Sustained human-to-human transmission of the novel coronavirus in the United States (US) appears today inevitable. The extent and impact of the outbreak in the US is difficult to predict and will depend crucially on how policymakers and leaders react. It will depend particularly on whether there is adequate funding and support for the response; fair and effective management of surging health care demand; careful and evidence-based mitigation of public fear; and necessary support and resources for fair and effective infection control.

A successful American response to the COVID-19 pandemic must protect the health and human rights of everyone in the US. One of the greatest challenges ahead is to make sure that the burdens of COVID-19, and our response measures, do not fall unfairly on people in society who are vulnerable because of their economic, social, or health status.

We write as experts in public health, law, and human rights, with experience in previous pandemic responses, to set forth principles and practices that should guide the efforts against COVID-19 in the US. It is essential that all institutions, public and private, address the following critical concerns through new legislation, institutional policies, leadership and spending.

ADEQUATE FUNDING AND SUPPORT FOR THE RESPONSE MUST BE PROVIDED

- Federal, state and local governments should act immediately to allocate funds to ensure that necessary measures can be carried out and that basic human needs continue to be met as the epidemic unfolds. Mitigating the impact of COVID-19 will be costly. Uneven distribution of resources will compromise collective control efforts and lead to unnecessary suffering and death. A major emergency congressional appropriation must be made for epidemic control and signed by the President, with quick disbursement to state and local actors on the frontlines of the response. In addition, these must be new funds that do not cannibalize existing health and safety net programs, nor social service programs, which are integral to protecting the public health in the long term.

- The federal government and federal, local, and state agencies must minimize disruption to government activities throughout the epidemic to continue providing public services to those who need them. Government must have a coordinated plan for keeping its operations running in the event of work absences. Priority should be given to essential services and support to the public, for example ensuring that Social Security, veterans’ and other benefits are not disrupted.

SURGING HEALTHCARE DEMAND MUST BE MANAGED AND PATIENTS AND HEALTHCARE WORKERS PROTECTED

- Our healthcare system will face severe burdens under all plausible scenarios. Hospitals must receive direct funding and adequate resources for enhanced surge capacity in order to handle the front-line response. Particular attention and funding must also be directed to primary care facilities and community health centers, especially those that are currently under-resourced even under normal circumstances. These front-line sites of healthcare provision need to act as gatekeepers to prevent the overburdening of tertiary hospitals and other acute care facilities and require support to allow them to fulfill this crucial role.
Healthcare workers and other first responders will be critical to the response. We must ensure their safety and give them fair working conditions. Healthcare workers must, for example, be given adequate protective equipment, be afforded reasonable respite, and be protected from discrimination arising out of their work with infected patients.

Healthcare facilities must be immigration enforcement-free zones so that immigration status does not prevent a person from seeking care. The COVID-19 response should not be linked to immigration enforcement in any manner. It will undermine individual and collective health if individuals do not feel safe to utilize care and respond to inquiries from public health officials, for example during contact tracing. Similar enforcement-free zones have been declared during hurricanes and other emergencies, including after the September 11 terrorist attacks. These policies should be clearly and unequivocally articulated to the public by the federal, state, and local governments.

Policymakers must work directly with insurance companies to allow all insured individuals to adhere to public health recommendations. It will be critical for policymakers to ensure comprehensive and affordable access to testing, including for the uninsured. Control efforts will be less effective if some fail to seek appropriate diagnosis or care due to large out-of-pocket costs or copays. Out-of-network or other insurance provisions cannot be allowed to disrupt local triage and patient allocation plans.

If therapeutics or vaccines are developed, policymakers must assure that they are affordable and available to all.

People residing in close living quarters are especially vulnerable to COVID-19 and will need special attention both to minimize transmission risk and address their healthcare needs in the context of an outbreak. These populations include those living in nursing homes or other congregate facilities; incarcerated populations in prisons, jails, and other detention facilities along with corrections officers and other personnel; the homeless living on the streets or in homeless shelters.

Other critical healthcare programs must be maintained during this crisis. People with chronic conditions depend on continuity of care to maintain their health. Whether it is dialysis for kidney disease, chemotherapy for cancer, or opioid agonist therapy for opioid use disorder, lapses in these programs can have disastrous implications for patients.

CLEAR, EVIDENCE-BASED COMMUNICATION IS CRITICAL TO MANAGE PUBLIC FEAR

Science needs to guide messaging to the public, and no government official should make misleading or unfounded statements, nor pressure others to do so. Honest, transparent, and timely reporting of developments will be crucial to maintaining public trust and cooperation. Suppression of information and attempts to manipulate it during the SARS epidemic in China exacerbated the crisis.¹ Clear, coherent, and uncontradictory messaging based on the best science will improve compliance and effectiveness of voluntary self-isolation, and other voluntary social distancing measures.²

Government and institutions must also actively prevent discrimination and scapegoating of individuals or groups. In the context of COVID-19, Chinese-American and other Asian-American

² Kavanagh, A.M., Bentley, R.J., Mason, K.E., et al. Sources, perceived usefulness and understanding of information disseminated to families who entered home quarantine during the H1N1 pandemic in Victoria, Australia: a cross-sectional study. BMC Infect Dis 2011; 11(2).
communities have already begun to face attacks on individuals linked to fears about the virus\textsuperscript{3,4}. The Centers for Disease Control and Prevention (CDC) has pointed out that such fears and misconceptions create “more fear or anger towards ordinary people instead of the disease that is causing the problem.”\textsuperscript{5} Local, state and federal officials should speak out against discrimination and stigma, and not use the outbreak to stoke xenophobia against Asian-Americans, other immigrant communities, and religious groups, for example.

- **Leaders should refrain from offering false assurances and should act aggressively to correct misinformation**, especially that which can incite panic and lead to hoarding of supplies and protective equipment. Governments must also provide comprehensive advice on best practices during epidemics, including proper personal hygiene and stocking up on, but not hoarding, needed supplies such as personal medications.

**SUPPORT AND RESOURCES MUST BE PROVIDED FOR FAIR AND EFFECTIVE INFECTION CONTROL**

- **The highest priority needs to be placed on allowing people to voluntarily cooperate with public health advice about prevention, by providing robust social and economic support and clear education.** Where social distancing measures are recommended, the government and relevant institutions should help ensure that people are in a position to comply, without excessive or unfairly distributed hardship. For example:
  - To enable people to cooperate with social distancing and other measures, policymakers must ensure that people are protected from job loss, economic hardship, and undue burden. If people are asked to avoid public transport or work, policymakers and employers should give them an explicit incentive to stay home, either with payments or by compensation for lost wages, as has been done elsewhere.\textsuperscript{6,7,8} Individuals will not cooperate with self-isolation or other voluntary social distancing measures if they are unable to provide for themselves and their families. For low-wage, gig-economy, and non-salaried workers, staying home from work has especially critical implications for economic survival.
  - The elderly and disabled are at particular risk when their daily lives and support systems are disrupted. Many have limited resources and depend on others to assist with care. Policymakers must explicitly accommodate these populations when making self-isolation recommendations.

- **Policymakers should base decisions on social distancing measures and closures on the best available science.** Employers, institutions, and schools should proactively determine adaptations and accommodations for closures (e.g. tele-communication or virtual education). These measures have been

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\textsuperscript{6} For example, Britain’s Health Secretary Matt Hancock sent guidance to tell employers that staff who have been asked to self-isolate must be able to clock that time as sick leave. See "Coronavirus UK: will I get paid if I take sick leave?", Guardian (Feb. 26, 2020), https://www.theguardian.com/world/2020/feb/26/coronavirus-uk-will-paid-take-sick-leave.


\textsuperscript{8} Pichler, S., Wen, K., and Ziebarth, N.R. Positive Health Externalities of Mandating Paid Sick Leave. Preprint on Research Gate (February 2020).
effective in mitigating the transmission of influenza. The abundance of evidence about influenza can help inform control efforts, but it will be important to recognize differences in the epidemiology of the diseases.

- **Special attention must be paid to the needs of people in long-term care or confinement, who are particularly vulnerable.** People in nursing homes or long-term care facilities, as well as those who are incarcerated or homeless, are at special risk of infection, given their living situations. These individuals may also be less able to participate in proactive measures to keep themselves safe, and infection control is challenging in these settings. Arrest and short-term incarceration can help amplify epidemics, and broader criminal justice policies should take into account the impact that policing and arrest policies have on health.

- **Mandatory quarantine, regional lockdowns, and travel bans have been used to address the risk of COVID-19 in the US and abroad.** But they are difficult to implement, can undermine public trust, have large societal costs and, importantly, disproportionately affect the most vulnerable segments in our communities. Such measures can be effective only under specific circumstances. All such measures must be guided by science, with appropriate protection of the rights of those impacted. Infringements on liberties need to be proportional to the risk presented by those affected, scientifically sound, transparent to the public, least restrictive means to protect public health, and regularly revisited to ensure that they are still needed as the epidemic evolves.

- **Voluntary self-isolation measures are more likely to induce cooperation and protect public trust than coercive measures, and are more likely to prevent attempts to avoid contact with the healthcare system.** For mandatory quarantines to be effective and therefore scientifically and legally justified, three main criteria must be satisfied: 1) the disease has to be transmissible in its presymptomatic or early symptomatic stages; 2) those who may have been exposed to COVID-19 must be able to be efficiently and effectively identified; and 3) those people must comply with the conditions of quarantine. There is evidence that COVID-19 is transmitted in its pre-symptomatic or early symptomatic stages. However, the contribution of infected individuals in their pre-symptomatic or early symptomatic stages to overall transmission is unknown. Efficiently identifying those exposed will be increasingly difficult as community transmission of the virus becomes more widespread, making quarantine a less plausible measure as community spread proceeds. Whether individuals can comply will be determined by the degree of support provided, particularly for low-wage workers and other vulnerable communities. While quarantines are in effect in many places already, their continuing and new use by federal, state or local officials requires real-time assessment and evaluation to justify them as the science and the outbreak evolve, through a transparent, open decision making process including external scientific and legal experts.

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• Public health officials must provide safe and humane conditions to individuals who are quarantined whether in homes, facilities, or communities. Government must ensure that anyone isolated or quarantined has access to the basic necessities, including food, water, medicine, and sanitation supplies. Assistance should be provided to individuals who are in need of support to maintain daily living, and attention must be given to religious and communication needs. The failure to do so will undermine trust, adherence to the intervention, and the overall effectiveness of quarantine. It will also be imperative not to impose inhumane or discriminatory conditions, as occurred on the Diamond Princess cruise ship, where passengers were quarantined to protect the population on land but were isolated in a high transmission setting. Furthermore, safe and humane conditions need to be provided to all quarantined individuals and do not differentiate between social or economic strata, or in the case of the Princess Diamond, between passengers and workers.

• Where mandatory measures are used, steps must be taken to ensure that people are protected from job loss, economic hardship, and undue burden. Government and employers must recognize that low-wage, gig-economy, and non-salaried workers who are unable to work because of quarantine or movement restrictions or other disruptions to the economy and public life face extraordinary challenges. They may find it impossible to meet their basic needs, or those of their family.

• Individuals must be empowered to understand and act upon their rights. Information should be provided on the justification of any mandatory restrictions as well as how and where to appeal such decisions. They should be afforded procedural due process, including universal access to legal counsel, to ensure their claims of discrimination or of hazardous conditions associated with their confinement are adjudicated.

• The effectiveness of regional lockdowns and travel bans depends on many variables, and also decreases in the later stages of an outbreak. Though the evidence is preliminary, a recent modeling study suggests that in China these measures may have mitigated but not contained the spread of the COVID-19 epidemic, delaying it locally by a few days, while having a more marked, though still modest, effect at the international scale, particularly if not combined with measures that achieved at least 50% reduction of transmission in the community. Travel restrictions also cause known harms, such as the disruption of supply chains for essential commodities. The authors of a recent review of research on the subject concluded that “the effectiveness of travel bans is mostly unknown” and “when assessing the need for, and validity of, a travel ban, given the limited evidence, it’s important to ask if it is the least restrictive measure that still protects the public's health, and even if it is, we should be asking that question repeatedly, and often.”

The COVID-19 outbreak is unprecedented in recent American history, and there is no playbook for an epidemiological event of this scope and magnitude. To mitigate its impact, you must act swiftly, fairly, and effectively. We urge you to take these recommendations seriously and act urgently so that we are best protected from the damage of this unprecedented microbial threat and the possible harms of an uninformed or poorly conceived response.

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[We thank Hanna Ehrlich, Rita Gilles, Mary Petrone and Kayoko Shioda, students at Yale School of Public Health and Yale Law School, for their assistance in the research and writing of this document.]

The letter will be sent to federal officials midday on Monday, March 2nd, but it will remain open for sign-ons at https://forms.gle/gxwhVkm5PnvFMCcR7. The online version of the letter will be updated every 24 hours as new endorsements come in. Please include your name, title and affiliation, which you can fill in at the bottom of the form at the link above. If you do not see your name listed 24 hours after you submit, please email covid19.openletter@gmail.com.

(Signatures last updated at 11:21AM on March 2)

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177. Lynn P. Freedman, Professor of Population and Family Health, Columbia University Mailman School of Public Health
178. Amelia Reese Masterson, Researcher, Community Alliance for Research and Engagement, Yale School of Public Health & Southern Connecticut State University
179. Carole H. Browner, Distinguished Research Professor, Center for Culture and Health, Semel Institute for Neuroscience and Human Behavior, Department of Anthropology, Department of Gender Studies, University of California, Los Angeles
180. Mary Crippen, Outreach Manager, Bronx Regional Health Information Organization
181. Caroline Jean Acker, Professor Emerita of History, Carnegie Mellon University
182. Erika Sabbath, Assistant Professor, Boston College School of Social Work
183. Dean Schillinger, University of California San Francisco, Professor of Medicine; Director, UCSF Health Communications Research Program
184. Ana Santos Rutschman, Assistant Professor of Law, Center for Health Law Studies, Saint Louis University School of Law
185. Agnes Usoro, Johns Hopkins University, Department of Emergency Medicine
186. Elizabeth Pendo, Joseph J. Simeone Professor of Law, Saint Louis University School of Law
187. John R. Stone, Professor, Creighton University, Dept. of Interdisciplinary Studies, Graduate Program in Bioethics, Dept. of Medicine, School of Medicine
188. Jacob Gross, Tufts University, Vice President of Tufts Public Health Society
189. Naomi Rogers, Professor of the History of Medicine, Yale School of Medicine
190. Jesse A. Goldner, John D. Valentine Professor of Law Emeritus, Center for Health Law Studies, Saint Louis University
191. Parveen Parmar, Associate Professor, Clinical Emergency Medicine; Chief, Division of Global Emergency Medicine, Keck School of Medicine, University of Southern California
192. Robert L. Cohen, NYC Board of Correction
193. Gordon D. Schiff, Associate Professor, Harvard Medical School
194. Mardge Cohen, Boston Health Care For the Homeless
195. Deborah C Glik, Professor, Dept Community Health Sciences, UCLA Fielding School of Public Health
196. Davidson H. Hamer, Professor of Global Health and Medicine, Boston University Schools of Public Health and Medicine
197. Doug Blanke, Executive Director, Public Health Law Center
198. Christina Nicolaidis, Professor and Senior Scholar in Social Determinants of Health, School of Social Work, Portland State University (PSU); Adjunct Associate Professor, Department of Medicine, Oregon Health and Science University (OHSU) and the OHSU-PSU School of Public Health
199. Lee Riley, School of Public Health, University of California, Berkeley
200. Eva Raphael, Dept of Family and Community Medicine, UCSF
201. Eric Nilles, Director, Program on Infectious Diseases and Epidemics, Harvard Humanitarian Initiative; Assistant Professor, Harvard Medical School; Attending Physician, Department of Emergency Medicine, Brigham and Women’s Hospital
202. Steven Galinat, JD Candidate, Temple University Beasley School of Law
203. Mary E. Wilson, Clinical Professor of Epidemiology and Biostatistics, School of Medicine, University of California, San Francisco; Adjunct Professor of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, Massachusetts
204. Trude Bennett, Associate Professor Emerita, Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
205. Joseph Fauver, Postdoctoral Research Associate, Department of Epidemiology of Microbial Diseases, Yale School of Public Health
206. Sarah B. Andrea, Postdoctoral Scholar, Department of Epidemiology, University of Washington School of Public Health
207. K. John McConnell, Professor & Director, Center for Health Systems Effectiveness, Oregon Health & Science University
208. Angela Garcia, Associate Professor of Anthropology, Stanford University
15. Leslie B. Hammer, Professor of Psychology, Portland State University
16. Pilar N. Ossorio, Professor of Law and Bioethics, University of Wisconsin Law School; Ethics Scholar-in-Residence, Morgridge Institute for Research
17. Mary E. Bushman, Research Fellow, Center for Communicable Disease Dynamics, Department of Epidemiology, Harvard T.H. Chan School of Public Health
18. Jason Harris, Chief, Division of Global Health; Associate Professor of Pediatrics, Harvard Medical School
19. Robert, Dubrow, Professor of Epidemiology, Department of Environmental Health Sciences, Yale School of Public Health
20. Jacob Bor, Assistant Professor of Global Health and Epidemiology, Boston University School of Public Health
21. J. Mijin Cha, Assistant Professor, Urban and Environmental Policy, Occidental College
22. Eva Harris, Professor, Division of Infectious Diseases and Vaccinology; Director, Center for Global Public Health, School of Public Health, University of California, Berkeley
23. Jean Lim, Associate Professor, Icahn school of medicine at Mount Sinai
24. JD Davids, Health Journalist, The Cranky Queer Guide to Chronic Illness
25. Sarah S. Bradley, Professor of Practice, Portland State University School of Social Work
26. Raina Plowright, Assistant Professor of Epidemiology, Department of Microbiology and Immunology, Montana State University
27. Juan C Salazar, Professor and Chair, Department of Pediatrics, UConn School of Medicine; Physician in Chief, Connecticut Children's Medical Center
28. Professor Rebecca Jordan-Young, WGSS, Barnard College; Director, Science and Social Differences Working Group, Columbia University
29. Jane E. Koehler, Professor of Medicine, Div. of Infectious Diseases, UCSF
30. Akiko Iwasaki, Professor of Immunobiology, Molecular Cellular and Developmental Biology and Dermatology, Yale University School of Medicine
31. Eugene Shapiro, Professor of Pediatrics and of Epidemiology, Yale University
32. Seth Alan Clark, Attending Physician; Assistant professor of Medicine and Psychiatry and Human Behavior, Alpert Medical School, Brown University
33. Nicole Angotti, Assistant Professor of Sociology, Department of Sociology and Research Fellow, Center on Health, Risk and Society, American University
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35. Alexander M. Capron, University Professor & Scott H. Bice Chair in Healthcare Law, Policy and Ethics, Gould School of Law and Keck School of Medicine, University of Southern California
36. Richard Bucala, Chief, Division of Rheumatology, Allergy & Immunology; Professor of Medicine, Yale School of Medicine
37. Susan L. Bickford, Professor of Mathematics, El Camino College
38. Donald Weinbaum, President, New Jersey Public Health Association
39. Arthur Reingold, Professor and Division Head, School of Public Health, University of California, Berkeley
40. Ruslan Medzhitov, Sterling Professor, Department of Immunobiology, Yale University School of Medicine
236. Joseph L Graves Jr., Professor of Biological Sciences, Dept. of Nanoengineering, Joint School of Nanoscience & Nanoengineering, North Carolina, A&T University and UNC Greensboro
237. Eran Bendavid, Associate Professor of Medicine, Stanford University
238. Howard P. Forman, Professor of Public Health, Radiology, and Management, Yale University.
239. Richard Skolnik, Former Lecturer Yale School of Public Health and the Yale School of Management
240. Michelle Poulin, Social Scientist, Gender Innovation Lab, Africa Region, The World Bank
241. Steffanie Strathdee, Associate Dean of Global Health Sciences, Harold Simon Professor, Co-Director of the Center for Innovative Phage Applications and Therapeutics, Department of Medicine, University of California, San Diego
242. Mary E. O'Brien, primary care physician, Columbia University
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267. Peter Daszak, President of EcoHealth Alliance, New York
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280. William M. Sage, James R. Dougherty Chair, School of Law and Professor of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin
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284. Adetutu Sadiq, student, UC Berkeley School of Public Health
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288. Deborah Ehrenthal, Associate Professor, School of Medicine and Public Health, University of Wisconsin-Madison
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298. Gary Weil, Professor of Medicine, Washington University School of Medicine
299. David R Hill, Professor of Medical Sciences, Director of Global Public Health, Frank H. Netter MD, School of Medicine, Quinnipiac University
300. David Stuppblebeen, Epidemiologist/Evaluator, Hawaiʻi Health & Harm Reduction Center and Junior Specialist, University of Hawaiʻi at Mānoa
301. Nicole Huberfeld, Professor of Health Law, Ethics & Human Rights, Department of Health Law, Policy & Management, and Professor of Law, Boston University School of Public Health
302. Jennifer Philips, Associate Professor of Medicine and Molecular Microbiology, Co-Director, Division of Infectious Diseases, Washington University in St Louis
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310. Jennifer Adamski, Assistant Professor & AGACNP Program Director, Emory University School of Nursing
311. Carolyn Miller Reilly, Clinical Associate Professor and ABSN Program Director, Emory University School of Nursing
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315. Brinda Emu, Associate Professor of Medicine/Infectious Diseases, Yale School of Medicine
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317. Arnab Mukherjea, Assistant Professor of Health Sciences (Public & Community Health); Adjunct Faculty Member, Pre-Professional Health Academic Program (PHAP), Department of Health Sciences, California State University, East Bay
318. Douglas D. Richman, Distinguished Professor of Pathology and Medicine (Active Emeritus); Director, The HIV Institute; Co-Director, San Diego Center for AIDS Research; Florence Seeley Riford Chair in AIDS Research (Emeritus), University of California, San Diego
319. Lori Peek, Professor, Department of Sociology and Director, Natural Hazards Center, University of Colorado Boulder
320. Janne Boone-Heinonen, Associate Professor of Epidemiology, School of Public Health, Oregon Health & Science University
321. Nino Ricca Lucci, Labor Organizer, UAW Region 9A, MPH Student, Columbia Mailman School of Public Health
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323. Mitch Stripling, National Director, Emergency Preparedness & Response, Planned Parenthood Federation of America
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325. Molly Dondero, Assistant Professor of Sociology, American University
326. Mariya Masyukova, Assistant Professor, Department of Family and Social Medicine, Montefiore Medical Center/ Albert Einstein College of Medicine
327. Corey Davis, Teaching Professor, Brody School of Medicine, East Carolina University
328. Rajesh T. Gandhi, Massachusetts General Hospital, Professor of Medicine, Harvard Medical School
329. Gary V. Desir, Paul B. Beeson Professor of Medicine Chair, Internal Medicine, Yale School of Medicine Chief, Internal Medicine, Yale New Haven Hospital
330. John Harley Warner, Avalon Professor of the History of Medicine, Yale School of Medicine, and Professor of History, Yale University
331. Scott C. Weaver, Professor and Chair, Department of Microbiology and Immunology, University of Texas Medical Branch
332. Connie Celum, Professor of Global Health and Medicine, University of Washington
333. Laura Ferguson, Assistant Professor, Keck School of Medicine; Director, Program on Global Health
334. Phillip Fiuty, Harm Reduction Program Manager, The Mountain Center
335. Vasilis Vasiliou, Susan Dwight Bliss Professor of Epidemiology, Department Chair of Environmental Health Sciences, Yale School of Public Health
336. Kristine Qureshi, Professor & Associate Dean, University of Hawaii at Manoa, School of Nursing and Dental Hygiene
337. David M. Morens, Bethesda, Maryland
338. Azita Emami, Robert G. and Jean A. Reid Executive Dean, University of Washington School of Nursing
339. Sydney A. Spangler, Assistant Professor, Lillian Carter Center for Global Health and Social Responsibility, Nell Hodgson Woodruff School of Nursing and Hubert Department of Global Health, Emory University
340. Ana V. Diez Roux, Dean, Dornsife School of Public Health, Drexel University
341. Usha Ramakrishnan, Interim Chair and Professor, Hubert Department of Global Health, Rollins School of Public Health, Emory University
342. John Santelli, Professor, Population and Family Health and Pediatrics, Columbia University
343. Joseph S. Ross, Professor of Medicine and Public Health, Yale University
344. Katharine Walter, Postdoctoral Fellow, Stanford University School of Medicine
345. Vidya Eswaran, Chief Resident, McGaw Medical Center of Northwestern University
346. Nina Harawa, Professor-in-Residence, Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at UCLA (DGSOM), Department of Psychiatry, Charles R. Drew University of Medicine and Science (CDU)
347. James Lloyd-Smith, Professor, Department of Ecology & Evolutionary Biology, University of California, Los Angeles
348. Lance Gable, Associate Professor of Law, Wayne State University Law School.
349. Sherril Gelmon, Professor, Health Systems Management & Policy, Director, PhD in Health Systems & Policy, OHSU & PSU School of Public Health
350. Risha Gidwani-Marszowski, Adjunct Associate Professor, UCLA School of Public Health
351. Carol S. Camlin, Associate Professor, Dept. of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco
352. Nicholas G. Reich, Associate Professor, Department of Biostatistics and Epidemiology, School of Public Health and Health Sciences, University of Massachusetts, Amherst
353. Joseph Craft, Professor, Yale University School of Medicine
354. Ibukun Fowe, Graduate Research Assistant, OHSU-PSU School of Public Health
355. Josiah “Jody” Rich, Professor of Medicine and Epidemiology, Brown University, Director of the Center for Prisoner Health and Human Rights, Attending Physician, The Miriam Hospital
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358. Denise Chrysler, Retired Attorney, Michigan Department of Community Health
359. Corey S. Davis, Former Chair, Orange County (NC) Board of Health, Teaching Professor, East Carolina University Brody School of Medicine
360. Michael S. Lyons, Associate Professor Emergency Medicine, University of Cincinnati College of Medicine
361. K.M. Venkat Narayan, Ruth and OC Hubert Chair of Global Health, Emory University
362. Tim Cunningham, Vice President of Practice and Innovation, Emory Healthcare; Adjunct Assistant Professor, Emory University School of Nursing; Adjunct Assistant Professor University of Virginia School of Nursing.
363. Brett Feret, Clinical Professor, Director of Experiential Education, University of Rhode Island College of Pharmacy
364. Dabney P. Evans, Associate Professor, Hubert Department of Global Health, Rollins School of Public Health-Emory University
365. Pooja Agrawal, Assistant Professor of Emergency Medicine, Yale University School of Medicine
366. Donald S. Burke, MD, Distinguished University Professor and Jonas Salk Chair of Population Health, University of Pittsburgh
367. Harsha Thirumurthy, Associate Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania
368. Maryana Arvan, Postdoctoral Scholar, Department of Psychology, University of Central Florida
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371. Rosemary K. Sokas, Professor, Department of Human Science; Georgetown University School of Nursing and Health Studies, Professor, Department of Family Medicine, Georgetown University School of Medicine
372. Marizen Ramirez, Associate Professor, Director, Midwest Center for Occupational Health and Safety, University of Minnesota School of Public Health
373. Andrew Goldstein, Assistant Professor at NYU School of Medicine
374. Sandra A. Springer, Associate Professor of Medicine, Yale School of Medicine, Department of Internal Medicine, Section of Infectious Disease
375. Jim Lavery, Professor and Conrad N. Hilton Chair in Global Health Ethics, Hubert Department of Global Health, Rollins School of Public Health and Faculty, Center for Ethics, Emory University
376. Ted Cohen, Professor, Department of Epidemiology of Microbial Diseases, Yale School of Public Health
377. Leslie I. Boden, Professor, Department of Environmental Health, Boston University School of Public Health
378. Ranit Mishori, Professor of Family Medicine, Georgetown University School of Medicine
379. Lorna Thorpe, Professor and Director, Division of Epidemiology, Vice Chair, Strategy and Planning, Department of Population Health, NYU Grossman School of Medicine
380. Kay Lovelace, Associate Professor of Public Health Education, School of Health and Human Sciences, University of North Carolina at Greensboro
381. Isabel Morgan, PhD Student, Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
382. Barak Richman, Bartlett Professor of Law and Business Administration, Duke University, Visiting Scholar, Department of Medicine, Stanford University
383. Joshua L. Warren, Associate Professor of Biostatistics, Yale University
384. Carolyn L. Westhoff, Sarah Billinghurst Solomon Professor of Reproductive Health, Columbia University
385. Maile Phillips, PhD Candidate, Department of Epidemiology of Microbial Diseases, Yale School of Public Health
386. Betty Kolod, Resident Physician, Mount Sinai Hospital
387. Michelle Mello, Professor of Medicine and Professor of Law, Stanford University
388. Peter C. Melby, Director, Division of Infectious Diseases; Director, Center for Tropical Diseases; Paul R. Stalnaker Distinguished Professor in Medicine; Professor, Internal Medicine (Infectious Diseases), Microbiology and Immunology, and Pathology, University of Texas Medical Branch (UTMB)
389. Joseph S. Ross, Professor of Medicine and Public Health, Yale University
390. Sangeetha Madhavan, Professor of African American Studies and Sociology, University of Maryland
391. Anne Davis, OB/GYN, Columbia University Irving Medical Center
392. Jennifer S. Hirsch, Professor of Sociomedical Sciences, Mailman School of Public Health, Columbia University
393. Poonam Daryani, Clinical Fellow, Global Health Justice Partnership of the Yale Law School and the School of Public Health, Yale University
394. Elizabeth Spradley, BHLI Project Connections in Baltimore City
395. Lisa M. Thompson, Associate Professor, Nell Hodgson Woodruff School of Nursing, Emory University
396. Julia Rosenberg, Yale National Clinician Scholar Post-Doctoral Fellow
397. Jenny Trinitapoli, Associate Professor of Sociology & Director of the Center for International Social Science Research, University of Chicago
398. Mary Clare Reidy, Director of Collaborative Partnerships, Health Federation of Philadelphia
400. Susan M. Mason, Assistant Professor, Division of Epidemiology and Community Health, University of Minnesota School of Public Health
401. Parmi Suchdev, Professor of Pediatrics and Global Health, Emory University
402. Robert A. Bednarczyk, Assistant Professor of Global Health and Epidemiology, Emory University
403. Thomas J. Stopka, Associate Professor, Department of Public Health and Community Medicine, Clinical and Translational Science Institute, Tufts University School of Medicine
404. Maggie Ornstein, Psychology, Sarah Lawrence College
405. Maggie Ornstein, Guest Faculty, Psychology, Sarah Lawrence College
406. Kimberley Shoaf, Professor and Associate Chief for Community Engagement, Division of Public Health, University of Utah
407. Gary Bubly, Vice Chair for Clinical Integration and Innovation, Department of Emergency Medicine, Alpert Medical School of Brown University
408. Robert Gatter, Professor of Law, Center for Health Law Studies, Saint Louis University School of Law
409. Hyeyoung Woo, Associate Professor, Portland State University
410. Steven Singer, Professor, Department of Biology; Director of Undergraduate Studies in Biology of Global Health; Director of Graduate Studies in Global Infectious Disease, Georgetown University
411. Alyssa King, Post-doctoral Fellow; Adjunct Professor, Department of Biology, Georgetown University
412. Anne G. Rosenwald, Professor of Biology; Professor of Microbiology and Immunology; Director of Undergraduate Studies in Biology, Georgetown University
413. Joshua Rodriguez, NYU/Bellevue Emergency Medicine
414. Heather-Lyn Haley, Assistant Professor, Family Medicine and Community Health, UMass Medical School
415. Lydia Aoun Barakat, Section of Infectious Disease, Yale School of Medicine
416. Melanie Gross Hagen, Associate Professor, Internal Medicine, University of Florida
417. Alyssa Jordan, RTI International
418. Peter C. Melby, Director, Division of Infectious Diseases; Director, Center for Tropical Diseases; Paul R. Stalnaker Distinguished Professor in Medicine; Professor, Internal Medicine (Infectious Diseases), Microbiology and Immunology, and Pathology, University of Texas Medical Branch (UTMB)
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Peter Lurie, President, Center for Science in the Public Interest

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

Organizational Signatures

1. Broken No More
2. Amnesty International USA
3. The Public Health Advocacy Institute
4. Big Cities Health Coalition
5. Prevention Point Pittsburgh
6. Any Positive Change
7. EcoHealth Alliance
8. Children's Aid
9. American Public Health Association (APHA)
10. The Johns Hopkins Center for Health Security
11. The Mountain Center in New Mexico
12. Center for Prisoner Health and Human Rights
13. The National Health Law Program
14. Collaborative for Health Equity Cook County, Chicago, Illinois