

No. 20-6055

IN THE
United States Court of Appeals for the Tenth Circuit

SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST
WOMEN OKLAHOMA CITY, on behalf of itself, its
physicians and staff, and its patients, ET AL.,
Plaintiffs-Appellees,
v.

J. KEVIN STITT, in his official capacity as Governor
of Oklahoma, ET AL.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Oklahoma
No. 5:20-cv-277-G
Hon. Charles Goodwin

**BRIEF OF THE AMERICAN PUBLIC
HEALTH ASSOCIATION AND EXPERTS IN
PUBLIC HEALTH AS *AMICI CURIAE* IN
SUPPORT OF PLAINTIFFS-APPELLEES**

Monica Haymond
ORRICK, HERRINGTON &
SUTCLIFFE LLP
1152 15th Street NW
Washington, DC 20005

Lisa T. Simpson
Matthew R. Shahabian
Rochelle F. Swartz
ORRICK, HERRINGTON &
SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000

Counsel for Amici Curiae

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INTEREST OF AMICI CURIAE¹

The American Public Health Association champions the health of all people and all communities, strengthens the public health profession, shares the latest research and information, promotes best practices, and advocates for evidence-based public health policies. APHA combines a nearly 150-year perspective and a broad-based membership working to improve the public's health.

The individual *amici* are leaders in public health: they include deans and professors, health commissioners, infectious disease experts, and directors of public health institutions. *Amici* have responded to SARS, Zika, Ebola, HIV/AIDS, tuberculosis, and other disease outbreaks, working as, or with, front-line public health practitioners, public health researchers, government advisory panels, legislators, global health security teams, and non-profit organizations to develop innovative solutions to emerging infectious diseases.

¹ A complete list of amici is attached as Appendix A. No party, party's counsel, or any person other than amicus or its counsel contributed money intended to fund preparing or submitting this brief. All parties have consented to the filing of this brief.

Amici share a professional commitment to evidence-based research and public health. From that perspective, *amici* are deeply concerned by Oklahoma’s decision to restrict access to abortions during the COVID-19 pandemic because it will endanger public health.

ARGUMENT

I. **Burdening Access To Essential Reproductive Healthcare During A Pandemic Is Not Justified Under Public Health Principles.**

Public health control measures must be “evidence-informed”: Pandemic response should be guided by the best available scientific evidence and respect for individual autonomy.² Any public health measure must be “proportional to the risk presented by those affected, scientifically sound, transparent to the public, the least restrictive means to protect public health, and regularly revisited to ensure that

² Ethics Subcomm. of the Advisory Comm. to the Dir., Centers for Disease Control & Prevention (CDC), *Ethical Guidelines in Pandemic Influenza* 8-9 (2007) (“CDC, *Ethical Guidelines*”), <https://tinyurl.com/yam7f63u>; CDC, *Field Epidemiology Manual: Developing Interventions* (2018), <https://tinyurl.com/yc3bnr4d>; Yale Sch. of Pub. Health & Yale Law Sch., *Achieving a Fair and Effective COVID-19 Response* 4 (Mar. 2, 2020) (“Yale COVID-19 Letter”), <https://tinyurl.com/squkg6w>; Am. Med. Ass’n, *AMA Underscores Importance of Science, Data in COVID-19 Fight* (Apr. 7, 2020), <https://tinyurl.com/ya2wtccs>.

they are still needed as the epidemic evolves.”³ Restrictions that are not evidence-informed and carefully tailored can cause the very harms to public health that the response to the pandemic intends to avoid.

A. Essential healthcare must be maintained during a pandemic.

An effective public health response must contain the spread of the contagion and maintain access to essential healthcare services.⁴ One category of pandemic-mitigation measures, referred to as “nonpharmaceutical interventions,” reduces the effective rate of human-to-human viral transmission through community hygiene, surveillance and diagnostic measures, isolation of the sick, and social distancing.⁵ These interventions can help maintain healthcare capacity until pharmaceutical interventions—vaccines and antiviral drugs—become

³ Yale COVID-19 Letter, *supra* n.2, at 1; *see also* CDC, *Ethical Guidelines*, *supra* n.2, at 5.

⁴ World Health Organization, COVID-19 Strategic Preparedness and Response Plan 2 (Feb. 12, 2020), <https://tinyurl.com/yadtahgu>.

⁵ Julia E. Aledort et al., *Non-pharmaceutical Public Health Interventions for Pandemic Influenza: An Evaluation of the Evidence Base*, 7 BMC Pub. Health 208, 210 (2007), <https://tinyurl.com/y7b39dwz>.

available.⁶ But because nonpharmaceutical interventions can limit individual freedom and cause unintended negative consequences, they must be approached with “great care” and carefully tailored to avoid outsized social harm.⁷

Restricting access to healthcare services during a pandemic should only be undertaken if there is evidence that it will improve public health and not endanger the health of patients who require access to those services. Guidance on nonpharmaceutical interventions discusses restrictions on social gatherings by closing schools, encouraging workplace telecommuting, and cancelling mass gatherings, not the restriction of access to essential healthcare.⁸

⁶ A. Wilder-Smith & D.O. Freedman, *Isolation, Quarantine, Social Distancing and Community Containment: Pivotal Role for Old-Style Public Health Measures in the Novel Coronavirus (2019-nCoV) Outbreak*, 27 *J. of Travel Med.* 1, 3 (2020), <https://tinyurl.com/yd4xx8hj>; CDC, *Ethical Guidelines*, *supra* n.2, at 2 n.8.

⁷ CDC, *Ethical Guidelines*, *supra* n.2, at 4.

⁸ *E.g.*, CDC, *Community Mitigation Guidelines to Prevent Pandemic Influenza—United States, 2017*, 66 *Morbidity & Mortality Wkly. Rep.* 1, 1-2, 6 (2017) (“CDC, *Community Mitigation*”), <https://tinyurl.com/y7fotw5d>; Joseph Barbera et al., *Large-Scale Quarantine Following Biological Terrorism in the United States*, 286 *J. Am. Med. Ass’n* 2711, 2711, 2716 (2001); Howard Markel et al., *Nonpharmaceutical Interventions Implemented by US Cities During the*

When considering postponing nonessential healthcare in a pandemic, one of the key questions is which health services are essential and “time-sensitive” and which are not.⁹ In evaluating particular procedures, officials should seek guidance from public health experts who can apprise them of the likely consequences of postponement based on evidence and sound medical judgment.

Without essential health services, many will suffer serious medical consequences or even die from conditions that were otherwise treatable. Experience in past epidemics has shown that lack of access to essential health services can result in increases in morbidity and mortality that outlast the epidemic and can result in more deaths than those caused by the epidemic itself.¹⁰

1918-1919 Influenza Pandemic, 298 J. Am. Med. Ass’n 644, 645 (2007), <https://tinyurl.com/r2sbucg>; Aledort, *supra* n.5, at 213.

⁹ World Health Organization, COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak 4 (Mar. 25, 2020), <https://tinyurl.com/razyn78>.

¹⁰ Inter-Agency Working Grp. on Reproductive Health in Crises, Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During the COVID-19 Pandemic 1 (Apr. 10, 2020), (“IAWG, COVID-19 Guidance”), <https://tinyurl.com/y99jxnlc>; cf. Nishant Kishore et al., *Mortality in Puerto Rico after Hurricane Maria*, 379 New Eng. J. Med. 162, 168 (2018).

In addition, denying access to essential health services undermines the effectiveness of public health guidance to self-isolate and practice social distancing. People are less likely to cooperate with public health directives if they need to seek other means of obtaining medical services.¹¹

B. Abortion is essential healthcare.

“Abortion is an essential health service.”¹² Access to abortion must be maintained during the COVID-19 pandemic because abortion is time-sensitive. While abortion is safe, potential health risks increase as it is delayed and gestation progresses.¹³

Restricting abortion means that delay can render abortion unavailable to women whose pregnancies are at later gestational ages when fetal abnormalities are diagnosed, or who face barriers in

¹¹ Yale COVID-19 Letter, *supra* n.2, at 3-5; Robert J. Blendon et al., *Public Response to Community Mitigation Measures for Pandemic Influenza*, 14 *Emerging Infectious Diseases* 778, 780 tbl.1 (2008), <https://tinyurl.com/y8mfxte5>.

¹² Michelle J. Bayefsky et al., *Abortion During The Covid-19 Pandemic—Ensuring Access to an Essential Health Service*, *New Eng. J. Med.* (Apr. 9, 2020), <https://tinyurl.com/ycgyv7qw>.

¹³ Int’l Fed. of Gynecology and Obstetrics, *Abortion Access and Safety With COVID-19* (Mar. 31, 2020), <https://tinyurl.com/y7q897dn>.

reaching a clinic. Births have far higher rates of maternal mortality and morbidity than abortions.¹⁴ The recent Ebola outbreaks in West Africa demonstrated the importance of maintaining reproductive health services during an epidemic, as obstacles in obtaining essential reproductive healthcare there led to dramatic increases in maternal morbidity and mortality.¹⁵

Given these risks, public health officials must ensure that the expected impact of any nonpharmaceutical intervention during a pandemic, such as restricting access to essential healthcare like abortion, will advance and not endanger public health.

¹⁴ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216-17 (2012), <https://tinyurl.com/ybph5ujz>.

¹⁵ See, e.g., Benjamin Black & Gillian McKay, Covid-19 and Reproductive Health: What Can We Learn From Previous Epidemics? (Mar. 19, 2020), <https://tinyurl.com/yad4mdp6>; Patricia A. McQuilkin et al., *Health-Care Access During the Ebola Virus Epidemic in Liberia*, 97 *Am. J. of Tropical Med. & Hygiene* 931, 934 (2017), <https://tinyurl.com/y7phxy65>.

II. Oklahoma's Restriction Of Abortions Will Exacerbate This Public Health Crisis With No Corresponding Benefit.

A. Interstate travel increases when abortions are not available locally.

Effective public health measures account for the negative consequences of interventions used to curtail a health crisis.¹⁶

Oklahoma contends that it is necessary to restrict abortion to reduce social contact and control transmission of COVID-19. But the consequences of restricting local abortion access will likely be to increase social contact by forcing women to travel out of state for care.

To slow transmission of COVID-19, it is vital to reduce interstate travel,¹⁷ as the disease is more likely to spread by daily and interstate

¹⁶ Kathryn Oliver et al., *Understanding the Unintended Consequences of Public Health Policies: The View of Policymakers and Evaluators*, 19 BMC Pub. Health 1, 1-2 (2019), <https://tinyurl.com/y6wg7o8w>.

¹⁷ See, e.g., CDC, *Public Health Recommendations for Community-Related Exposures*, <https://tinyurl.com/t7fnvba>; CDC, *Community Mitigation*, *supra* n.8, at 1; Scott Gottlieb et al., Am. Enter. Inst., National Coronavirus Response 3-4 (Mar. 28, 2020), <https://tinyurl.com/vldomvg>; World Health Org. Writing Grp., *Nonpharmaceutical Interventions for Pandemic Influenza, National and Community Measures*, 12 Emerging Infectious Diseases 88, 92 (2006), <https://tinyurl.com/y8u53zbz>.

travel than from international sources.¹⁸ For pregnant women, travel is unavoidable whether for pregnancy-related care or abortion care. But Oklahoma’s abortion restriction will further increase interstate travel, as women in states with more restricted abortion access are likely to travel farther to obtain an abortion.¹⁹ Under Oklahoma’s restriction, 91% of women seeking abortions will need to travel more than 100 miles to access abortion care in another state.²⁰

Because pregnant women who travel out of state for abortions will interact with more people—for gas, food, or bathrooms along the way—increasing interstate travel will increase contacts,²¹ and Oklahoma’s abortion restriction is likely to increase transmission of COVID-19.

This endangers the health of the pregnant women who are exposed to

¹⁸ Joseph R. Fauver et al., *Coast-to-Coast Spread of SARS-CoV-2 in the United States Revealed By Genomic Epidemiology* 7 (Mar. 26, 2020), <https://tinyurl.com/yabr7wt9>.

¹⁹ Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 *J. Women’s Health* 708, 708 (2013); Jonathan Bearak et al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care*, *Guttmacher Inst.* 1 & tbl. 1 (updated Apr. 8, 2020) <https://tinyurl.com/y7u299dn>.

²⁰ Bearak et al., *supra* n.19.

²¹ *See, e.g.*, Emergency Application, App.14, 151-52, 163, 233, 307-08, *Planned Parenthood Center for Choice v. Abbott*, No. 19A1019 (U.S. Apr. 11, 2020).

SARS-CoV-2 during their out-of-state travel and creates additional potential transmission events during their time away and when they return home. These consequences run counter to an evidence-informed approach to controlling the current pandemic.

B. When abortion is restricted, longer pregnancies require more healthcare contacts and use more PPE.

Restricting abortion access will also require more women to carry their pregnancies longer, including to term, leading to an increased risk to pregnant women and a likely increase in healthcare contacts and personal protective equipment (“PPE”) use.

Women who remain pregnant longer because of restrictions on access to abortion will likely have more contacts with the healthcare system. First, forcing women to wait until the directive expires or until they can arrange out-of-state travel to obtain an abortion will impose delay.²²

²² See Kari White et al., *Experiences Accessing Abortion Care in Alabama among Women Traveling for Services*, 26 *Reproductive Health* 298 (2016).

Second, pregnant women attend an average of 11.4 prenatal visits during their pregnancy.²³ Some doctors have begun providing telehealth visits, but pregnant women still attend a minimum of four prenatal visits.²⁴ And a substantial proportion of pregnant women seek emergency care.²⁵ In one recent study, 49% visited the emergency department at least once, and 23% visited twice or more.²⁶ Pregnant women with a comorbid condition—about 27% of pregnant women in the United States—are even more likely to seek emergency care due to complications.²⁷ Restricting or delaying access to abortion increases risks to maternal health and the frequency of healthcare contacts,

²³ Urania Magriples et al., *Prenatal Health Care Beyond the Obstetrics Service: Utilization and Predictors of Unscheduled Care*, 198 Am. J. Obstetrics Gynecology 1, 5 (2008), <https://tinyurl.com/ydb2xq27>.

²⁴ Rupsa C. Boelig et al., *MFM Guidance for COVID-19*, Am. J. Obstetrics & Gynecology MFM 1, 2 (Mar. 2020), <https://tinyurl.com/ychyq5lb>.

²⁵ Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 24 Acad. Emergency Med. 940, 940-41 (2017), <https://tinyurl.com/yan96osp>.

²⁶ *Id.*

²⁷ *Id.* at 943.

thereby undermining the effectiveness of social distancing policies for reducing viral transmission.²⁸

Women who receive timely abortions, in contrast, use and interact with fewer healthcare resources. Abortions generally do not require hospital facilities—most take place at an outpatient facility.²⁹ Major complications from abortions are rare—occurring in only 0.23% of abortions—and rarely require hospitalization, with its attendant PPE usage and contacts with healthcare workers.³⁰ Restricting access to abortion during the COVID-19 pandemic not only fails to conserve PPE and limit contacts, it causes women to carry their pregnancies further than they otherwise would and results in increased contacts and PPE use.

An evidence-informed evaluation based on data and sound medical judgment leads *amici* to the exact opposite conclusion from that of the

²⁸ See Sonja A. Rasmussen et al., *Pandemic Influenza and Pregnant Women*, 14 *Emerging Infectious Diseases* 95, 97 (2008), <https://tinyurl.com/ybkkch67>.

²⁹ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 175, 177 & tbl.1 (2015), <https://tinyurl.com/y74qp2dg>; Grace Shih & Robin Wallace, *First-Trimester Pregnancy Termination: Uterine Aspiration*, UpToDate (Jan. 2020).

³⁰ Upadhyay, *supra* n.29, at tbl.3 178-79.

State: There is no public health benefit to restricting access to abortion during the COVID-19 pandemic. The State's directive forecloses access to an essential healthcare service, reduces the effectiveness of social distancing by increasing travel and contacts, and requires more healthcare resources. Restricting access to abortion needlessly endangers the welfare of pregnant women and the general public.

III. Oklahoma's Restriction Of Abortions Will Exacerbate Deeply Rooted Health Inequities.

Effective public health responses minimize the risk of morbidity and mortality by accounting for existing inequity in healthcare access.³¹ Restricting access to abortion worsens preexisting inequalities by placing disproportionate burdens on low-income women and women of color.³²

³¹ See Sandra Crouse Quinn & Supriya Kumar, *Health Inequalities and Infectious Disease Epidemics*, 12 *Biosecurity and Bioterrorism* 263, 265-67 (2014) ("*Health Inequalities*"), <https://tinyurl.com/y8kal3wv>.

³² See Human Rights Watch, *US: Address Impact Of Covid-19 On Poor* (Mar. 19, 2020) ("*HRW, Covid-19 On Poor*"), <https://tinyurl.com/y8wbv4w7>; *Health Inequalities*, *supra* n.31, at 265-67.

Three out of four pregnant women who seek abortions are low-income.³³ And the children of women who are denied abortions are more likely to live in poverty.³⁴ Low-income pregnant women are also unlikely to have the means to travel out of state to seek medical care, which may lead to an increase in unsafe abortions,³⁵ and their serious and life-threatening complications.³⁶

Even when Oklahoma's restriction is lifted, low-income women will suffer disproportionately in obtaining abortion healthcare due to economic hardship,³⁷ the difficulty of scheduling appointments,³⁸ and a likely shortage in treatment capacity as demand for treatment surges when clinics reopen.³⁹

³³ Guttmacher Institute, *Induced Abortion in the United States* (Sept. 2019) (“*Induced Abortion*”), <https://tinyurl.com/l789emu>.

³⁴ ANSIRH, *Women's Access to Abortion Improves Children's Lives* (Jan. 2019), <https://tinyurl.com/y9xjtkwg>.

³⁵ Kari White et al., *The Potential Impacts of Texas' Executive Order on Patients' Access to Abortion Care* 3, Tex. Pol'y Evaluation Project, Mar. 2020 (“*White, Potential Impacts*”), <https://tinyurl.com/y7krvh8f>.

³⁶ Susheela Singh et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access* 4 (2018).

³⁷ Alan Berube & Nicole Bateman, *Who Are the Workers Already Impacted by the COVID-19 Recession?*, Brookings (Apr. 3, 2020), <https://tinyurl.com/ydcx5vbl>.

³⁸ *E.g.*, White, *Potential Impacts*, *supra* n.35, at 3.

³⁹ *Id.* at 2.

* * *

Allowing Oklahoma’s flawed public health rationales to justify restricting abortion will lead to profound consequences on women’s ability to access timely, safe abortion and will negatively impact the public’s health.

CONCLUSION

The Court should deny the motion for a stay.

Respectfully submitted,

/s/Lisa T. Simpson

Lisa T. Simpson
Matthew R. Shahabian
Rochelle F. Swartz
ORRICK, HERRINGTON &
SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000

Monica Haymond
ORRICK, HERRINGTON &
SUTCLIFFE LLP
1152 15th Street NW
Washington, DC 20005
(212) 506-5000

Counsel for Amici Curiae

April 24, 2020

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 27(d)(2)(A) because this brief contains 2578 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook 14-point font.

ORRICK, HERRINGTON & SUTCLIFFE LLP

/s/ Lisa T. Simpson

Lisa T. Simpson

Counsel for Amici Curiae

CERTIFICATE OF DIGITAL SUBMISSION

All required privacy redactions have been made as required by 10th Cir. R. 25.5 and the ECF Manual. No paper copies are required pursuant to 10th Cir. R. 27.2. Additionally, this filing was scanned with ESET Endpoint Security antivirus using the latest version (6.8.400.0), mostly recently updated on April 23, 2020.

ORRICK, HERRINGTON & SUTCLIFFE LLP

/s/ Lisa T. Simpson

Lisa T. Simpson

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the appellate CM/ECF system on April 24, 2020.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

ORRICK, HERRINGTON & SUTCLIFFE LLP

/s/ Lisa T. Simpson

Lisa T. Simpson

Counsel for Amici Curiae

APPENDIX A

List of *Amici Curiae*

This Appendix provides amici's titles and institutional affiliations for identification purposes only and not to imply any endorsement of the views expressed herein by amici's institutions.

Deborah Allen, ScD

Deputy Director for Health Promotion
Los Angeles County Department of Public Health

Oxiris Barbot, MD

Commissioner
NYC Department of Health

Deborah A. Bartz, MD, MPH

Associate Professor
Harvard Medical School
Obstetrics and Gynecology
Brigham and Women's Hospital

Ronald Bayer, PhD

Professor, Sociomedical Sciences
Co-Director, Center for the History and Ethics of Public Health
Mailman School of Public Health
Columbia University

Chris Beyrer, MD, MPH

Desmond M. Tutu Professor of Public Health and Human Rights
Department of Epidemiology
Johns Hopkins Bloomberg School of Public Health

Caroline Buckee, DPhil
Associate Professor of Epidemiology
Department of Epidemiology
Associate Director
Center for Communicable Disease Dynamics
Harvard T.H. Chan School of Public Health
Harvard University

Alice Chen, MD
Adjunct Assistant Clinical Professor of Medicine
David Geffen School of Medicine at UCLA

Mary Ann Chiasson, MS, MPH, DrPH
Professor of Clinical Epidemiology in Medicine
Mailman School of Public Health
Division of Infectious Diseases
Columbia University Irving Medical Center

Susan E. Cohn, MD, MPH
Professor of Medicine
Division of Infectious Diseases
Feinberg School of Medicine
Northwestern University

Deborah Cotton, MD, MPH
Professor of Medicine
Boston University School of Medicine
Professor of Epidemiology
Boston University School of Public Health

Wafaa El-Sadr, MD, MPH, MPA
University Professor of Epidemiology and Medicine
Director, ICAP
Columbia University

Barbara Ferrer, PhD, MPH, MEd
Director
Los Angeles County Department of Public Health

Jonathan Fielding, MD, MPH, MA, MBA
Distinguished Professor of Health Policy and Management
UCLA Fielding School of Public Health
Distinguished Professor of Pediatrics
UCLA Geffen School of Medicine

Linda P. Fried, MD, MPH
Dean and DeLamar Professor of Public Health
Mailman School of Public Health
Professor of Epidemiology and of Medicine
Senior Vice President
Columbia University Irving Medical Center
Columbia University

Sandro Galea, MD, MPH, DrPH
Dean and Robert A. Knox Professor
School of Public Health
Boston University

Maria F. Gallo, PhD
Associate Professor and Interim Chair
Division of Epidemiology
College of Public Health
Ohio State University

Samantha Garbers, PhD

Associate Professor

Heilbrunn Department of Population & Family Health

Mailman School of Public Health

Columbia University

Gregg Gonsalves, PhD

Assistant Professor, Epidemiology of Microbial Disease

Yale School of Public Health

Associate (Adjunct) Professor

Yale Law School

Yale University

Andrew Goodman, MD, MPH

Clinical Professor of Public Health Policy and Management

NYU School of Global Public Health

Celine R. Gounder, MD, ScM, FIDSA

Clinical Assistant Professor of Medicine and Infectious Diseases

Department of Medicine

NYU Grossman School of Medicine

Nathan D. Grubaugh, PhD, MS

Assistant Professor

Department of Epidemiology of Microbial Diseases

Yale School of Public Health

Yale University

Jodie L. Guest, PhD, MPH

Professor of Epidemiology

Vice Chair, Department of Epidemiology

Rollins School of Public Health

Emory University

Kelli Hall, PhD, MS
Associate Professor
Heilbrunn Department of Population & Family Health
Mailman School of Public Health
Columbia University

Margaret A. Hamburg, M.D.
Foreign Secretary
National Academy of Medicine

Eva Harris, PhD
Professor, Division of Infectious Diseases and Vaccinology
Director, Center for Global Public Health
Chair, Infectious Diseases and Immunity Graduate Group
School of Public Health
University of California, Berkeley

Elizabeth Janiak, SCD
Assistant Professor
Harvard Medical School

Heidi E. Jones, PhD, MPH
Associate Professor
Department of Epidemiology and Biostatistics
Director, Doctoral Program in Epidemiology
City University of New York School of Public Health

Mitchell Katz, MD
President and CEO
NYC Health + Hospitals

Deborah Kaplan, DrPH, MPH, R-PA
Assistant Commissioner
Bureau of Maternal, Infant, and Reproductive Health
Division of Family and Child Health
NYC Department of Health and Mental Hygiene

Nancy Krieger, PhD
Professor of Social Epidemiology
Department of Social and Behavioral Sciences
Harvard T.H. Chan School of Public Health
Harvard University

Marc Lipsitch, DPhil
Professor of Epidemiology
Director, Center for Communicable Disease Dynamics
Harvard T.H. Chan School of Public Health
Harvard University

Mark Lurie, PhD
Associate Professor of Epidemiology
Brown School of Public Health
Brown University

Nicole Lurie, MD, MSPH
Independent

Pooja Mehta, MD, MSHP
Clinical Assistant Professor
Department of Obstetrics & Gynecology
Louisiana State University Health Sciences Center
New Orleans School of Medicine

Michael Mina, MD, PhD
Assistant Professor
Department of Epidemiology
Member, Center for Communicable Disease Dynamics
Harvard T.H. Chan School of Public Health
Harvard University

Gina Novick, PhD, CNM, FACNM
Associate Professor
Yale School of Nursing
Yale University

Jennifer Nuzzo, DrPH, SM
Senior Scholar
Johns Hopkins Center for Health Security
Associate Professor
Department of Epidemiology
Johns Hopkins Bloomberg School of Public Health

Saad B. Omer, MBBS, MPH, PhD, FIDSA
Director, Yale Institute for Global Health
Professor of Medicine (Infection Diseases), Yale School of Medicine
Susan Dwight Bliss Professor of Epidemiology of Microbial Diseases
Yale School of Public Health

Nancy S. Padian, PhD, MS
Adjunct Professor of Epidemiology
UC Berkeley School of Public Health
UCSF Institute of Health and Aging

Kimberly Powers, PhD, MSPH
Associate Professor of Epidemiology
The University of North Carolina at Chapel Hill

Leslie Roberts, PhD, MSPH
Professor
Mailman School of Public Health
Columbia University

Roger Rochat, MD
Professor
Global Health and Epidemiology
Rollins School of Public Health
Emory University

Joshua A. Salomon, PhD
Professor of Medicine
Center for Health Policy
Stanford University School of Medicine

Anthony D. So, MD, MPA

Professor of the Practice, Department of International Health
Director of IDEA Initiative
Johns Hopkins Bloomberg School of Public Health

Andrea Swartzendruber, PhD, MPH

Assistant Professor
Department of Epidemiology and Biostatistics
University of Georgia College of Public Health

Janet Turan, PhD, MPH

Professor
Birmingham, Alabama

Sten H. Vermund, MD, PhD

Anna M.R. Lauder Professor and Dean
Professor of Epidemiology (Microbial Diseases)
Yale School of Public Health
Yale University

Judith N. Wasserheit, MD, MPH

William H. Foege Chair, Department of Global Health
Professor of Global Health & Medicine
Adjunct Professor of Epidemiology
University of Washington

Julie Womack, PhD, CNM, FNP-BC

Associate Professor
Yale School of Nursing
Yale University