look at it, what looks like normal is killing, my friends and family. And I don't find that to be acceptable. So this chapter, we touch on a lot of things. And it's good that we are at the beginning of the book, because we really want it to tie how all these social determinants, economics, education, employment, environment, and all those things affect health. And all of these things were impacted by COVID. So we looked at our chapter as somewhat setting the tone, which was also a challenge for us, because we wanted to talk about all the things, but this is more of like a survey, but these are a lot of things that affected how COVID panned out. But the other chapters go into more detail about some of these education, economic issues that also occurred.

**Madeleine Braksick:** This book is such a great call to action, it's not a back to normal that we need. It is a new normal that involves a lot of change. A lot of necessary change. This chapter, like you said, it sets the tone for the rest of the book, the way the chapters organized is you're like, ***“Oh, you think that's it? No, there's more”.*** And, and even within those subtopics when that comes to mind is the safer at home, stay at home narrative. It wasn't just here's what it looks like to stay at home, you're saying, here's what the average home environment looked like, here's what a neighborhood would look like. And then here are the environmental hazards that a lot of these communities were predisposed to because of systemic racism, there were all these points of entry and to each of these sections of the chapter. And I thought it was just so it was compelling and it was so well written. So you learn a lot and you back it up, like everything. I mean, my word is striking for this chapter. So I think one of the other kind of myths that you covered that we haven't talked about is the vaccine. You spoke to vaccine hesitancy and getting vaccinated versus getting educated. Can you speak a little more to that?

**Keisha Bentley-Edwards:** Yes, I'm always frustrated. And one of the things I was frustrated about is that there was all this hand wringing about. People don't trust health systems, they don't trust the government, how are we going to convince them to get the vaccine and really focusing a lot of effort on how do we educate Black people. If you look at the early numbers, there really wasn't a very big difference between the hesitancy of black people and the hesitancy of white people. So if we were to look at December of 2020, when it was the vaccines were first getting approved, there was really just a very slight, it was like 2, 3% difference between black and white people. The difference is, is the way that the rollout happened, it prioritize people who are more likely to be white. So you had people over 75, physicians and nurses, and then even teachers. And so what happened is that the way that the way that you got people to want to be with vaccination, and this was true for all groups is that they had to know someone who was vaccinated. So instead of making sure that the people that black people who were more than willing and waiting to get vaccinated got those early. They weren't there was just as focused on educating. And so the problem is, is that they the same time that they were focusing on educating those folks who are also doing mis education campaigns, we're also sitting doing that competing information out. And meanwhile, no one knew someone who had received the vaccine. So if all you're getting is a whole bunch of information, that is very distant, and not a personal connection, once it was time, and then you also have the conflicting information coming from the CDC and other like, you're not really in a high risk group. The emphasis was on, let's give information to people of color, instead of saying, let's get the people who are most willing, let's go what the low hanging fruit first, and get them to also say I'm okay, so that we can spread it out. And that's really where I get to that's where I was like, there's emphasis on educating black people while we're getting the shots in the arms of white people.

**Paul Anthony Robbins:** And to extend that point, what we're looking at is black people being presented with this idea that they're not really old enough to get these things, nor are they really smart enough to know that they should get these things, nor they essential enough to get these things and buy these things. I mean, the vaccine and so all of this is building to the same sorts of systemic disparities that we see. So now, not only it disparate in the outcomes at the beginning, or the sorts of risks at the beginning, but as we're watching this sort of thing play out and be implemented. And this potential solution minimizing severe risk is coming out, people can't really get out of their own way. The system can't get out of its own way to implement policies that help these people, because they never have really tried to do that, or to they've never been able to do it effectively should I say. I think there's a lot to factor in as well as like, where was some of the same efforts in educating other people from other groups? Because I would say black people weren't the only ones who were hesitant, or that sort of thing. And honestly, it's less impactful to the broader society if we are because we're a smaller proportion. Were they addressing white people in white people's hesitancy to the same degree?

**Keisha Bentley-Edwards:** Well, why people were more likely to be in the group never.

**Paul Anthony Robbins:** That's it. I was about to get on that too. Like, there were black people who could be convinced if you talk to them

**Keisha Bentley-Edwards:** And talk to them like it, like they had said, and they were coming that these were when they were hesitant, that it was a rational reason for them to be hesitant. You have to also acknowledge that it's rational for folks to be like,***“Wait, you got this, like this thing. We just found out about this 10 months ago”.*** And then now all of a sudden, there's a vaccine. And especially if you think about AIDS has been around popularly known for the last 40 years, and there's no vaccine for that. So you're gonna tell me that they had 40 years. And people don't understand the way science works that this was building on existing science. But you have to think about what are the rationales that people are using? And if you're just saying, just take it, just trust me on this? Well, you haven't been too trustworthy before this. Why should I take your word for it?

**Paul Anthony Robbins:** Well, and related to a lot of that, there was a lot of talk about Tuskegee, and everybody's just like, black people don't trust the medical field and medical profession and science because of Tuskegee, and Tuskegee was a long time ago. There are black people who don't trust it because of that, but it doesn't take that. I can literally and I'm not gonna go into detail on this stuff right now. But I can literally think of like five members of my family who have died in for questionable reasons, while doing what should be normal medical procedures, and thinking about that sort of thing, even with as much knowledge as I have, and as many doctors as I know, and as many as I've interacted with in all kinds of positive way. I'm still a bit nervous. So now I'm trying to think about for these other people, why are you acting like this is a historical thing, and it isn't really present? And why do you expect them to just get over it and let the shots happen and go about their lives, rather than being willing to just sit there and explain to them and have people who they trust, explain to them what's going on, rather than using the racist tropes and stereotypes and trying to use those sorts of things to prompt people to do things. And I'm not going to elaborate on that, because I'm not trying to get in trouble. Keisha, you know what I'm talking about, though.

**Keisha Bentley-Edwards:** Even with Tuskegee, even if we were to say it was Tuskegee. Tuskegee oftentimes is misunderstood. Tuskegee was about withholding, medical known medical treatment, versus the vaccine. Hesitancy is about a treatment that has a great deal of effectiveness and trying to get that to people. So that's something that I do like to make that distinction about. But just like Paul said, we can talk about Tuskegee. But we also have to talk about what people experienced in their own lives or they go take when, when their self-advocacy is seen as aggression, or non-compliance, those things have to be considered what's happening in your own health system? Who are the gatekeepers that may interfere with health care, and contributing to that distrust?

**Paul Anthony Robbins:** And are these people willing to challenge the status quo, which might say that if I have run into a black patient who I say, ***“Hey, you should get a vaccine?”*** And they say, ***“Nah, I don't really want to do that”***. Some doctors will just be like, I heard that they were less likely to want to do it. I'm just gonna let it go. And others will be like, ***“Well, can you tell me more about why you're doing? Why you're saying that?”*** And here's some of the things I know, as your trusted health care professional. Like, here's some things I can say to you.

**Keisha Bentley-Edwards:** And this was especially true for pregnant people. That was something else we didn’t talk. We didn’t get a chance to really talk about it. And part of it is that it was still evolving, while we were writing is about pregnant people. And the level of risk, I felt like it took about a year before people really understood they knew that we all know that pregnant people are immunocompromised, because you got to a whole other human, sometimes in my case to humans is. So your body is doing a lot. And it doesn't really need the interference of a lot of a virus while it's doing this very important work. But the miscommunication, the misinformation about the vaccine, the fact that the system did not test when they were doing clinical trials, that they did do clinical trials on pregnant people. So you can't even say that this is FDA approved during pregnancy, even though we know how risky it was for pregnant folks to have to go through a pregnancy and get COVID. And the risks that it provided to the parent as well as to the infant is. I mean, the risk for stroke for death for both baby and parent were incredibly high. And those are the things that aren't really understood as far as the general population, because the people were saying, if you have if you get vaccinated while you're pregnant, and you have a boy child, and you get the vaccine, they're going to be inputted. Like, do you understand, but most people that's the thing, there's an assumption that people understand biology. As someone who has a good idea about biology, I'm always stunned by how folks don't understand the way the reproductive system works. Even though there's always talk about the reproductive system and considering how much the society puts an emphasis on sex, you would think that there would be a better understanding of reproductive health. But oftentimes, those reproductive concerns come in for vaccines for adults, as well as those who are carrying babies. Obviously, that's not true.

**Madeleine Braksick:** I'm thinking we need a pandemic divided part two because there's unfortunately a lot on the cutting triangle

**Keisha Bentley-Edwards:** You try to be concise, but there are a lot of rabbit holes that could go that we could go into.

**Madeleine Braksick:** Well, all very worthy and important, worthy of a deep dive. The chapter closes with sub recommendation, some points, I think one of the big things we've talked about is kind of messaging and information around healthcare. The last lines of the chapter, here's my word again, striking. But you wrote, ***“We must recognize that in the first year and a half of the pandemic, if Black Americans died of COVID-19, at the same rate as white Americans, more than 44,000, black people would still be alive”***. This odd me thinking, like we've mentioned a couple of times, we're still in this. So where do we go from here?

**Keisha Bentley-Edwards:** Hearing that number, again, especially knowing this summer, , in the United States, we've lost with 30, 40,000 people to COVID, just this summer, so we are still, like you said very much into it. We really have to really rethink about what's possible. A lot of how we do things differently, is really breaking what we see as the norms. And saying just because this is all this is our normal, because it's always existed this way doesn't mean that it has to continue to exist and perform in these ways. So part of it is just saying, we're not going to stop with impossible, we're going to just keep on going till we start getting the results that we want. And the results that I want and who I know you want and Paul once is that we all have a shot at a healthy life.

**Paul Anthony Robbins:** We need to start asking equity focused questions at the governmental level, I don't think we do that often. Which is why it takes a while before anyone thinks even for a second that we might need to disaggregate data that we might need to think about who is being affected more and think about the possibility, even beforehand, before we have to watch it happen to 1000s, or millions of people. Just thinking beforehand. Maybe this could affect people differently based on different social factors that we keep seeing over and over again, affecting people. And so to me, being more equity focused not only in the questions that we ask, and our plan to answer those questions, but also more equity focused in the solutions. So thinking about how can we get solutions out here? How can we help people out who, again, are going to be most affected by it by things? And I think we struggle with that, especially in a country that people are often thinking about themselves at times or thinking about, what's the quality look like? And how do we all get the same thing. And if we don't all get the same thing, then things must not be fair. And one example of this is unrelated to COVID. But we talk a lot at the cook center about student loans, and some of those sorts of things. And so I'm not going to comment on whether $10,000 is enough, or I don't want to get into that sort of fight. But I think that there being a discussion about how we shouldn't do anything for student loan relief, because it doesn't help all Americans, because some don't go to college. It doesn't help people who've already paid off their loans and that sort of thing. I'm like, I hear you, and why can't we do things that that do target those people and help them as well as doing this thing to help these people? I think we always have this zero sum game. And we always have this focus on equality. And we don't stop to think enough about how to target things. And I think that that that's going to continue to work to our detriment.

**Madeleine Braksick:** Absolutely. It’s not a tradeoff.

**Keisha Bentley-Edwards:** But it's not mutually exclusive. So helping one person doesn't mean that other folks can also be helped or that other people don't need help if you help one group. There's one other thing about the disparities I wanted to bring up. And besides for an assumption of a biological inferiority, or some type of biological flaw that people assume that black people have, there's also an assumption of just irresponsible black people. All young black people are partying, that's why they're dying more from COVID. Or if they didn't get COVID, they would just shoot each other, like these types of ideas of almost not even almost deserving to get sick and die. So they're not doing thing. So they could wear a mask if they want to. They can stay home if they want to, but they're just out there being irresponsible. So that's why they're dying more. And if you see this or COVID, you see this for heart disease, for hypertension, all of these things, there's always an assumption that it's an individualized behavioral aspect. But when you start comparing the behaviors of white people and the behaviors of black people and they're sitting in similar behaviors, rather that the effects the return on investment, is not the same for black people as it is for white people. And we see this in wealth. And we also see this in health, that even when black people are engaging in healthy behaviors, that what we get back in return is not the same as far as great health and a lot of it has to do with the health systems that we're in. Because we don't get the response from providers as we should when we make our concern. So these are the things we have to the other myths that have to happen in order for equity occur is that we have to recognize that this is not a biological flaw, we have to recognize that black people are not irresponsible. And we have to recognize where the systems are in place that are actually an impediment to health outcomes.

**Madeleine Braksick:** Absolutely. And there's a lot of great and important work to be done. I think this chapter and this conversation have been just amazing. I loved hearing more about your work and your expertise. And I think it's a brilliant call to action.

**Paul Anthony Robbins:** Thank you for your time and for letting us talk about this chapter. It's very important to us and the people who are reflected in it are very important to us. So thank you very much.