
## Conversation with Natalia Linou
## Ashley Hopkinson
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**Ashley Hopkinson: Can you tell me a little bit about your background and the work that you're doing now?**

**Natalia Linou:** I'm Natalia Linou. I am the Deputy Director of UNDP's HIV and Health team. We are a large team, headquartered in New York, but we have regional and country-level work. I'm a social epidemiologist in training, and that means I'm someone who thinks about how health is advanced outside of healthcare. So I'm not a physician; I'm a doctor because of the PhD. It's really thinking about what shapes the determinants of health and, most importantly, health equity. So I've done a lot of work within the UN system working in different regions, including the Arab world, but I also have done very local work. I was in the New York City Health Department for a few years, and I've also worked in local government in Brookline, Massachusetts. So I've done the global to the local. And at the core of what I am focused on is how we advance health and wellbeing for people and how we do it in a way that advances it equitably across the globe, but also within our communities.

**Ashley Hopkinson: What is distinctive about your approach to health and wellbeing? How do you feel your work is unique in this broad field, where people tend to be siloed?**

**Natalia Linou:** I'll start by saying that oftentimes in health journalism, people think about what you can do as an individual, so you'll have self-help; or if it's sunny, make sure you put on your sunscreen [type of stories]. So physicians, your doctor, or people who work in nutrition or sports and health, they may be giving individual advice, but those of us in public health think about population levels. So yes, you, Ashley, as an individual should eat your fruits and vegetables as much as you can.

But for me as a social epidemiologist, my question is: Does your neighborhood have a fresh fruit and vegetable store that you can access, where the fruit and vegetables are cheap enough that you have time after work? So really thinking about population-level health. It's what drives healthy choices. And

not from an individual perspective—like, did Ashley make the right choices?—but did we as policymakers, did we as a community make it easy for people to live a healthy life?

To some extent, traditional public health has focused very much on smoking, tobacco, eating, exercise. But increasingly, we have very little if any control over the environmental determinants: air pollution; access to green space; clean, toxin-free environments; and our products, [from] hair products to what we wash our clothes with. So this is about the policies, the laws, the regulations. An organization like UNDP, how we think about health is really around governance, around law, around human rights.

It's not about your doctor telling you to stop smoking. It's us making sure that we're taxing smoking tobacco appropriately so that it's not a choice that people make. So it's really a shift in how you advance health and how you advance health equity by thinking about populations.

What we have to pay attention to is health equity. So if we're seeing disease patterns by groups, there is no genetic reason why a certain group should have more cancer or more asthma or more HIV. It's because the policies that we've put in place have failed that group of people. And it may be because the neighborhoods are not healthy or safe, or it may be because we have discriminatory laws that harm LGBTQ communities in parts of Africa.

Health is really about governance. It's about the law, it's about human rights, it's about environmental protections. It's not simply about your doctor telling you to eat five fruits a day.

**Ashley Hopkinson: What does it take to convince others to understand the importance of population and policy and governance? What has helped when you're speaking to people outside of the public health space?**

**Natalia Linou:** Health is a political issue. Nobody believes that people should have unequal opportunities to live healthy lives.

In the United States there are maps showing life expectancy between subway lines. In places like Australia or New Zealand, we know the differences in life expectancy between indigenous Aboriginal communities versus the white settler communities. So showing really stark data has been important.

But in a place like UNDP, we use a framing called human development, and it's about how we think about people's dignity and wellbeing in a holistic way, and really questioning the idea that governments should be striving [only] for GDP or economic progress. Really it's about human wellbeing, dignity, and life. And that's where health is critical.

COVID made it quite obvious that without people's health, you can't have a striving economy. But even before that, many of us in this field were saying health is part of the public transport conversation. It is part of safe jobs and occupational health.

What has been challenging for people in the past is that if health is seen as purely biomedical, and we're only striving for advancements in medicines—which are important—we're not really seeing what we can achieve at the population level. [We can do] so much more through our urban planning, our development choices, the way we even conceptualize wellbeing.

**Ashley Hopkinson: What do you think leaders and policymakers can do to improve collaboration and advanced progress in the space of public health? What is missing on that side?**

**Natalia Linou:** Often a lot of the funding and a lot of the energy, including the money that hospitals spend, goes towards tertiary care and treatment. We're thinking about precision medicine or technological solutions, when in fact a lot of the core reasons why we have such striking health challenges are inequalities—inequalities in our system of how we organize ourselves.

Let's revisit taxation, let's revisit the way we provide services to people, or let's revisit investments in public education, in public infrastructure, and in a green climate, so that we don't have these inequities. The challenge sometimes is that we're looking for a silver bullet when in fact we just need to be doing something about the growing inequality that we're seeing within and between countries, and making the daily lives of individuals easier and better so that people can live healthier lives.

For someone like me who's a social epidemiologist, we focus a lot on what we call root causes or structural determinants of health in different countries. The structures are reinforced where power is controlled, whether it's industry or certain groups of people, whether we're talking about racism or sexism or ableism or other isms that ensure a hierarchy, so that people don't have the same opportunities and can't live in dignity.

The phrase that the UN likes to use is leaving no one behind. I think that's a really important phrase. And oftentimes when we're looking for technological solutions or for the medicine that will cure this cancer and Alzheimer's—of course it's important, but people are still dying of the most basic issues like malaria and HIV.

We're trying to extend life for those who have already made it to 80, and we haven't yet dealt with diarrhea and other things that are happening because of inequality in the world. So I would like to see more emphasis on the boring diseases of poverty and inequality [than on] the technological solutions

to extend life beyond 80—which I don't think is a bad thing, but I think it needs to be thought of holistically.

I think we actually have under-investment in aging and social isolation. It's just that sometimes the way it's portrayed, it's like, how can we advance this healthy skin so you look like 20 years younger or something like that. That is where I'm critical, not of [treating] dementia or Alzheimer's—that has to be dealt with because it's so important. I think there is work to be done across the board, but in terms of really recognizing the connections and realizing that there are potential co-benefits.

I work in the climate space right now, because I think that's going to be a huge multiplier of inequalities. We already are living in a highly unequal world with a lot of health inequities. I think in 10 years, 20 years, 30 years, the inequities are going to be at a completely different level if we don't deal with the climate crisis, the heat, and who's going to be impacted. It feels like a blind spot that not enough people from the health community are paying attention to. I think people are saying, oh, we still need to deal with maternal mortality—and of course we do, but if we don't take into account the climate crisis, it's going to be a disaster. So that's an area where I've decided to focus a lot of my attention right now.

It's urgent, because it's going to be a multiplier of health inequities. We see stark inequities within countries and in between countries, and those are just going to be exacerbated. [For example,] zoonotic diseases. We're going to have malaria in places we've never had it before. With heat, you're going to see more heart attacks and strokes.

Everything is just going to get worse. But what we found with COVID is that it doesn't get worse for everyone equally; it gets worse for communities that are already struggling with health inequities. We know that's going to be the case with climate change too. It's not going to be equal. Sometimes we like to say, oh, everybody's going to suffer, and it's true. But some people and some communities are going to suffer so much more.

People are going to lose access to health services in a storm, or there's going to be more cyclones and extreme weather events. That's one thing, but it's actually the heat and some of the less visible killers that are going to be the main drivers, I think.

The public health community has to be part of the conversation, because the climate crisis is only going to be dealt with politically if governments deal with it. And to a large extent, the folks who are trying to negotiate that part are ministries of environment and energy.

The health sector is at the table sometimes, but not enough. My hope is to try and bridge that with work that we do, with work that the WHO does with other communities. One way that has worked is getting doctors and nurses as spokespeople, and personal narratives work. So when doctors talk about a child they have seen who has asthma that is triggered continuously because of wildfires — some of the personal stories have been quite powerful narratives.

There's opportunities to show governments the costs that they could save by investing in making some climate decisions now because they're going to save it later from, for example, their healthcare bills. Many wealthy countries spend a lot on healthcare, and if their emergency rooms are going to go beyond capacity, if you could prevent some of that—public health is all about prevention.

There are economic cases that can be made, but ultimately I'm hopeful that the health message will resonate from a dignity perspective, and that it will be a political perspective. I've seen a lot of success working with young people who can connect the dots across different agendas, who understand that health is important, and for many of them, mental health is one of the elements that they've been raising.

**Ashley Hopkinson: I spoke to a young person from the WHO Youth Council, and I was so inspired. She was very focused, very passionate, very driven. I wonder if you could tell me a story of impact that you've seen, about something that has worked. Do you have an example of a project or an initiative that you felt excited about?**

**Natalia Linou:** There's a lot of work that I could highlight, and what I find most exciting is when working directly with impacted communities. So at the FXB Center for Health & Human Rights at Harvard, a lot of the work that was happening with Roma communities was quite exciting and interesting. Allowing people to define wellbeing: What does it mean? Does it mean being able to live free from discrimination in your daily life? Does it mean being able to have choices? And I bring that up because it links to the human development approach of UNDP, and a lot of the approaches of the health team of UNDP have been putting people who have lived experience at the center. At UNDP, a lot of our work on HIV involves LGBTQIA communities that are at risk or are criminalized, and therefore at risk of being put in situations where health harms are escalated.

But those stories are hard to capture in terms of impact because it's really about process. It's around who's at the table. How do you elevate voices?

A lot of the more tangible work that UNDP does is thinking about health systems. What does a resilient low-carbon health system look like? And in places like Zimbabwe, UNDP has invested in solarizing

health facilities, recognizing that we have a dual challenge. In many parts of the world, people still do not have access to energy. There are hospitals or clinics in rural communities where women are giving birth by candlelight. So really thinking about how we can expand access to energy and therefore access to healthcare and education. How can we do that in a way that leapfrogs dirty fuel, so that we're not using diesel and polluting the environment, [and instead] using solar? How can we do that in a way that thinks about local employment and gender equality and rights? There have been some really successful initiatives of solarizing health clinics that UNDP has been involved with, [including] in Zimbabwe. In Yemen they did it in a way where local women were trained to do the upkeep.

What is the outcome we want? We want access to energy, access to health. Then this has to be done in a way that is clean, that thinks about local benefits, so that it's not an external vendor coming in to set up and upkeep the solar panels, but local community members are learning. Those are examples where wellbeing is at the focus, because it's not one outcome. Wellbeing is holistic. It is health, education, livelihoods, clean environment, all in one. Now, to some extent, those [initiatives] are still small. We're talking about a clinic or a few clinics. But I think that is the model by which we can move towards what it means to have sustainable development, which is the term that UNDP uses. Is there a way to ensure that the benefits of a green transition are felt by everyone, local communities, young people, women, indigenous communities? I think people are thinking really creatively, and the modality of who's at the table has changed—so, civil society groups being at the table along with government and international partners. So I'm hopeful that wellbeing is a new frame.

**Ashley Hopkinson: It's hard to keep people with lived experience at the center when you try to do massive projects. You can lose your center.**

**Natalia Linou:** Exactly. Actually, in Zimbabwe, it did expand, and I think the majority of the health clinics are now solarized. So in some countries it has gone to scale. And it is a challenge to go to scale in a way that continues to reflect the community preferences and really be beneficial to everyone.

You probably have come across the Kingdom of Bhutan's happiness [index]. And there are other ways that people are starting to say, how do we evaluate ourselves? How do we compare our countries? Going beyond GDP and that whole agenda. The health community has a lot to say to that. Fundamentally we say that health inequities are unfair. They're purely unfair, unjust. We should all be able to live in similar health, then wellbeing and going beyond GDP could be measured by how well people are able to live. There's also been a shift within the health community from just measuring years of life to quality of life, living pain-free. You don't want to live 20 years [without] good health. How many years of good health do you have?

**Ashley Hopkinson: What has doing this work taught you about collective wellbeing? What are some lessons or takeaways that you might have?**

**Natalia Linou:** Let me start with a kind of downer, which is that this isn't easy. It's not automatic. People still often think about progress as zero-sum. They think that to get ahead, someone else has to fall behind. This concept of collective wellbeing and solidarity, that we can have a different model, that everyone benefits, I think goes against how people are taught to think about [resources]. In fact, we do have limited resources. We have one planet. We have limited water. So there is something to be said about limited resources, and yet we're not really thinking about collective wellbeing the way we should be.

My one lesson is that it's going to be difficult because of the inequities that are already ingrained, especially between the global north and the global south in terms of consumption. The consumption levels of an average American versus anyone else in the world is ridiculous.

Even if all cars became electric cars, we still would have probably more cars than we need. So the conversation really needs to shift, not between moving from gasoline powered cars to electric cars, but to public transportation, to changing our footprint. In order to really think about collective wellbeing, you're going to have to have some radical changes in the global north, where people have gotten used to a very comfortable life. There's nothing easy about it, because we're used to a certain lifestyle that has to shift.

So that's one. The second is [inequities] within countries. In the United States, there's still so much racism. In other countries there's so much grouping that happens based on religion or tribe, whether we're talking about the Roma in Europe or other communities across the world, certain groups have benefited historically, and that's about power. And that power usually maps to political power. So it'll be difficult to do something about these deep inequities without challenging political power.

**Ashley Hopkinson: In the absence of structures to support this work, how do we measure if we're moving toward better wellbeing? What will be the new markers of progress?**

**Natalia Linou:** One of the collective measures that is valuable to think about is trust—trust in institutions and in each other. That's harder to measure, but I think these are important metrics. There has been a real loss of trust in institutions, which I think drives people to be more individualistic: I have to get things done for myself and for my family.

For collective wellbeing, we need to have a collective mentality. And if we believe in the way that government is organized, then it's believing in our public institutions, our education system. How do we rebuild trust and feelings of community in order to get there?

On the environmental front, there's a real mistrust, especially among young people, that our generation can get anything done. I honestly have heard young people say it's too late. So we're falling into a bit of fatalism. That's a challenge that we need to be honest with. And maybe they're right. But mistrust from the young generation that there is really a future to hope for is a really big one.

I think we need to be honest that there has been political pushback. There's more polarization in many countries [where there had been] progress, whether we're talking about women's rights, LGBTQ rights, or even environmental protections. We have seen regressions. So this assumption that progress is linear is not true. We go back and forth. And there has been backlash around some progress.

I started off saying that I'd be a little pessimistic, and I am pretty pessimistic, but I'm in this work because I'm fundamentally an optimist. You can't stay in this work if you don't believe that there is a solution. So while I recognize that the world has disappointed so many people, and we are so behind on even the UN sustainable development goals, I still have some hope in this idea of collective wellbeing.

Some of the hope stems from the young people that you talk to. They inspire me, too. And some hope lies in science. I do have hope for science and people working across institutions and academia. Some hope in political leaders that I have seen in recent years in some countries, especially seeing more women, more people of color, more indigenous leaders. So there's a little bit of hope, but I don't know. I have some hope from the funders who are giving a little bit more flexible money, that it's not so narrowly focused, because I do think funders shift the development agenda in a way that suits their interests or their academic curiosity; I have some concerns about that.

**Ashley Hopkinson: Let's say the support is there, you have the funding, it's flexible, and you have the people. As a social epidemiologist, what would you like to see grow and expand and change? What would that look like?**

**Natalia Linou:** It depends on the context and the country. I do think that public transportation is something that we have completely underinvested in as a society. So that's my silver bullet that really isn't a silver bullet. But whether we're talking about New York City or Boston or Addis Ababa or Athens, Greece, where I grew up, really investing in public transportation across the world could be a solution, and rethinking urban planning in a way that is climate smart, but also allows people to get to jobs.

I'm going to share with you a technological solution and then one that is more philosophical—connected to the concept of time… In UNDP, there were some really interesting studies many years ago around women's time— feminist economics that showed that women would go to work, then come home and have to cook, clean, take care [of the family] and basically had zero time for themselves. So there's clearly a gender dimension. Time also comes up with public transportation, if you're commuting for two hours. So the question of how we use our time is really important.

**Ashley Hopkinson: I've spoken to people in the care economy, and [time] has come up around all the unpaid labor that women tend to take on.**

**Natalia Linou:** The care economy piece is critical. Also from the climate and environment perspective, in many low income countries where women are still collecting wood or water. We know that the climate crisis is increasing their time burden because of having to walk further or things like that.

I grew up in Athens, Greece. There's sadly a big fire raging in Athens right now. So that's top of my mind, but also Lebanon. And I spent a lot of time in Syria, and I've traveled to Palestine and Yemen. It's difficult to prioritize environmental wellbeing in moments of such political distress.

That's another dimension.

**Ashley Hopkinson: How do you prioritize health and human rights and collective wellbeing in a world where everything feels urgent?**

**Natalia Linou:** I think it's tailoring my language. Fundamentally, people's wellbeing is the language. I don't think we should be saying the word "health." I think we should be saying "dignity." We should be focusing on human dignity, human wellbeing, and encapsulating all of it. Because you really can't live in dignity if you don't have health or education or a job that is at least not demeaning or exploitative, if you don't have your basic human rights.

So I've been quite drawn to UNDP because of this human development lens and also this holistic lens. A lot of health professionals are like, I do asthma, I do cancer, I do HIV.

But if you look across the board, it's the same people at the population level dying of asthma or cancer or TB or premature mortality. In any country, you will find, it's a certain group of people, and it's usually discrimination. Discrimination is at the heart of it, and it's discrimination that is implicit, explicit, in the law.

I've always said, I care about inequality in our world, and that's why I'm drawn to this idea of communal wellbeing as well as metrics. And really it's metrics of inequality that will show us that things are getting better for everyone, and faster for those who have been left behind historically.

We need to be focused not only on everybody's health improving, but on those who have been left behind historically catching up, whether that is Roma populations in Greece or indigenous communities in New Zealand. We know it's the same.

And health is useful because it's a metric. We have the data, we know who is living and dying, and inequality is literally written on people's bodies. And the focus for me of environment and climate change right now is because I am terrified that it'll take us in completely the opposite direction, that there's all this talk around moving toward health equity, but the climate crisis is going to be so extreme that it's going to trump every effort we have made so far to narrow the gap on HIV treatment or asthma or under five mortality.

We focus so biomedically to close the gap that we've missed the big risk, which is the climate crisis. So that's why I have focused on that. But fundamentally, my goal has always stood the same: to say that people need to live in dignity. And dignity requires a focus on equality and equity, and thinking about it both at the global level between countries, but importantly within countries, too.

**Ashley Hopkinson: Thank you, Natalia.**

*Ashley Hopkinson is an award-winning journalist, newsroom entrepreneur and leader dedicated to excellent storytelling and mission-driven media. She currently manages the Solutions Insights Lab, an initiative of the Solutions Journalism Network. She is based in New Orleans, Louisiana.*

** This conversation has been edited and condensed.*