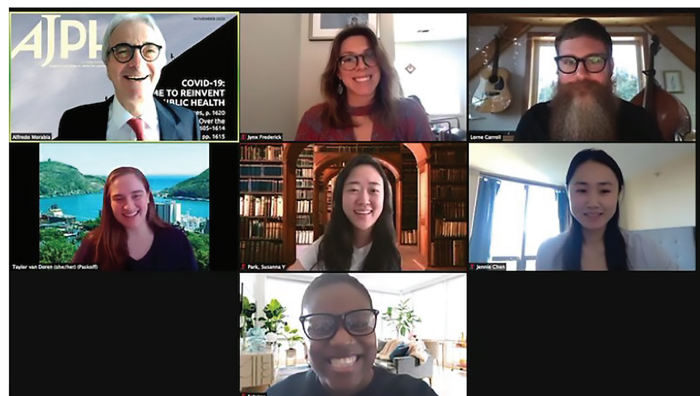


Deconstructing "Normal" for a More Equitable Post-COVID-19 World



History tells us that postpandemic worlds (e.g., after the second pandemic of plague in the 14th century and the 1918 influenza pandemic) were dramatically altered in almost every conceivable way, from human biology and demography to politics, economics, and religion. The reality that we left at the beginning of 2020 can no longer be restored.

In discussions throughout our tenure as the *AJPH* 2021 Student Think Tank cohort, we found ourselves contemplating what it might mean to "return to normal" once the COVID-19 pandemic is over. Two viewpoints became apparent: (1) normal, as a construct, is relative to individuals or groups, and (2) the prepandemic normal as an indicator of equity was not working for everyone. Exacerbations of health and economic inequalities glared as the pandemic disrupted our lives. Disenfranchised people, such as those with disabilities, people of color, those residing in low- to middle-income households, and those with chronic illnesses, found themselves at the crosshairs of COVID-19, a stressed health care system, and economic shock. Perhaps conceptualizations of what we previously deemed as "normal" need to be challenged given that, in the practice of public health policy and leadership, realities are not static; normal is a fluid state in constant change as opposed to something to which we can collectively return.

At the start of our fellowship as the *AJPH* Think Tank, we developed a mission to collaborate with each other and other public health students, to promote student engagement, to support equitable resources for present and future leaders, and to endorse intersectionality in public health practice. We believe that each of these goals serves as a framework to encourage more intentional practices beyond our fellowship. Reconstructing normal to promote health equity must include large-scale collaboration at the community and international levels with a focus on global, not national,

self-interest. In addition, we must prop up students and early-career professionals from backgrounds and experiences that have been institutionally marginalized into positions of leadership with ample resources to promote information sharing, to fight misinformation and disinformation, and to focus on mutual aid.

The state of public health in prepandemic times already included a laundry list of issues that aimed to narrow health equity gaps in areas such as access to health care and mortality rates. Mass deaths, overworked first responders, and racial injustice swept across the globe, with many people feeling the initial shock of collective pandemic trauma. However, those who faced worse health conditions, loss of income, and racial injustice experienced the collective trauma in an almost familiar way. "Normal" for the marginalized meant navigating institutions and structures that were not built with them in mind. For many, COVID-19 has maintained or worsened these navigational paths. We feel a profound duty to ponder more deeply how we can directly address the health of populations by elevating existing strengths within communities, equitably distributing resources to communities in need, and keeping leaders accountable in terms of policies that shape the lives of those they represent.

We have an opportunity to build a public health apparatus and a world that are more equitable than what we left behind in 2020.

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10 Years Ago

Integration of Social Epidemiology and Community-Engaged Interventions to Improve Health Equity

Collaborations between social epidemiologists and community-engaged intervention researchers can enhance the contributions of both to reducing health inequities. Unlike their colleagues in other types of epidemiological research, social epidemiologists do not have clinical counterparts. Cardiovascular epidemiologists partner with cardiologists and nephrologists; cancer epidemiologists partner with oncologists. To acquire effective investigative approaches and the ability to translate results to actionable knowledge, social epidemiologists must forge partnerships with those who are targeting social determinants through health-enhancing policies, practices, and interventions. Similarly, this interaction enriches community-engaged intervention researchers' creation and modification of interventions, measurement of appropriate constructs, evaluation findings, and generation of new theories and strategies for change. Developing and translating data into real-world use with community players then becomes a more important role for both sets of researchers.

From *AJPH*, May 2011, p. 827

11 Years Ago

Health Equity and Public Health Leadership

Public health in general, and health equity in particular, promote themes of human interconnection, egalitarianism, and community. Fundamentally, we are all interdependent and interconnected, with "promises to keep." Building community involves invoking the theme of shared responsibility that can be made explicit by effective public health leaders. Achieving true health equity means that despite our differences and diversity, a revitalized community can arise that truly acknowledges the health aspirations of each individual. . . . Leadership in health equity remains unfinished business for the 21st century. A future free from health inequity will require renewed commitment to unite the forces of science, practice, and policy for positive social change. All sectors of society must heed the call and many can contribute.

From *AJPH*, Supplement 1 2010, pp. S10-S11 *passim*

POST PUBLICATION UPDATE

4/18/22: When originally published, the online full-text version of this article listed the incorrect academic degrees in the author byline for Lorne Carroll and Zhangying Jennie Chen. Carroll's degree was missing and Chen's degree was incorrectly listed as BSN. The original PDF version of the article was correctly published with the appropriate degrees and has not been altered.

An erratum has since been issued indicating the change in the online version. [AJPH](#)