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A Formative Assessment of Disability Inclusion in Public Health Pedagogy and Practice

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

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Although inclusion of disability in the learning environment has shown significant benefits for both disabled and non-disabled students (Capp, 2017), current evidence suggests that disabled students face significant barriers to inclusion in the classroom environment (Lindsay et al., 2018). Furthermore, only 14.3% of Master of Public Health (MPH) programs offer courses focused on disability as compared to the 84% of disability-centered courses offered by the same schools in non-MPH graduate programs (Akakpo et al., 2020). Finally, little research focused specifically on graduate and professional students with disabilities currently exists. This special studies project sought first to understand the current state of disability inclusion at the Rollins School of Public Health and then to identify community-centered, evidence-based recommendations for change using a mixed-methods design which included surveys for students (N=57) and faculty and staff (N=40), key informant interviews with RSPH faculty, staff and leadership (N=5), and focus group discussions with disabled students (N=8). Low response rate and small sample size on quantitative measures limited further statistical analysis. Rapid qualitative analysis was used to identify themes, codes and subcodes related to disability and inclusion. Notable qualitative findings from this research include newly identified barriers for graduate students seeking accommodations, the role of “non-mandatory culture” in disability inclusion efforts, and community-driven, evidence-supported recommendations for future improvement. Recommendations include: increased institutional support for faculty and students; formal support networks for disabled students; and community-building professional development for all RSPH community members.

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Chapter 1: Introduction

Rationale

The concept for this thesis developed out of the lived experiences of the author and a number of other graduate students with disabilities enrolled in the Rollins School of Public Health (RSPH). After identifying anecdotally that the current policies, curricula, and culture at RSPH seemed to have important gaps regarding disability, assessing the current state of disability inclusion at RSPH and developing evidence-based, community-centered recommendations for improvement were identified as a suitable and relevant special studies project.

Problem Statement

At present, students in colleges, universities, and other institutions of higher education do not qualify for the same disability-related rights and degree of academic access as students in the primary and secondary education system, whose academic rights and access are protected by federal legislature such as the Individuals with Disabilities Education Act (IDEA) and Every Student Succeeds Act (ESSA) (Office of Special Education and Rehabilitation Services (OSERS), 2021). With respect to disabled students in tertiary education, the majority of the evidence base is centered on undergraduate students; much less research exists regarding the lived experiences, barriers and facilitators to successful education for graduate and professional students with disabilities (Snyder et al., 2019; Grimes et al., 2019; Lindsey et al., 2018; Smith et al., 2019). Although many institutions of higher learning have shifted to prioritizing diversity, equity and inclusion (DEI) activities to better serve their students, disability is often a secondary or tertiary priority of DEI, or not included at all (Brown, 2021). Only 11.9% of graduate students in 2016 identified as having one or more disabilities, a sharp decline from the 19.4% of undergraduate students with disabilities, which likely indicates that graduate students with disabilities face additional or different barriers to accessing academia (Snyder et al., 2019). At present, however, very little has been written exploring the intersections of disability and the increased academic expectations and external pressures unique to graduate and professional students. Even less evidence exists concerning effective methods of improving the academic experiences of graduate and professional students with disabilities.

Purpose

The purpose of this special studies project is twofold: first, to explore the current state of disability inclusion at RSPH through a formative needs assessment; and second, to establish a list of recommendations that RSPH could implement to improve disability inclusion in the future. As discussed further below (see Chapter 2, Literature Review), increased inclusion of disability in curricula, culture and academic policies is beneficial not only for students with disabilities but for currently-abled students as well (Capp, 2017).

Research Question

The central questions this research seeks to answer are thus:

1. How does RSPH understand and operationalize disability and disability inclusion in its organizational policies, pedagogy, curricula, and culture?
2. What interventions could be implemented that can minimize harm and improve disability inclusion at RSPH?

Significance

Given that one of the four goals in the RSPH Goals Statement is to “sustain an inclusive, diverse academic community that fosters excellence in instruction, research, and public health practice” (RPSH, 2022, n.p.), the results and recommendations from this special studies project could be used to better achieve this goal. In addition to potential improvements to the learning environment that will support disabled students’ academic and personal success, this project could also have further effects on public health practice through the increased inclusion in the RSPH curricula of disability issues in the context of public health.

Definition of Terms

A more thorough discussion of terms and definitions can be found in Chapter 2, Literature Review. This section includes brief definitions for relevant terms and concepts used throughout this manuscript.

Community Based Participatory Action Research (CBPAR): Participatory research practices and methods which include and center the contributions and opinions of the community being studied during one, multiple, or all stages of research, from planning to data collection to analysis

Disability: “[dis]functioning at one or more of these [..] levels: impairments, activity limitations, and participation restrictions” (WHO, 2002, p 10) The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment” (ADA, 2010).

Diversity: As defined in Emory University’s Institutional Statement on Diversity, diversity “is understood broadly to mean race, ethnicity, gender, disability, national origin, age, health status, religion, sexual orientation, gender identity, gender expression, socio-economic standing, immigration status, family background, neurodiversity, intersectional identities, and the broad representations of human existence” (Intercultural Education Advisory Group, 2020)

Equity: As defined in Emory University’s Institutional Statement on Diversity, equity is “the guarantee of fair treatment, access, opportunity, and advancement for all students, faculty & staff, while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups” (Intercultural Education Advisory Group, 2020).

Inclusion: As defined in Emory University’s Institutional Statement on Diversity, “inclusion is the active, intentional and ongoing engagement with the principles of diversity—in our scholarship, our curriculum, co-curriculum, business operations, and infrastructure” (Intercultural Education Advisory Group, 2020).

Intersectionality: As defined by Kimberle Crenshaw, intersectionality is “a lens through which you can see where power comes and collides, where it interlocks and intersects” (Crenshaw, 2017, n.p.); it seeks to understand the intersections of power and oppression within an individual or group’s lived experiences.

Pedagogy: The theories and methods for learning used by instructors; often incorporates the psychosocial factors that can impact learners’ understanding of material (hooks, 1994)

A Note on Language

As with many marginalized communities, the vocabulary and language of disability is ever-changing and subject to scrutiny both internally among the disability community and externally among the academic community studying disability. Language has been weaponized against people with disabilities in both casual and institutional contexts. Additionally, the disabled community, like all other social identity groups, is not a monolith. While there are terms and phrases that have been explicitly identified as harmful or inappropriate by large swaths of the community, there is no consensus on what one term *is* "best" or most appropriate, although using person-first language is often identified as a best practice for service providers (WHO, 2002).

Person-first language centers the person rather than their condition or ability—for example, "a person who uses a wheelchair" uses person-first language, but the phrases "she's wheelchair-bound" or "he's a cr*pple" do not. Initially, person-first language was advocated as a way to increase empathy from able-bodied people and replace often-harmful slang terms that stripped people of their humanity with more accurate language that does not assign a status or diagnosis to people with diverse bodies or minds (Nielsen, 2012). While some people with disabilities prefer person-first language, others have expressed their discontent with person-first language, suggesting that currently-abled people should not need such reminders to see disabled people as human (McRuer, 2006). Additionally, the term "people with disabilities" is often shortened to PWD, an acronym that can further distance scholars from the humanity of disabled people—especially when surrounded by other jargon and acronyms that often create dense academic writing, inaccessible for many of the people who could benefit from the results of that research (Piepzna-Samarasinha, 2018).

Language surrounding disability has evolved over time as well, as labels and diagnoses once deemed appropriate in legal and medical settings have become slurs and, in some cases, been reclaimed by members of the community. Critically examining the ways in which we use language is essential for qualitative research, especially in the context of academic institutions which so often other and exoticize those on the margins (Lorde, 2007). The information in this document seeks to be as accurate and rigorous as possible, but not at the expense of causing harm to disabled individuals and communities.

With all this important context in mind, the author has chosen a few different approaches to including, editing and censoring potentially harmful language. The general guidelines are listed below.

1) Ableist and outdated terminology may be included in direct quotes from historical sources for the express purpose of exploring cultural and historical context. If inclusion of harmful language is not necessary for understanding of context, it may be censored.
2) To accurately reflect the experiences of disabled people, direct quotes about their own lived experiences which use “politically incorrect” or medically inaccurate terms or language will not be edited or removed.
3) Harmful language unrelated to disability (including racialized language and slurs) in direct quotes will be censored but not removed.
4) In the writing of this document, the author will use the terms identified by a majority of community members as the most appropriate for use by non-group members.(For example, labelling Autistic people as “low-“ or “high-functioning” is still considered acceptable by many medical professionals; Autistic people often reject this binary as both ableist and inaccurate. This document will not use those labels.)
5) To center people with disabilities, this document will use the terms “students/people with disabilities” and “disabled people/students” somewhat interchangeably but will avoid use of the “PWD” acronym. This document will also center people with disabilities by using the term “currently abled” rather than terms that other and pathologize disability like “able-bodied” or “normal” to describe those who do not currently have a disability.

Positionality Statement

In the interest of both clarifying expectations and disclosure of personal biases, the author finds it necessary to disclose her relationship to disability as well as other identities that may affect the subjective truths outlined in this document. The author identifies as a white bisexual Southern disabled cis woman; she has both cognitive disabilities and a genetic condition that causes chronic pain, fatigue, and other physical limitations.

Chapter 2: Literature Review

Defining Disability

Defining disability is notoriously challenging, both in modern times and throughout history. Some limit definitions of disability to only those who have been diagnosed with a specific condition by a medical professional; this definition excludes those whose disabilities have nothing to do with an illness, including people with limb differences obtained through physical trauma. Others might define disability as the inability to work, although many disabled people are an active part of most workforces. Some theorists exclude chronic illnesses like diabetes or psychological conditions, also known as mental illnesses (Piepzna-Samarasinha, 2018). Historically, disability has been a contextually defined state of being, often tied to concepts of community involvement and ability to labor (Nielsen, 2012). Especially in the United States, a certain degree of difference in the function or form of the mind or body was accepted as within the continuum of "able-bodied;" as long as someone could participate in some form of work within the community, their number of limbs, ways of moving, or ability to hear were historically considered within the range of "normal."

The most common models of disability are the medical and social models. The medical model focuses on the diagnosis and medicalization of physical and mental difference, with most of the emphasis placed on explicitly identifying the "problem" and then treating that problem with medication, surgical intervention, or other methods (Marks, 1997). This model focuses its attention on allowing people with disabilities to "blend in" and keep up with *normates*, as Rosemarie Garland-Thomson calls currently-abled people (Garland-Thomson, 2017). The social model, on the other end of the spectrum, defines disability as a social status, suggesting that the societal barriers created by ableist systems are the only barrier to people with disabilities' full participation in society (Marks, 1997). This model was revolutionary in its argument that our societies and systems, rather than actual people with disabilities, must change, but it is commonly critiqued as a theory which invalidates the actual lived experiences of people with disabilities—needing a personal care assistant's help to use the bathroom *is* a limitation, and no amount of positive thinking or activism can "fix" a person with quadriplegia (McRuer, 2006).

In 2002, the World Health Organization (WHO) introduced the "International Classification of Functioning, Disability and Health" (ICF), which focuses on disability not as the absence or lack of "good health" but as a measure of one's ability to function in their bodies, personal lives, and society. To gain a full understanding of an individual's functioning in biological, personal, and social contexts, this biopsychosocial approach integrates *impairments*, problems in function or structure of a body part; *activity limitations*, difficulties a person has in completing certain activities; and *participation restrictions*, limitations on one's ability to participate in their community or society (WHO, 2002). The interaction of contextual factors, which include personal and ecological factors, is central to this definition. *Ecological factors* are those aspects of a person's environment that affect their disability, like social attitudes toward disability, inaccessibility within the built environment, and legal and governmental structures; while *personal factors* are internal, influence the experience of disability for that individual, and can include gender, family environment, coping skills and strategies, and profession (WHO, 2002).

The United Nations' Convention on the Rights of Persons with Disabilities (CRPD) uses the term "persons with disabilities," defined as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others," (CRPD, 2006, Article 1). Previous international human rights policy often used language that was paternalistic or relied on comparisons to a mythical "normal," but, as demonstrated by the above quote, current human rights policy has shifted to a human rights focused understanding of disability.

In the United States, disability has always been a category used to exclude those who do not fit within social, civic and economic norms. Early American law established "the legal and ideological delineation of those who embodied ableness and thus full citizenship, as apart from those whose bodies and minds were considered deficient and defective" (Nielsen, 2012, p. 50). Women seeking education and the right to vote, immigrants seeking a safe harbor from persecution, and enslaved African people seeking basic human rights and freedoms have all been declared disabled at various points in American history by medical, legal, and social systems as a means of discrediting and excluding so-called undesirables from participating fully in society (McRuer, 2002; Schwiek, 2009).

The modern disability rights movement, a cogent, cross-ability collective of people with disabilities and their allies, was born in the United States during the massive push for civil rights in the 1960s and 1970s and began at and around the University of California, Berkeley campus (Nielsen, 2012). The movement utilized community organizing and coalitions with other civil rights groups like the Black Panthers to form an interconnected network of d/Deaf[1] and hard-of-hearing (HOH) people, wheelchair users with conditions like polio, muscular dystrophy and quadriplegia, blind people, and others whose bodies demonstrated the true diversity of the human body and mind (Nielsen, 2012). Their tireless activism forced the signing of Section 504 of the Rehabilitation Act of 1973, advocated for improved rights for children and adults with disabilities, and continues to protect and improve the lives of people with disabilities. Over the past few decades, the term "disability rights" has become the umbrella term for the various groups and social movements who have been advocating for disabled people's rights.

Disability justice, a newer movement which developed in the early 2000s in response to the disability rights movement, argues that "all bodies are caught in the bindings of ability, race, class, gender, sexual orientation, sexuality, citizenship. We are powerful not despite the complexities of our identities, but because of them. Only universal collective access can lead to universal, collective liberation," (Sins Invalid, 2019, p14). Disability justice core principles include cross-disability and cross-movement solidarity, intersectionality, and collective access and liberation; disability justice has moved away from the rights-based framework of the disability rights movement, which is not applicable for all people in all situations (Sins Invalid, 2019). It does not seek to invalidate the disability rights framework, but to improve upon it by offering an alternate perspective which centers Black and brown sick and disabled queer people in its leadership and activism.

While a complete discussion of the numerous, nebulous definitions of disability is beyond the scope of this special studies project, the working definition of disability that will be used here is the ICF's, which includes "dysfunctioning at one or more of these [..] levels: impairments, activity limitations, and participation restrictions" (WHO, 2002 p 10). This definition

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[1] The term "d/Deaf" is used to refer to people who both have a condition which causes deafness (lowercase "d" deaf) and people who are culturally Deaf. Deaf culture developed in part due to exclusion by hearing people and has become a thriving sub-culture which celebrates signed languages and shared cultural values and experiences (Richardson, 2014).

incorporates the biopsychosocial model without depending explicitly on comparisons to a mythical “normal,” and its inclusive nature holds space for those people whose disabilities may not be included in other, more specific definitions, like those with chronic illnesses or mental health conditions.

Domestic and International Human Rights Policies Relevant to Students with Disabilities

People with disabilities have historically faced significant challenges to their inclusion in the social, cultural, political, and economic spheres, and although a patchwork of international human rights and domestic policies have improved the situation somewhat, disabled people still face extreme barriers to full realization of their human rights. Although all people are technically granted the right to education under Article 26 of the 1948 Universal Declaration of Human Rights, people with disabilities continue to be excluded from educational opportunities and attainment worldwide (UDHR, 1948). People with disabilities are more likely to live in low- and middle-income countries, whose existing governmental and civil infrastructure for supporting disabled people are less robust and who may have fewer laws and policies regulating the rights of disabled people or less ability to enforce the policies they do have (AUCD, 2016). Those who live in higher-income countries are often still at the mercy of domestic policies which, when implemented, can create higher barriers to educational access and attainment.

International human rights policy identifying people with disabilities as a vulnerable population began with the 1975 Declaration on the Rights of Disabled Persons; this declaration defined the basic human rights that should be afforded to people with disabilities, but much of its language became outdated in the ensuing decades of disability rights advocacy (United Nations, 1975). In 2006, the Convention on the Rights of Persons with Disabilities outlined a more complete and inclusive declaration of the human rights of people with disabilities, signed by 164 UN member states including the United States (CRPD, 2006). Article 24 of the CRPD enshrines people with disabilities’ right to education that is accessible, inclusive, and of high quality at primary, secondary and tertiary levels, as well as the protection of reasonable accommodations for students with disabilities. A 2016 general comment on the right to inclusive education went further, explaining that states party to the CRPD should include people with disabilities in all stages and levels of academic planning, implementation, monitoring and evaluation, and stating that “persons with disabilities…must be recognized as *partners* and not merely recipients of education” (CRPD, 2016, emphasis added).

In the United States, students with disabilities have faced significant barriers to realizing their right to education. While one piece of federal legislation allocating funds to support blind students has existed since 1879, most other children with disabilities did not have consistent, nationwide access to education, and what access did exist was not protected by law or federal funding (OSERS, 2021). The disability rights activism of the 1960s and 70s did lead to several notable pieces of federal legislation protecting the rights of students with disabilities and allocating funding for specialized institutions like Gallaudet, a university that focuses on educating d/Deaf students, as well as the 1979 creation of the Office of Special Education & Rehabilitation Services (OSERS, 2021).

The 1975 Education for All Handicapped Children Act (EHA) reported that more than a million American children with disabilities were excluded entirely from the educational system, and significantly higher numbers of students with disabilities whose educational needs were not being met in their current setting; this federal legislation allocated increased funding for students with disabilities and established Individualized Education Plans (IEPs) for all students with disabilities in primary and secondary education, to be created with the input of educational faculty and staff, the student themselves and their parent(s) or caretaker(s) (OSERS, 2021). Although the EHA helped millions of American students, there have been unforeseen negative consequences for students with and without disabilities. Students identified as disabled were often separated from their currently-abled peers into “special ed” classrooms, where many did not have equal access to higher-level concepts, classes or social learning opportunities (National Council on Disability, 2018). Currently-abled students were impacted indirectly, as inclusive classrooms have been linked to improved academic achievement and understanding for all students, improved societal beliefs and norms around disability inclusion, and development of increased empathy, problem-solving and other important life skills (National Council on Disability, 2018). The ADA, passed in 1990 did not notably impact educational access for students with disabilities in primary and secondary school systems. Title II of the ADA does require that all government funded and publicly accessible institutions—including institutions of higher education—ensure and protect full and equal access for people with disabilities, a vitally important policy change for students in post-secondary education who had previously not been guaranteed reasonable accommodations in the classroom (ADA, 2010).

In 1986, the EHA underwent significant changes to become the Individuals with Disabilities in Education Act (IDEA), which was revised multiple times before the most recent amendment in 2015, the Every Student Succeeds Act (ESSA). IDEA and ESSA regulate education policies for disabled students in primary and secondary schools (National Council on Disability, 2018). While Section 504 of the Rehabilitation Act of 1973 and Title II of the ADA do define some protections and reasonable accommodations for students with disabilities in college and beyond, the IDEA and the ESSA are not applicable to students in collegiate and university settings because higher education is not required in the United States; this phenomenon often has significant effects on the support systems and services that many students with disabilities can rely on to obtain equal access in higher education (OSERS, 2021).

Disability in Public Health Ethics, Pedagogy, and Practice

Disabled people are, as a whole, more likely to engage with public health professionals than their currently-abled counterparts, especially in the context of global public health. The UN estimates that more than one billion people—approximately 15% of the global population—live with some form of disability, and a disproportionate number of disabled people live in low- and middle-income countries (LMICs) (WHO, 2020). Poverty and disability are closely associated, likely due to environmental and social determinants of health, and people with disabilities are disproportionately affected by natural disasters, climate change, and pandemics (Kett et al., 2009; WHO, 2020), as the Coronavirus Disease 2019 (COVID-19) pandemic has clearly demonstrated .

Public health has largely viewed disability from the medical perspective, as acute health emergencies to be solved or unique cases to be handled by specialist clinicians. Such a limited view of disability, coupled with concerns about theoretical cost and inconvenience, has caused disability to become a secondary issue in both international development and global public health; global and community public health and human rights policy regarding disability “is often discussed by experts who have ‘solutions,’ but who are not themselves disabled and rarely work directly with persons with disabilities,” (Kett et al., 2009). Exclusion of disabled people from decisions that affect their own physical or mental health is in direct opposition to the ethical standards and theoretical underpinnings of public health and the core values of the disability rights movement, and yet the opinions and lived experiences of people with disabilities are rarely considered in public health policy decisions or even taught in graduate level public health courses.

The American Public Health Association (APHA)'s Code of Ethics has several core values and action guidance recommendations related to promoting and protecting human diversity, including disability, in public health practice and education (APHA, 2019). The core values of *health justice and equity* and *inclusion and engagement* explicitly identify marginalized communities, including people with disabilities, as central foci for the work done by public health practitioners and educators. Partnership and input from community members and stakeholders about programs and projects involving those communities is identified as a central tenet in all domains of the APHA's action guidance recommendations, from assessment to evaluation and administration. Specific guidelines of relevance include: domain 4.4, "Engage with the community to identify and address health problems"; domain 4.8, which focuses on establishing a competent public health workforce through comprehensive educational and practice requirements; and recommendations 4.11.6-8, which promote strong ethical integrity and standards of conduct for public health professionals (APHA, 2019). Each of these recommendations reminds public health professionals to educate themselves about populations they are working with, ask for—*and actually incorporate*—the perspective of community members in programming, planning and evaluation, and be aware of their own positionality through reflexivity and ethical consideration.

Community Based Participatory Research, Intersectionality, and Positionality

As the result of forced isolation, lack of educational access, and power differentials related to social capital, academic research about disability is often performed by currently-abled people with minimal contact with disability in their own lives (O'Toole, 2017). This emotional and mental distance between the research*er* and the research*ed* exists in direct opposition to the oft-repeated mantra of American, South African, and global disability rights activists beginning in the 1990s, "nothing about us without us" (Charlton, 2000). Furthermore, such separation between the community and the researcher goes against principles of community-based participatory action research (CBPAR), as discussed further below.

Reflexivity is, in its simplest form, intentional self-awareness done in the research process; in more practical terms, reflexivity asks the researcher to “recogniz[e] how we actively construct our knowledge,” an especially essential skill to use when conducting quantitative and qualitative research (Finlay, 2002). Understanding our intersectional identities and positionality as researchers helps us to question our research practices and findings, recognize the power differentials that may exist between academic researcher and community and what effect this may have on the research process, and increase the quality of the knowledge gained from research.

Public health as a discipline has warmed to community-focused, participatory research methods as a valid research methodology in recent decades. CBPAR methods are those which include and center the contributions and opinions of the community being studied during one, multiple, or all stages of research, from planning to data collection to analysis (Jason & Glenwick, 2016). CBPAR’s roots lie in the works of Paulo Friere and Augusto Boal, among many other theorists, and place equal value on all the different ways of knowing; CBPAR encourages the education not of individuals but of the community together through sharing knowledge and skills (Jason & Glenwick, 2016). CBPAR is especially valuable as a method in underserved and marginalized communities, as collaborative research is seen as more beneficial and less exploitative from the community perspective. Marginalized people’s unique expertise and historical and scientific knowledge has been brushed off as myth or storytelling for centuries, especially when their ways of knowing do not fit Western standards, so the opportunity to share one’s own opinions, skills and experiences as the expert on their own lives is a new one for many (Nagata et al., 2012).

Intersectionality can be an essential framework for use with any vulnerable population. A concept first defined by Kimberle Crenshaw in an exploration of the unique experiences of Black women as compared to both White women and Black men, intersectionality argues that each of us holds numerous identities, both self-chosen and assigned, and that these identities overlap and intersect in ways that affect how each of us accesses and uses power and privilege (Crenshaw, 1989). Intersectionality as a framework allows us to explore the differences between individuals from a novel perspective, one which does not assume that all individuals experience the same events the same way; this is especially important given the mounting body of research suggesting that our identities have notable and direct impacts on our behaviors, our experiences, and even our physical and mental health, as demonstrated by the impact of phenomena like racial weathering on health disparities (Forde et al., 2018).

The cross-identity nature of disability makes an intersectional lens especially necessary, as beautifully stated by disability scholar Michael Berube: “disability (in its mutability, its potential invisibility, its potential relation to temporality, and its sheer variety) is a particularly elusive element to introduce into any conjectural analysis, not because it is so distinct from sexuality, class, race, gender, and age but because it is always already so completely intertwined with everything else” (Berube, 2007). Intersectionality also centers those traditionally on the margins, with the expectation that when those who are most oppressed are free of the structural and personal harm directed at them, everyone will be free, a value central to disability justice activism (Piepzna-Samarasinha, 2018).

International public health organizations and human rights bodies have identified a pressing need for intersectional approaches to investigating, identifying, and addressing human rights violations and public health events, as one-size-fits-all approaches have proven ineffective at best and actively harmful at worst (UNFPA, 2018). Additionally, the tendency in international human rights policy to define specific groups whose human rights are more vulnerable (as in the numerous conventions on the rights of women, children, people with disabilities, and racial minorities) has led to inequal and inconsistent response to and messaging about intersectionality in human rights responses and interventions (de Beco, 2020). When working with marginalized or othered groups like people with disabilities, an intersectional approach to research is necessary, as these populations have historically been subject to incomplete, inaccurate, and unethical research practices which can further strip their communities of their knowledge, resources, and collective efficacy (Shaw et al., 2020).

An essential aspect of intersectionality, especially in qualitative research, is an understanding of the researcher’s positionality. The use of “researcher as instrument” in qualitative research allows for an understanding within the research context that the ways that researchers ask questions, structure theories, and collect and analyze data are all affected by the positionality of the researcher (Hennink et al., 2011). Intersectionality scholars have argued that "what makes an analysis intersectional…is its adoption of an intersectional way of thinking about the problem of sameness and difference and its relation to power," (Cho et al., 2013, p 795). Further, being known as a member of the community that a researcher studies can increase that researcher's access to invaluable information, while researchers whose identities offer them significantly more access to power than the vulnerable populations they study can negatively affect not only the value of information gained but the people who provide information (Shaw et al., 2020).

Within existing research, people with disabilities are underrepresented in research about their own lives, with researchers often looking to caretakers, parents, home healthcare workers, and others for information, consent and opinions instead of to disabled people themselves (Hahn & Beaulaurier, 2001). Additionally, disability scholars have noted that separation of academic scholars from community scholars—those who may not have a degree, but who have a lifetime of experience with disability—should be taken as a warning sign that academic scholarship is no longer attuned to the needs, problems, strengths, or lived experiences of disabled people (O'Toole, 2017). Actively focusing on intersectional analysis helps to minimize potential harm and maximize potential gain, especially for a population that is seldom actually listened to by the very professionals who seek to help them (Shaw et al., 2020; Hahn & Beaulaurier, 2001). The reviewed literature also shows that the same can be said for CBPAR and Positionality approaches to disability research.

Disability, Stigma, and DEI in Higher Education

Stigma is often directly tied to social and cultural attitudes, knowledge and behaviors about disability. The extended history of disability in the United States is one of forced isolation—those whose disabilities were significant or obvious enough were (and still are) isolated into asylums, jails, and long-term care facilities or, if financially possible, hidden from public view in the home, while those whose disabilities were harder to explain, invisible, or unvalidated by medical professionals and peers were isolated by the silence of keeping their disability to themselves (Nielsen, 2012). Many of the challenges of disability—poverty, inadequate healthcare, social isolation, and ableist violence, among innumerable others—are not inherently caused by disability, but rather by the response to disability from other individuals and society at large (McRuer, 2006; Hahn & Beaulaurier, 2001). Although ableism has been identified as a systemic form of violence much like racism and sexism, it has not successfully been incorporated into many current DEI efforts outside of those accommodations and requirements established by federal policy (Wolbring & Lillywhite, 2021)

The successes of disability rights activism have led to much more "mainstreaming" of disabled people, especially in the context of education, as students with disabilities and their supporters have clamored for students to be in, as the federal policy states, "the least restrictive possible [educational] environment," which is for most students the general classroom (National Council on Disability, 2018). This push for mainstreaming has provided enormous and significant benefit for the academic lives of many students with disabilities, but such efforts can be harmful as well; the social stigma of disability dissuades the majority of postsecondary students with disabilities from accessing disability accommodations (Lindsay et al., 2018). Students whose disabilities are more stigmatized (like psychiatric disabilities) less likely to request and use accommodations, more anxious about disclosing their disability, and less likely to successfully complete their studies than students with less-stigmatized disabilities (Kupferman, 2014).

As a result, students whose disabilities are invisible are often doubly marginalized, as even DEI activities that do include disability often focus solely on those whose disability is in some way visible to others (Garcia et al., 2020). Many DEI programs and policies, including Emory's policy, identify the protected identities outlined in federal Equal Employment Opportunity (EEO) laws, which protect workers from discrimination based on "race, color, religion, sex (including pregnancy, transgender status, and sexual orientation), national origin, age (40 or older), disability, or genetic information," as central facets of human diversity and central to DEI work (US Equal Employment Opportunity Commission, 2022). EEO policies serve to ensure that everyone has equal access to opportunities in the workplace, but in the context of institutions of higher education, these protections can be implicitly or explicitly extended to students (Blumsztajn, 2020).

This lack of disability in DEI work at colleges and universities is especially concerning given that the history of the disability rights movement in the United States is inextricably linked to—

and would not have developed the same way without—post-secondary institutions. The Independent Living movement, one of the most well-known and successful subsets of the disability rights movement, can directly trace its inception to the friendship and later activism of several wheelchair users all placed in the same “dorm” at University of California, Berkeley: the campus infirmary (Nielsen, 2012). Although the push for inclusion in higher education that began with the diverse human rights movements in the 1960s has always theoretically included disability in DEI work, current trends in DEI suggest a false equivalence between antiracism and DEI—that is to say, many institutions are so focused on incorporating antiracist values and policies into their DEI work that they neglect other aspects of diversity, like disability (Garcia et al., 2020; Brown, 2021). In fact, one qualitative study found that many higher education administrators do not include disability as a component of student diversity (Aquino, 2020).

Disability in Post-Secondary Classrooms and Curricula

Less than six percent of National Institutes of Health staff self-identify as having a disability, and about half of those who have disabilities are over 65, indicating that young people with disabilities are significantly underrepresented in all science fields, from medicine to public health to engineering (NSF & NCSES, 2021). People with disabilities are disproportionately impacted by many public health emergencies and challenges, and yet public health students rarely get exposure to disability content even in higher-level graduate programs. Out of seventy Masters of Public Health (MPH) programs surveyed in 2019, only ten offered at least one course focused on disability, an especially disheartening rate when compared to the percentage of non-MPH graduate programs at those same schools with courses focused on disability—a whopping *84 percent* (Akakpo et al., 2020). Other disciplines, from social work and psychology to nursing and medicine, have all identified people with disabilities as a social group with unique experiences, support needs, and risk factors, a population worthy of dedicated study because of the diversity within and among it (NASW, 2022; Smeltzer et al., 2015).

In 2016, the Association of University Centers on Disabilities released a set of 4 disability competencies intended for inclusion in master of public health (MPH) programs in conjunction with several governmental bodies and the Centers for Disease Control and Prevention (CDC) ; these competencies require that students learn to: (1) discuss models of disability over the lifespan; (2) discuss assessment methods used with people with disabilities; (3) identify the impact of public health activities on disabled people's health outcomes; and (4) implement and evaluate strategies to increase people with disabilities' participation in preventative, health promotion, and health management programs (AUCD et al., 2016). Although these competencies map closely and can be used in conjunction with all governing bodies' codes of ethics, core competencies, and essential curricula, they have not been officially incorporated into any required competencies and thusly have not been adopted by most MPH programs.

Though public health has been slow to explicitly define people with disabilities as a vulnerable population, there are some indicators that public health education and practice are beginning to incorporate disability content. Nearly 65% of MPH programs have considered adding disability content into their curricula, and researchers suggested that faculty, staff and members of leadership show a degree of awareness of and engagement with disability-related issues that may be higher than previous data would suggest (Akakpo et al., 2020). Additionally, the COVID-19 pandemic has created a unique space in the public sphere for disability rights, as the ethics of rationed medical care, the social and health effects of "long COVID," and equitable educational access for students with disabilities during remote learning have all been discussed at length within and outside of public health education and practice (Twardzik et al., 2021).

Chapter 3: Methodology

It was determined that in order to adequately understand the current state of disability inclusion at RSPH, it was necessary to explore the perspectives of three distinct groups of stakeholders: (1) public health students with disabilities, who can speak directly to their own experiences and suggest changes based on their unique expertise; (2) faculty members, who play a vital role in establishing classroom culture and have direct interactions with students with disabilities; and (3) Master of Public Health program leadership and administrative staff, who respectively have direct influence on institutional policies and individual interpersonal interactions with students.

Given the formative research character of this study, it required both a deep understanding of the issue at hand, for which qualitative methods are more suitable, and comprehensive knowledge of the larger context, the latter of which is often more easily measured quantitatively. Therefore, this research employed a mixed-methods approach, utilizing surveys (quantitative instruments) for students and faculty/staff as well as in-depth interviews and focus group discussions (FGD) (qualitative techniques) for student participants.

Study Population and Sample

Participants were recruited for quantitative surveys through convenience sampling; links to surveys were shared though emails from RSPH stakeholders sent via list-serv, as well as digital advertising in appropriate newsletters (including the Graduate Student Government Association's Gradzette) and on the Accommodate database portal used for students with disabilities (See Appendix A for contents of recruitment materials). Survey data were collected anonymously from RSPH students, faculty and staff who voluntarily consented to participate in these surveys. Participants who consented to possible contact for future qualitative research were associated with their survey responses using a separate survey to ensure anonymity of survey data. An incentive for study participation was offered in the form of entry into a raffle for one of two e-gift cards worth $25.

Key informants were identified based upon their role or position within the school of public health using the parameters discussed above. First, leadership informants whose professional roles at RSPH were directly related to the dimensions of interest, including administrators responsible for potential policy change, were identified through formative research on current RSPH policies, procedures, organizations, and mechanisms of decision-making, as well as an informal version of snowball sampling in which the researcher identified members of leadership who would be best suited to speak on the topics and areas of interest as defined by the researcher. A total of three key informants were identified in this manner, although one was unable to participate in the research process.

Second, faculty and staff who could serve as key informants were identified through the quantitative data collection process and purposively sampled based on depth of potential information as well as their social identities and positionality. Once identified, these faculty and staff members were recruited via email; three key informants were recruited, thusly for a total of five key informant interviews. The only non-leadership administrative staff member interviewed did not have a directly student-facing role, but their inclusion was deemed important because their role at Emory had direct impact on students' functioning and well-being.

Students with disabilities who consented to contact for future qualitative research were purposively sampled for focus group discussions based on responses to the quantitative survey; FGD participants were selected based on their positionality in addition to the depth of data suggested by their survey responses in order to intentionally examine the intersectionality of disability inclusion as it relates to other social identity factors. This method of purposive sampling used for faculty members and students reduces potential researcher confirmation bias in qualitative sampling while still allowing for selection of participants who are likely to provide increased depth and quality of information (Moser & Korstjens, 2018).

Quantitative Research Design

Quantitative data is useful for several different research purposes, from demographic information that can be used to stratify participants by sub-group membership and analyze within data to survey measures that can, with relatively high accuracy, measure complex concepts. Using existing and validated quantitative measures to assess inclusion generally across the larger community of RSPH enabled not just a more accurate, representational understanding of disability within the program but also facilitated less biased sampling in later qualitative data collection. Further, the results of the quantitative research were used to inform questions asked in key informant interviews and focus group discussions.

All faculty and staff completed the same basic demographic data in the survey. The first disability-related question assessed general functioning broadly, while the second question explicitly asked if participants had a disability or other chronic health condition. The use of these two questions in conjunction allowed segmentation based both on the actual reduction of function associated with disability and the presence or absence of a disability identity. In addition to this demographic data, all surveyed faculty and staff completed a version of the Attitudes Toward Teaching All Students scale (ATTAS-mm) which was modified for this study to better represent the academic environment in post-secondary education (Gregory & Noto, 2012).

A separate survey was created for use with student participants. Student participants were asked to complete a set of questions gathering demographic data, including their primary department within RSPH. In addition, they completed the Washington Group Short Set on Functioning – Enhanced (WP-SS) scale and a question regarding disability identity to evaluate their disability status and identity. Finally, this survey also asked student participants to complete a version of the Student Perceptions of Classroom Support scale (SPCS) which was modified to more accurately represent their academic environment. For further description of the instruments used, see below.

Qualitative Design

Qualitative approaches to research offer a different form of pertinent data than quantitative approaches, with much greater focus on depth of information and gaining a more nuanced and complete understanding of a specific phenomenon from the perspective of the people who are experiencing the phenomenon. Qualitative research allows for exploration of root causes for specific health issues, “intangible” or hard-to-measure phenomena like personal satisfaction, and public health issues that are more complex or harder to access with quantitative methods like criminalized drug use (Guest, Namey & Mitchell, 2017). In formative needs assessments, qualitative approaches allow community members to directly and clearly explain their priorities, needs, and those solutions that may be amenable and culturally sensitive in their own words (Altschuld & Kumar, 2009). Formative needs assessments often include qualitative data from stakeholders within the community as well as key informants who hold important positions or can affect change in the community to gain a deeper and more nuanced understanding of the diverse needs of all people involved in a system being assessed (Altschuld & Kumar, 2009).

The amount of qualitative data needed for research depends largely on the intended purpose; grounded theory work may require individual interviews and FGDs with hundreds of distinct participants to fully encapsulate a theory, whereas case studies may only require a handful of qualitative interviews in conjunction with the existing body of research (Guest, Namey & Mitchell, 2017; Hennink et al., 2019). In order to gain what can be considered a complete understanding of a qualitative research concept, it is necessary to fully understand both the breadth of different topics associated with the central focus of the research (code saturation) and what those different topics mean to participants (meaning saturation) (Hennink et al., 2017). Hennink and colleagues have reported that although the vast majority of codes (84% for FGDs) were present within the first few instances of data collection, reaching meaning saturation was not possible until after a minimum of eight individual interviews or six focus group discussions (Hennink et al., 2019; Hennink et al., 2017).

Formative needs assessments, however, serve a slightly different purpose than observational or cohort research or grounded theory, and as such, their goal is not based in achieving the same level of meaning saturation. Formative needs assessments are focused on identifying and exploring the basic needs of a population, as well as areas for future exploration with further qualitative and quantitative research (Altschuld & Kumar, 2009).

For this formative needs assessment, two qualitative techniques were identified for use: (a) key informant interviews, which were used with RSPH faculty, leadership, and administrative staff who had lived experience and/or expertise deemed relevant; and (b) focus group discussions, employed to elicit information from disabled students.

Interviews with key informants have been shown to be a time- and labor-effective method of gaining significant insight into the cultures, policies, and social and behavioral norms of systems, communities, and institutions (Bernstein et al., 2019; Altschuld & Kumar, 2009). After consulting the evidence base, including theory and prior research on disability in higher education, the author created three interview guides, which were later combined into the master key informant interview guide available in Appendix B. Semi-structured key informant interviews performed for this research focused on exploring and understanding four of the central aspects of the RSPH system through the perspectives of leadership, faculty and staff: (1) barriers and facilitators to disability inclusion for faculty and staff, with a focus on support and education opportunities related to disability; (2) development, design and approval of RSPH curricula and content relating to disability; (3) classroom, RSPH, and Emory policy development and implementation as it relates to disability; and (4) the relationship between DEI practices and disability at RSPH (see Appendix B for key informant interview guide). These focus areas were identified as central aspects of disability inclusion at the interpersonal, community, and institutional levels of the Socio-Ecological Model. Participants for the key informant interviews were identified based on the role(s) they fulfill in the organization and those roles' relationship to the dimensions of interest.

FDGs are an especially effective qualitative technique to gain large amounts of information from a group with shared characteristics—in this case, public health graduate students with disabilities—especially when evaluating programs, exploring shared experiences, and identifying community-centered solutions to issues (Moser & Korstjens, 2018). Focus group discussion activities can generate data regarding group understanding and norms related to a topic, common responses to situations, and potential solutions for group-identified problems (Altschuld & Kumar, 2009). The FGD guide for this special studies project was created by the author in a method similar to that used for the key informant interview guide, using theory and the existing evidence base. This guide incorporated an activity which required the creation of a problem tree by participants. Since the focus group discussions were the last data to be collected, the focus group discussion guide also incorporated iterative themes and concepts discovered during the research process from the survey results and key informant interviews. The complete guide and visual aids used can be found in Appendix C. Given the relatively large pool of existing research on barriers and facilitators to accessibility and inclusion in postsecondary institutions, the focus group discussions included in this special studies project sought to narrow focus to those barriers and facilitators that are particularly salient or unique to our population, as well as explore potential solutions for common or especially noteworthy areas of disability exclusion and/or inaccessibility.

Data Collection Procedures

Quantitative Procedures

All surveys were administered digitally through the SurveyMonkey platform. Quantitative data collection for faculty and staff began the second week of December, 2021 and formally ended in mid-January 2022, allowing 40 days for participants to respond. The quantitative survey for students opened in early January 2022 and closed in mid-February, allowing 35 days for participants' responses. To ensure participants' anonymity, the survey did not record or store participants' names or IP addresses. Participants' responses were securely stored on the SurveyMonkey cloud and protected by a password until March 2022, when the final copies of the data were transferred to the author's personal, password-protected computer. Once the final data was securely stored, it was deleted from the SurveyMonkey cloud.

Quantitative participants were recruited through convenience sampling, utilizing pre-existing email listservs and both written and visual recruitment materials (see Appendix A). A raffle for one of two $25 Amazon e-gift cards served as an incentive. After completing the main survey, participants who were interested in participating in further qualitative research were redirected to a separate survey hosted on Google Forms to share their contact information. Participants linked their survey responses with their contact information using a four-digit number that they chose, thus further protecting participants' anonymity. Using a secondary survey was determined to be the best choice for qualitative recruitment, since even if the security of the main survey data had been threatened, participants' anonymity would be protected using this method.

Qualitative Procedures

To effectively assess and explore the need for disability inclusion at RSPH, the author conducted five in-depth interviews with key informants and two FGDs with students with disabilities.

Qualitative data collection began in mid-January 2022 and ended the first week of March 2022. All key informant interviews were scheduled to last an hour and were conducted via Zoom platform due to scheduling challenges and ongoing health risks associated with the COVID-19 pandemic. The full text of the master key informant interview guide is available in Appendix B. Two FGDs were held with a total of eight student participants, all of whom were identified through the survey process and recruited via email.

In order to accommodate focus group participants who were uncomfortable with in-person contact as a result of their disability and/or the COVID-19 pandemic, both focus groups were held virtually, using the Zoom platform. Each focus group discussion lasted approximately 90 minutes; see Appendix C for FGD guide and description of activities. Audio recordings of these interviews and of the focus group discussions were initially transcribed by an external artificial intelligence transcription service, Otter.ai, and then manually checked against the audio file for accuracy and completeness.

All key informants were sent a de-identified copy of the transcript of their interview and were asked to approve the transcript before this special studies project was published. Student focus group participants were sent the final copy of this report and the executive summary but were not asked to approve the focus group transcripts due to the fact that their potential risks were lower than those of key informants and the reporting strategies selected by the author for this special studies project were deemed to be sufficient to protect participants' anonymity. After transcripts were approved by key informant participants and the focus group transcripts were checked against the audio recording three times by the author for accuracy, all audio recordings were destroyed in accordance with existing data security and management protocols.

Instruments Design

Faculty and Staff Survey:

Attitudes Toward Teaching All Students (ATTAS-mm) Scale

In order to gain increased understanding of faculty and staff knowledge, behaviors and attitudes about disability inclusion, both faculty and staff participants were asked to complete part (leadership and administrative staff) or all (faculty) of an adapted Attitudes Toward Teaching All Students scale (ATTAS-mm), a nine-item measure designed to assess the three critical educator attitudes discussed in depth above: cognitive, behavioral and affective attitudes toward disability inclusion (Gregory & Noto, 2012; see Appendix D). The author sought and gained consent from the scale's author to use a modified version of this scale for this special studies project. Staff participants, who often engage with students exclusively outside of the classroom setting, were asked to complete a version of the scale which did not include items Q7 or Q8, both of which refer to training about inclusive methods of classroom instruction. The ATTAS-mm reports a Cronbach's alpha of α=0.833, indicating strong internal validity (Gregory & Noto, 2012). Additionally, the wording of item two was edited to remove reference to "special education" classrooms, as such support services as separate courses for disabled students are largely unavailable in postsecondary education and are not utilized in this academic program.

The ATTAS-mm provides insight into faculty and staff's comfort with disability conceptually, their attitudes towards disability in academic settings, and their level of confidence in working with students with disabilities. This information can help to identify areas where intervention may be particularly effective, as well as potential barriers and facilitators to disability inclusion for faculty and staff.

Student Survey:

WP-SS Enhanced

In addition to providing basic demographic data, all student participants were asked to complete the Washington Group Short Set on Functioning Enhanced (WP-SS Enhanced), a twelve-question measure of personal function across eight domains of disability (Washington Group on Disability Statistics (WGDS, 2020b)(see Appendix E). The WP-SS Enhanced has been validated for use in screening for disability with all adults and designed for use in conjunction with other disability-related survey measures (WGDS, 2020a).

This measure was intentionally designed to minimize disability-related stigma, has been approved for international use by the United Nations and other relevant human rights and public health bodies, and has demonstrated strong validity and reliability regardless of cultural differences in disability identity. It enables segmented analysis by area(s) of functioning affected and minimizes the impacts of social desirability bias and disability stigma on measuring disability prevalence accurately (Washington Group on Disability Statistics, 2020a). A question on self-identification was added to further explore potential differences in understanding based on disability identity (or lack thereof).

Student Perceptions of Classroom Support (SPCS) Scale

Very few measures assessing opinions, attitudes and behaviors relating to disability inclusion in education have been designed for use with students with disabilities; and of those that do exist, most are designed for children and adolescents under the age of 18 (O'Rourke & Houghton, 2006). This is an unfortunately common gap in all data about people with disabilities, as most assessment measures related to disability focus on the experiences of health or supportive care workers, family members, or caretakers rather than the experiences of the disabled people themselves (Hahn & Belt, 2004). Developing and administering assessments that are inclusive of and accurate for children and adults with disabilities—or retrofitting existing assessments for accessibility—can be challenging or expensive, and as a result many surveys and statistical analyses simply exclude people with disabilities as outliers or ineligible for participation based on their disabilities (Hahn & Beaulaurier, 2001; O'Rourke & Houghton, 2014).

The Student Perceptions of Classroom Support scale (SPCS), a scale appropriate for use with students 12-19 years old, assesses students' perspectives on the impact of accommodations on their academic and social outcomes (O'Rourke & Houghton, 2006). This scale has reported extremely strong internal and external validity for both outcomes, with $\alpha=0.92$ for academic outcomes and $\alpha=0.87$ for social outcomes, significantly outperforming the $\alpha>0.6$ standard for survey validity, and has been specifically designed for disability accessibility, with visual and auditory alternatives to the traditional numbered Likert-type scale (O'Rourke & Houghton, 2014). The author sought and gained consent from the scale's author to use a modified version of this scale for this special studies project. An abridged version of this scale was administered to this project’s student participants as a generalizable indicator of preferred inclusive educational practices (see Appendix F).

Although this scale was initially developed for use in adolescents ages 12-19, its simple and clear language is largely appropriate for graduate students. With minor edits to reflect differences in secondary and postsecondary educational policies and practices, the SPCS scale was included in the student survey created for this project, as it was deemed most appropriate for use in this setting by the author. It was expected that SPCS measures would allow this study to better understand what students want or need in classrooms and identify recommendations that directly impact those needs and wants, in addition to provide data from which to sample qualitative research participants.

The scale was adapted to this study by changing some of its terms as to reflect current U.S. standards for reasonable accommodations in postsecondary education. Also, due to the increased availability of screen-reading software and other technological accessibility tools, as well as the limitations of the survey software used in this study (Survey Monkey), a visual representation of the scale was not included.

Quantitative Analysis

The initial sample sizes suggested for the quantitative arm of this special studies project aimed for 20 faculty participants, 30 staff participants, and 80 student participants . Planned quantitative analysis methods for the expected quantitative sample included the use of Welch t-tests to assess the existence and significance of potential differences, both those between faculty and staff participants and those differences between currently-abled and disabled students (West, 2021). Additionally, quantitative analysis was also expected to include basic statistics including mean, median, and mode. Due to limitations discussed in further detail in the Results below, a complete quantitative analysis was deemed inappropriate after data collection ended due to the low participant numbers.

Qualitative Analysis

Rapid qualitative analysis (RQA) was deemed the most appropriate method for analyzing the qualitative data collected for this research due to time constraints and the limited scope defined for this project (Nevedal et al., 2021). Before data analysis began, the author created a list of deductive codes based on existing theory and evidence from the academic literature. Interviewer notes were also used to identify deductive codes. After two rounds of editing, a codebook was finalized. The table included in Appendix G defines each code, as well as inclusion and exclusion criteria where relevant. In general terms, information that did not specifically relate to participants' perspectives on disability and DEI *in public health pedagogy and practice* was excluded from coding, even if that information was associated with participants' personal lived experiences. Qualitative data was included in the analysis process if it directly or indirectly related to disability or any other aspect of DEI.

Once checked for accuracy against the audio recording and anonymized by the author, all key informant interview and FGD transcripts were summarized using a Rapid Analysis Summary form (see Appendix H for a sample of the form). In order to increase scientific rigor, all transcripts were summarized and coded twice, once by the interviewer/author and once by a currently-abled coder unrelated to the project. The summary forms were then compared by the author to assess inter-coder reliability, which was high. (Due to the nature of RQA and time constraints, it was not possible to quantitatively evaluate inter-coder reliability at the time of writing.) The summary forms were then used alongside the codebook to code and collate responses. Once coded, the author described the results as presented in Chapter 4.

Ethical Considerations

Since this project was created as a formative assessment of a program and is not meant to be generalized to the larger population, Emory Institutional Research Board (IRB) approval for the study was waived. Ethical risks to survey participants were minimal, given that the survey software did not record the IP addresses or other personally identifiable information. Participants who chose to opt into possible further qualitative research were redirected to a separate survey to gather their contact information, thus minimizing any risk of unwanted identification by survey-only participants.

The ethical considerations for the qualitative arm of this special studies project, however, were significant, especially given the potential risks to key informant and student participants. Since for faculty and leadership and administrative staff key informants, there were higher risks associated with sharing their experiences and opinions of their workplace, it was deemed necessary that the results of this research be presented with minimal identifying information. Thus, the results presented in Chapter 4 include purposefully vague descriptors for participants, including identifying them only as “faculty members,” “staff members” or “members of leadership”, etc. While this does limit discussion of personal factors that may affect participants’ views and experiences, protecting the anonymity of participants was prioritized.

Student participants faced different but equally salient potential risks, including potential social consequences if identified by others and potential emotional or mental distress associated with discussing disability and discrimination. Before facilitating any focus group, the author collated a list of disability-friendly support resources, both on- and off-campus to be provided to any students who experienced emotional or mental distress. Student participants were encouraged to reach out to the facilitator or notetaker of the focus group via direct private message on Zoom to express experiencing distress during the focus group discussion, get direct peer support, and or find out how to get connected with previously identified resources.

Students’ specific conditions are not discussed or disclosed in this report, although more broad terms like “chronic health conditions” or “physical disability” may be used when absolutely necessary for the context of a quote or anecdote. Finally, students’ initials have been changed to protect their anonymity while allowing for some method of identification within the context of this report. While these protections also limit some nuance in results and discussion, the anonymity and physical and emotional safety of participants was approached in this project as central to ethically conducted and presented research.

Chapter 4: Results

Quantitative Results

Although survey responses are summarized below, it was deemed inappropriate to run a complete statistical analysis on data from the two surveys (faculty and staff survey and the student survey). This decision was made largely due to the limited sample size of available responses and the associated increased potential for false conclusions of statistical meaning based on statistical results. As a result, the quantitative results presented in chapter 4 are exclusively descriptive in nature.

Faculty and Staff Survey Results

11 faculty and 29 staff members completed the faculty and staff survey for a total N=40. Demographic data for faculty and staff is summarized below in Figure 4.1.

Figure 4.1: Faculty and Staff Demographic Data

Demographics	**Category**	**Respondents**	**Percent**
Gender Identity	Female	39	79.59
	Male	9	18.37
	Non-Binary	1	2.04
Age	20-29	12	24.49
	30-39	9	18.37
	40-49	11	22.45
	50-59	8	16.33
	60-69	6	12.24
	70-79	2	4.08
	80+	1	2.04
Ethnic or Racial Identity	African-American or Black	7	14.29
	East Asian	1	2.04
	Hispanic/Latinx	3	6.12

	South Asian	4	8.16
	Southeast Asian	3	6.12
	White	33	67.35
	Mixed Race	1	2.04
Functional Limitations	Everyday Activities	6	12.24
	Communicating or Socializing	5	10.2
	Any other activity	3	6.12
	No difficulty	38	77.55
	Prefer not to Answer	1	2.04
Disability Identity	Yes	22	44.9
	No	26	53.06
	Prefer not to answer	1	2.04
Primary Employment Status	Faculty	11	22.45
	Staff	30	61.22
	Other/None	8	16.33

Faculty and staff answered slightly different versions of the ATTAS-mm scale, designed to measure attitudes toward inclusion. Results are summarized in a graph in Appendix I. Faculty generally reported a higher degree of complete agreement with all survey questions than staff participants, although this difference may be due to the small sample size of faculty compared to staff. Nearly all respondents (10/11 faculty and 27/29 staff, 90.9% and 93.1% respectively) completely agreed that they want others to perceive them as creating a welcoming and inclusive environment for students with disabilities.

Generally, staff were more likely to somewhat agree than to completely agree with the statements included in the modified ATTAS-mm. 90.9% (N=10) of faculty completely agreed that disabled students can be trusted with classroom responsibilities; while only 48.3% (N=14) of staff completely agreed with the same statement, 31% of staff *somewhat* agreed with the statement bringing total staff agreement with this statement to 79.3%. Faculty also reported higher complete agreement with the statement that disabled students can be effectively educated in regular classrooms—63.6% of faculty completely agreed, while only 20.7% of staff completely agreed (N=6). This finding is, however, relatively deceptive—when factoring in those staff members who somewhat agreed with the above statement (N=17), 79% of staff supported disabled students' presence in regular classrooms.

Although 63.6% of faculty (N=7) and 20.7% of staff (N=6) completely agreed that students with disabilities should be educated in regular classrooms, only 18.2% of faculty (N=2) and 10.3% of staff (N=3) completely agreed with the next statement, that disabled students should be educated in regular classrooms "because they will not take up too much of the teacher's time." Even when including participants who somewhat agreed with this latter statement, only 63.6% of faculty (N=7) and 41.4% of staff (N=12) agreed, a notable difference from the 90.9% of faculty (N=10) and 79.3% of staff (N=23) who agreed with the initial statement that students with disabilities can be effectively educated in regular classrooms.

Another nuance discovered in the results of this survey is related to training opportunities for faculty related to pedagogy. While 72.7% of faculty (N=8) completely agreed that they would be interested in learning about pedagogy from fellow faculty members who are well-trained in disability inclusion, only 4 of the 11 (36.4%) of participants completely agreed that they would be interested in differentiated instruction, a pedagogical method which seeks to include students of all skill levels in the classroom environment.

Student Survey Results

Demographic characteristics of student respondents are summarized below in Table 4.2. 63 students responded to the survey, although 6 did not complete the survey and were therefore removed from the sample, for a total sample size of (N=57).

Figure 4.2: Student Demographic Data

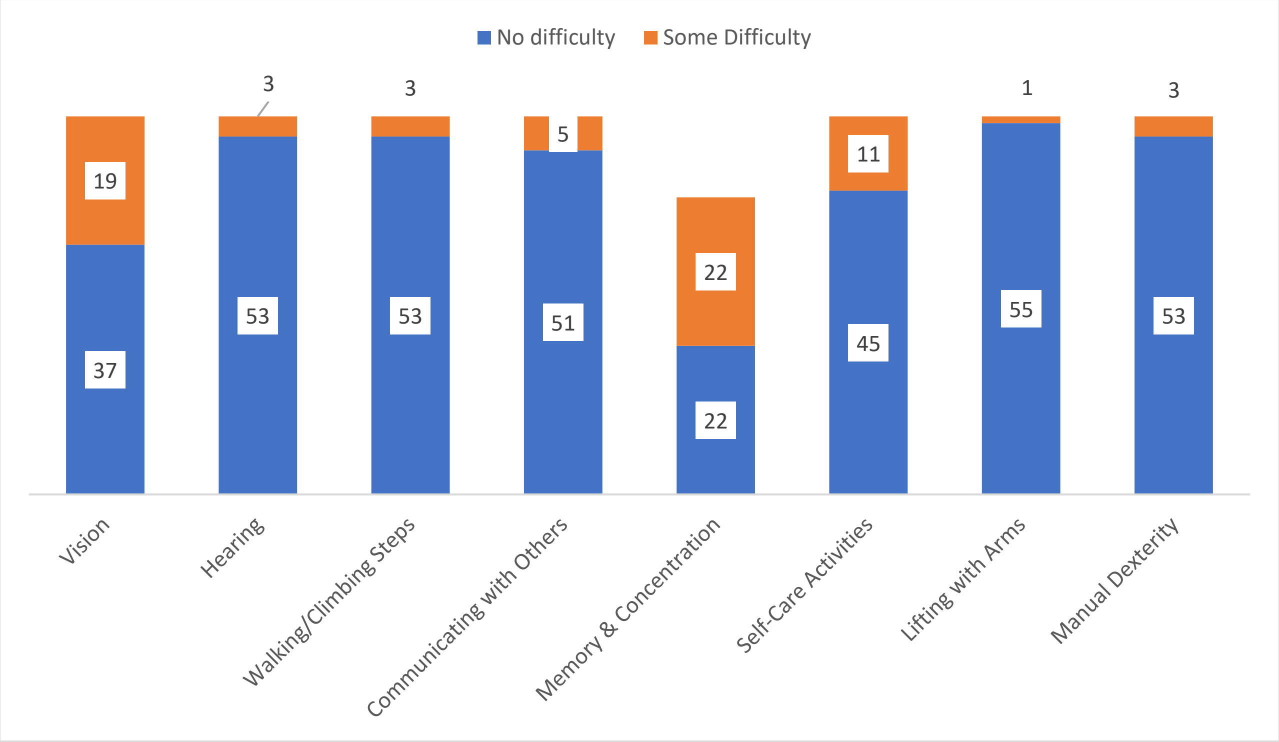
Demographics	Category	Respondents	Percentage
Gender	Female	53	88.33
	Male	2	3.33
	Non-Binary	5	8.33

Age	20-24	29	48.33
	25-29	23	38.33
	30-34	6	10
	35-39	2	3.33
Ethnic or Racial Identity	African-American or Black	11	18.33
	East Asian	6	10
	Hispanic/Latinx	4	6.67
	South Asian	3	5
	Southeast Asian	3	5
	White	36	60
Academic Background	Humanities	3	5
	Social Sciences	18	30
	Natural Sciences	13	21.67
	Formal Sciences	2	3.33
	Applied Sciences	34	56.67
Disability Identity	Yes	13	25.49
	No	29	56.86
	I'm not sure	9	17.65

Student responses to the WP-SS, which assesses disability as it relates to functional limitations, are summarized below in Figure 4.3. Also included in the WP-SS Extended there were four additional questions, designed to measure how often respondents experience anxiety and depression and how intense those feelings of anxiety and depression are. 47 of the 56 student respondents—*85.7% of all student responses*—reported feeling anxious daily or weekly. Students reported their level of anxiety as relatively high; only 8 students (14.04%) reported that their feelings of anxiety were low-intensity, while almost half (49.12%) reported moderate anxiety and 36.84% reported high anxiety. Only 16 of the 56 participants (28.07%) reported feeling depressed daily or weekly, although only 10.53% reported never feeling depressed. Almost 60% of students (N=34) reported feeling depressed monthly or a few times a year.

Nearly half (47.37%) of participants reported that their depression was moderate, while 22.81% reported less severe depression and 19.30% reported more severe feelings of depression.

Figure 4.3: Student Responses to WP-SS Extended



The results of the Student Perceptions of Classroom Support scale were overall mixed, demonstrating the personal nature of preferred accommodations for students. A complete summary of results is available in Appendix J. The following are the results which were identified as notable (defined as those scale items which 36 or more students said would be "Some Help" or "A Lot of Help"). The cutoff for notable results was identified by determining the point at which a majority of participants (about two-thirds [67%]) agreed that a specified accommodation would be useful for them. The two-thirds cutoff was selected rather than a 50% cut-off point in order to identify those accommodations that would be beneficial for a notable majority of student participants.

Teaching Assistants and Classroom Environment

73.2% (N=41) of participants reported that having a Teaching Assistant (TA) in the classroom would be helpful, with 48.21% (N=27) reporting that having a TA is very helpful. Almost half of respondents (48.21%, N=27) suggested that other students following classroom rules (like masking, no internet browsing during class) was very helpful to their learning; another 17.86% reported this as somewhat helpful. Similarly, 26 respondents (46.43%) suggested that a quiet classroom is very helpful for their learning and 28.57% (N=16) suggested it would be somewhat helpful.

Use of Group Projects

Support for group projects was high, with 32.14% (N=18) suggesting that group projects are somewhat helpful and 39.29% (N=22) suggesting that they are very helpful. 75% (N=42) of participants reported that working with another student who is knowledgeable in the subject is somewhat or very helpful.

Explicit Communication of Course Expectations

Almost 90% (N=50) of participants suggested that coursework and assignments being explained clearly would be helpful, with 67.86% (N=38) reporting such explanations as very helpful. More than 80% (N=45) reported that their instructor telling them exactly what to work or study would be some help (25%, N=14) or very helpful (55.36%, N=31). More than 80% of participants reported that an instructor telling them exactly what to study or learn would be very helpful, with nearly 65% (N=36) reporting that it would be very helpful.

Instructors' Role in the Learning Environment and Relational Dynamics

92.85% (N=52) reported that both an instructor's friendliness and positivity and interesting or enjoyable subject matter were helpful or very helpful in the classroom, with 82.14% (N=46) reporting that instructor attitude is very helpful and 83.93% (N=47) reporting that engaging subject matter is very helpful. Additionally, nearly 86% (85.71%, N=48) of respondents suggested that being taught by an instructor they knew and liked would be somewhat or very helpful, with 62.5% (N=35) reporting such circumstances as very helpful.

Qualitative Results

As part of the qualitative research, a total of 5 key informant interviews were conducted with two faculty members, two members of leadership, and one administrative staff member whose work was largely separate from student interactions but has significant impact of disabled students' experiences at RSPH; limited additional information on key informants is available in Figure 4.4. In order to protect the confidentiality of participants and prevent potential social or economic harm as a result of participation, the titles or exact roles and responsibilities of any key informant are not specified in this report, and some demographic information is only be shared in aggregate. See *Ethical Considerations* in Chapter 3: Methodology for more information.

3 of the 5 key informants identified as women and 2 identified as men; four identified as white and one as Black. The primary departments in which key informants teach courses included Behavioral & Social Health Education Sciences (BSHES), Biostatistics (BIOS), Global Health. Administrative staff and leadership staff represented the Information Technology (IT) department, Student Affairs, and Academic Affairs.

Figure 4.4: Demographic Data Key Informants

Key Informant	*Years Employed by Emory**	*Recruitment Strategy*
Faculty (1)	10+	Survey
Faculty (2)	20+	Survey
Leadership Staff (1)	20+	Identified by Researcher
Leadership Staff (2)	10+	Identified by Researcher
Administrative Staff	5+	Survey

** = Rounded down to nearest 5 to protect participants' anonymity*

Two focus group discussions were conducted with students; one focus group included two students, one who identified as having a disability and one who did not, while the other focus group consisted of four self-identified disabled students and one student with a disabling condition who did not identify as a disabled student. Student participants were all recruited from the sample of survey participants who consented to contact for participation in the qualitative research phase. A summary of relevant data for focus group participants is available below in Figure 4.5, although some data will only be presented narratively in summary to protect the anonymity of participants.

Seven of the eight total student focus group participants identified as women; the other participant identified himself as male. One student participant identified as Asian American, 3 student participants identified themselves as Black or African-American, and the remaining four identified as white. All student participants reported having a condition that would classify as a disability according to ICF standards, although 2 of those students did not self-identify as having a disability or being disabled. The disabilities reported by student participants included learning disabilities, limb differences, chronic pain conditions, and autoimmune disorders, among others. One student was pregnant at the time of the focus group, mentioned here only because of the notable degree of similarity between her experiences as a pregnant person and others' experiences with physical disability and chronic pain.

Figure 4.5: Relevant Data on Student Focus Group Participants

Participant ID	*Age*	*Primary Department of Study*	*Student Status*	*Focus Group ID*
DD	32	Global Health (GH)	1st Year MPH	FGD1
EB	24	Behavioral & Social Health Education Sciences (BSHES)	1st Year MPH	FGD2
FN	29	GH	2nd Year MPH	FGD1
KO	24	GH	2nd Year MPH	FGD1
NJ	23	Epidemiology	1st Year MPH	FGD1
NY	33	Health Program Management	PhD Candidate	FGD1
TS	28	GH	2nd Year MPH	FGD2
YD	35	GH	2nd Year MPH	FGD1

The following are the themes, codes, and sub-codes identified in the qualitative results from both key informant interviews and FGDs. Two main themes were identified: (1) Public Health and Pedagogy, which includes three codes and subcodes exploring the role that disability plays, both in the pedagogy of public health education and in public health practice; and (2) Culture of Inclusion at RSPH, which includes a number of codes and subcodes related to the current state of inclusion at RSPH and recommendations for future improvements to the culture of inclusion.

Theme I: Public Health & Pedagogy

This dimension explored participants' perception of the role that disability currently plays in public health practice & pedagogy. Although there was a consensus among all participants that disability is an important concept for public health professionals to understand, participants' opinions were varied concerning the most effective methods of providing that understanding.

Within this theme, three codes and subcodes were identified: Curriculum Development, Tools and Guidelines, and Training. Understanding the process of curriculum development was essential to the process of identifying solutions. The tools and guidelines that faculty and staff use to develop curricula were of particular interest as a method of identifying potential resources for faculty and staff. Additionally, professional development and training opportunities related to disability and other aspects of diversity, equity and inclusion (DEI) were salient within this theme. For further discussion of how public health and pedagogy may be leveraged to improve the culture of inclusion, see Chapter 5: Discussion.

Code: Curriculum Development

This code explored the development, implementation and assessment of curricula and materials for RSPH courses. In addition to exploring where disability belongs in public health curricula and how faculty can best include disability in their curricula, this research sought to understand the curriculum development and approval process more broadly to effectively target those areas within the current process where it makes the most sense to incorporate disability inclusion in the future.

All student, faculty and staff participants agreed that disability should be included in the RSPH curriculum in some way, often suggesting that disability should be discussed in more topical classes like Complex Humanitarian Emergencies or Global Elimination of Maternal Mortality from Abortion (GEMMA) or as a social determinant of health in Behavioral, Social & Health Education Sciences (BSHES) courses. Of the four faculty and leadership participants who currently teach courses at RSPH, none mentioned discussing disability in their current course content; multiple participants suggested that this lack of discussion was because they teach courses that focus on methods and skills like statistics or programming rather than topics that focus on more social determinants of health.

Four of the eight student participants reported hearing any discussion of disability in any courses they had taken thus far; two had heard about disability in topical courses and two had discussed disability in methods-based courses. Generally, discussion of disability in the classroom was limited even when it happened; one student from the Epidemiology department reported that "[disability] does get mentioned [in a specific course], but usually in passing, like when we talk about study design or selection bias[…the professors have] emphasized that you have to kind of just do the work to get the correct data, but they haven't necessarily given tips on how to make things more accessible" (NJ, FGD1).

The one student who reported more in-depth discussion of disability in the classroom was from the BSHES department; in two of their classes, other students who were doing disability-related research had been invited by instructors to present information on how to design and conduct inclusive research and curricula for public health education. That student, EB, did, however, counter those stories with a point of contention: "BSHES is all about health campaigns. But there's so little attention on making them [Section] 508 compliant and accessible. But that's not really in the BSHES curriculum." Another student, NY, reported that in an Introduction to Health Policy course for which they served as a teaching assistant (TA), "I wanted to make sure that we really covered it [disability], especially in the Medicaid lessons, in terms of like, quality of health care for disabled individuals and that kind of thing, but mostly I had to sort of go off the roadmap for that because it was not really built into the curriculum."

Subcode: Tools and Guidelines

This subcode encompassed discussion of existing and suggested documents, checklists, or theoretical frameworks that educators can use to improve disability inclusion in their pedagogy. About half of faculty, staff and leadership participants reported being aware of extant tools and guidelines like Section 508 regulations, which establish guidelines to include visually impaired folks and the Universal Design for Learning guidelines, which were developed to help educators create and present content effectively to all learners; one student discussed Section 508 regulations (see above) and another student briefly mentioned using universal design. Students in both focus groups suggested offering accessibility checklists or accessibility handbooks as a low-barrier-to-entry resource for faculty and staff, as discussed further below (see: Faculty and Staff-Focused Suggestions). Both members of leadership interviewed for this project discussed the creation of a DEI-centered checklist which debuted to faculty and staff in March 2022; this checklist is discussed further below in “Faculty and Staff-Focused Suggestions”.

Code: Training

The Training code included all discussion of relevant training and other learning opportunities participants knew of or had participated in. These training modalities included self-paced online modules, formal training or professional development opportunities offered through RSPH or Emory, and external training and education opportunities. Although the focus of this project is on disability, training opportunities related to DEI more broadly were also included in this code, as educational opportunities related to one aspect of DEI can often be adapted to a different or more specific facet of human diversity.

All student participants reported a desire for faculty and staff to know more about disability, however they expressed varying levels of support for formalized or mandatory training requirements. One student, YD, commented that “It seems like there needs to be some sort of minimum basic training, like, when you have a student that comes to you, and they say, ‘I have a disability, I need accommodations,’ these are the steps that you take. I mean, it's going to be different for everybody and depend a lot on the individual accommodations, but there should be some sort of minimum,” while a student in the other focus group, EB, expressed skepticism regarding the efficacy and meaningful impact of required training: “there’s lots of different data about whether racism and diversity trainings are actually helpful [or] whether they’re just more of the parade. Although I will say that some of those things I’ve learned and taken away a lot [from diversity trainings], so maybe if it’s done right, training would be helpful.”

Leadership and faculty participants were overall resistant to the idea of mandatory training or professional development requirements. This causes of this resistance were reported to be a multitude of external factors, discussed in depth below in the “Barriers and Facilitators to Inclusion” code (particularly the “Contextual Factors,” “(Lack of) Institutional Support for Faculty and Staff,” and “Non-Mandatory Culture” subcodes). The staff participant, however, was more open to the idea, suggesting that “[what would be useful for faculty and staff in training and professional development opportunities] is understanding some of those perspectives [that] will help us prepare technology better to solve the problems that people with disabilities experience when they're trying to learn and work at Rollins."

Additionally, key informants were asked to share their perspective on why a notable difference developed in the faculty and staff survey with regards to pedagogical training opportunities, where faculty reported that they would be much more interested in learning pedagogical skills from knowledgeable faculty than formalized training opportunities. Key informants suggested that this variance in agreement may be due to the perception that formalized pedagogical training is less desirable or has less perceived benefit than informal opportunities to learn from their fellow RSPH faculty about the strategies that work best for them.

Theme 2: Culture of Inclusion at RSPH

This theme explored relevant factors that contribute to or inhibit a culture of inclusion at RSPH, including: participants' understanding of disability; their personal and professional experiences with disability; their perspectives on DEI at RSPH; programs and policies related to disability and inclusion; and barriers and facilitators to disability inclusion, including recommendations for change and improvement.

Code: Dimensions of Disability

This code sought to understand the ways that participants conceptualize and understand disability as a concept. Nearly all participants, regardless of positionality and role within RSPH, understood disability as a nuanced, complex concept with several different contributing factors. Given that disability is a concept with many definitions and constructed meanings, it was important to understand what conditions and ability levels participants associated with the concept of disability. Within this code, two subcodes emerged, centered around whether participants understood disability to exist either as a dichotomous "in or out" variable or as a spectrum of ability, access and visibility.

Subcode: Spectrum of Disability

This subcode explored the concept that disability is multifaceted and exists on a spectrum. Participants discussed a number of different dimensions of disability within the spectrum that they identified, including but not limited to: not all disabilities are physical; not all physical disabilities are visible to others at all times; not all mental or developmental disabilities are invisible all the time; and disability as a state of being that people can move into and out of throughout their lives. As stated by one member of leadership, a person with a disability “has abilities that lie outside of what we typically and historically, sort of consider the norm, so maybe differences in learning, differences in sensory perception, differences in information processing, certainly differences in physical ability, differences in mental functioning, cognitive functioning, those types of things.” Of the 12 total participants interviewed, 11 explicitly discussed disability as a complex social and medical construct with dimensions that exist on one or more spectrum(s).

Subcode: Dichotomy of Disability

The “Dichotomy of Disability” code explored the concept of disability as a dichotomous one. It included either/or understanding of disability, such as visible vs invisible disabilities and physical vs developmental vs learning disabilities. Although multiple participants discussed disability as a dichotomous state at various points in the interview and focus group process, only one participant exclusively discussed disability as a dichotomous concept. Generally, participants used a dichotomous understanding of disability as a point of contrast with the concept of disability as a spectrum, as when TS, a student in the second focus group, stated “I thought there was going to be some separation of the kind of physical and mental disabilities [in one of the FGD activities], and then where [they align]…but there’s also the other third [category of disability] where it’s both, right?”

Code: Professional Experience with Disability

This code explored participants’ professional experiences with disability, whether that experience was related to navigating the formal accommodations process, negotiating informal or unofficial accommodations, or, less frequently, their research or practice outside of the scope of the classroom. It also includes students’ perspectives on navigating accommodations and exposure to disability in the academic environment. These more specified experiences with disability are explored further in the associated subcodes Navigating Formal Accommodations, Unofficial Accommodations, and Other Professional Experience.

As discussed above (see “Curriculum Development”), few participants reported incorporating disability into their curricula or being exposed to disability in their classes. Nearly all of the professional experiences with disability that faculty, staff and leadership members reported were directly linked to providing accommodations for disabled students. Student participants' most notable interactions with disability in the professional and academic environment were also generally centered around navigating disability and accommodations in the classroom, although there was some discussion among students about disability-related interactions they had with their fellow students.

Subcode: Navigating Formal Accommodations

This subcode encompassed the ways in which faculty, staff and students navigate the process of gaining formalized access to reasonable accommodations for disabilities in the workplace or classroom environment. In addition to understanding the process of navigating formalized accommodations through the Department of Accessibility Services (DAS, formerly OAS) from the student and faculty perspective, this code includes faculty, student and administrative perspectives on the benefits of accessing accommodations through DAS. Although this code did heavily overlap with the Department of Accessibility Services code (discussed further below), this code focuses heavily on the interactions between faculty, staff, members of leadership, and students.

All faculty and leadership participants reported having students in the classes they teach who access formal accommodations with varying frequency—faculty and members of leadership who taught larger or introductory courses at the master level reported receiving between 3 and 8 requests for accommodations at the beginning of every semester during which they teach. One faculty participant who works largely with PhD students observed that although they had received accommodation requests both in the past and during the most recent academic year, those requests were infrequent, and that they saw this relative rarity as "an indication of the system, that we actually don't have as many people who have a recognized disability at that level, at the school."

Generally, the process of navigating formal accommodations was described thusly by both faculty and members of leadership and students: the faculty member receives a communication from DAS disclosing that a student in their class has requested reasonable accommodations (often referred to as an "accommodation letter"); a meeting was scheduled between the student and the professor to discuss the reasonable accommodations in the first week or so of a semester; the faculty provided the accommodations listed on the DAS letter and/or agreed-upon in that student-faculty meeting. Although no faculty members or members of leadership discussed the phenomenon in their descriptions of the process, three of the eight student participants mentioned that they had the option *not* to disclose their accommodation needs if they didn't feel as though the accommodations would be relevant, helpful or needed in a given class—faculty members are informed of a student's accommodations only after their courses are identified by the student as requiring some accommodation(s). All faculty, members of leadership and staff who had engaged with the formal accommodations process reported that they saw one-on-one meetings with students to discuss their accommodations as a positive opportunity to, as one faculty member put it, "open up a line of communication from the beginning."

All faculty and leadership participants also reported a higher degree of comfort in navigating accommodations when students went through the formal DAS process. As one member of leadership put it, "the biggest benefit [of formal accommodations] is that I don't have to make any judgements[…] I know that the work has already been done and it has been determined that X, Y and Z are appropriate accommodations for the student, so I don't second-guess those, I just take them for what they are." As discussed further below, perceived or real limitations on what questions faculty can ask regarding accommodations were cited by all faculty and members of leadership as a limitation to the formal accommodations process. (See "Effective Communication, Challenges in the Accommodations Process").

There was some variance among faculty and members of leadership about the ways that course content and structure affect the ease of accommodating students with disabilities. One faculty member suggested that more traditional lecture-based and formally structured courses are more easily accommodated than more lecture-heavy or experiential courses, as "in that [more structured] kind of scenario, it is much easier if you miss a class session that I go, like, 'okay, so do the readings, here's the in-class exercise, I have an answer hey for this, you have classmates to work with,' and usually it is not a major issue." Another faculty member, however, suggested that flexibility with deadlines can be tricky to navigate as a professor, especially in half-semester skills-based classes where "the way the grading system works, giving an incomplete requires a certain amount of the work to be done. So there's pressure from both sides of, you have to have a grade input in there, and you have a student who is unable to meet the standard [deadlines] and doesn't have enough time to get their work done, so they [face pressure to] do a poor job and not really understand the material [in order to get a grade]."

Five of the eight total student participants had sought (and successfully received access to) formal accommodations but were often dissatisfied with elements of the process for varying reasons. Three students reported having faculty or staff attempt to deny them the reasonable accommodations outlined in their DAS documentation. Four students also reported feeling significant discomfort when negotiating accommodations with faculty because they felt forced to share more than they were comfortable with the professor about their condition and/or interactions with faculty members that “made it seem like they were doing me a favor” (KO, FGD1).

One student, YD, reported that they intentionally don’t request accommodations they are entitled to in classes: “if I don't feel like the class is set up in a way that would be difficult for me, I don't even bring it up with them. It's only if there's like something specific about this class that's going to make it more challenging. Then I'm like ‘okay, I'll select that one course and then I'll send my letters to those to those people because I'm—I'll deal with the stigma, you know, for my own wellbeing.’” From the faculty perspective, one participant reported that “I think the hardest part is if the, if the student doesn't request accommodation until there's a problem. And I know that can't always happen, because sometimes things haven't sort of surfaced before.” (These divergent perspectives are discussed further in the Discussion section.)

Subcode: Unofficial Accommodations

This subcode explored how participants navigated and understood unofficial or informal requests for accommodations based on their disabilities or other needs. In addition, this code identified reasons why the formal accommodations process may not be accessible for students due to disability-related stigma, the challenges for faculty of providing unofficial accommodations, and how and why faculty and members of leadership navigate encouraging students to seek formal accommodations.

All faculty and leadership participants identified at least one reason why students may not feel comfortable seeking formal accommodations. As one member of leadership put it, “because of probably very challenging prior experiences with DAS offices at other institutions, and so forth, or stigma related to the disability that they're experiencing--they don't feel comfortable going to the DAS office[…]I'm not saying that there's not a good reason why some students are reluctant. It just makes the process much more difficult. And also it puts them at a disadvantage, because you can't really connect them to services as well as if you had something at hand.” Three of the faculty and leadership participants reported that they (or other faculty) had concerns about the “fairness” of providing unofficial accommodations and making decisions about what students deserved “special treatment.”

The staff participant reported that technology-based requests for accommodations in recent memory have not been explicitly disability-related, saying, “none of [the requests we have gotten], I should say, have had to do with individuals approaching us to say ‘I have a certain specific disability. And I would like the technology to be handled in a certain way to accommodate that.’ I'm not aware of a single request over the last year that we've had to accommodate something like that. In every case, it's been more of a preference or support type thing.”

Both faculty and student participants mentioned experiences where faculty or staff encouraged students to seek formal accommodations. One student, NJ, reported that after meeting with an advisor to discuss deferring their studies, they sought formal accommodations due to that advisor’s support, noting that “I think that I was very lucky to have met her as well because from what I've heard not everybody has a good experience with [seeking support for disabilities from faculty and administrators].” One faculty member had had similar conversations with several students throughout their time at Emory, mentioning that when those conversations arose, they sought to be sensitive to the fact that “This is where the stigma comes in play. This is where the system comes into play, right? And who knows [about their disability], and how does this [process] work, but also, [the student is] a person who's made it this far in our educational system, kind of thinking they have kind of coped with it.”

One member of leadership did suggest that there are important questions to consider regarding the structural equity of the formal accommodations process: “Are there actually barriers? Because what if someone doesn't have a formal diagnosis? What if someone doesn't have a doctor that they can refer to? Does that mean that they don't have a reason to request accommodations, especially in the classroom type of format?” This sentiment was also present in the first focus group, where all student participants agreed that navigating formal accommodations can be especially challenging while also coping with the intense pressures of graduate school and external forces like working, transportation to doctors’ appointments. All three students who had sought diagnosis for one or more disabilities while in the MPH program reported facing significant challenges in the diagnostic process that hampered their access to formal accommodations, citing a lack of qualified assessment professionals and healthcare system issues related to the COVID-19 pandemic.

Subcode: Other Professional Experience

This code explored how disability intersects with participants' professional work at or outside of RSPH, exclusive of navigating formal or informal accommodations in the classroom. Those intersections could be related to: participants' professional, research or study interests; research-centered interactions about disability with funders, participants, statisticians, or other researchers; and disability-related experiences with other faculty and staff.

Three of the five faculty, staff and leadership participants discussed the relevance of disability to their own careers, research opportunities, or public health practice, albeit relatively briefly. One source of increased awareness of disability stemmed from a training grant one faculty member was involved in: "[when the grant proposal] came back to us, our diversity plan was very strong on race and gender, but we didn't mention disability. And that's what the reviewers called out. So that that's made me very sensitive to making sure that's part of the plan [moving forward]."

One important nuance related to this code, introduced by student NY, is "how hard it is to do research on our own communities…it's just brutally difficult to read some of the casual ways some researchers talk about what you've gone through, or [to] read how heavy all of the findings are." That being said, four student participants reported that their understanding of disability had a direct impact on their public health interests and future practice. One student, KO, reached out to me personally about a week after participating in the focus group discussion and shared that "I think I found my purpose (at least for now) in public health! I realized ever since [the] eugenics [movement], there's been a lack of disability perspectives in the reproductive justice movement and a lack of SRH [sexual and reproductive health] research among people with disabilities[…]I don't think I could have imagined combining these passions before [accepting my disability identity]."

Code: Personal Experience with Disability

This code included discussion of how disability impacted participants or their loved one(s) directly and significantly for a period longer than 6 months—*if and only if* that disability had some notable impact on their professional or educational experiences. All participants reported at least some personal experience with disability. Given the scope of this research and my ethical responsibility to protect the personal stories and confidentiality of participants, however, discussion of personal experience with disability in this report is limited to that which directly impacted participants' professional and educational experiences.

For example, one member of leadership's decision to go into the field of personal and public health was informed by their experiences with disabled family members: "when you see this around you and you understand that people need assistance to operate—I think that just probably was part of my motivation for going into this field." Only one of the five faculty, staff and leadership participants directly linked their research or public health practice to disability.

In focus group discussions, students' contributions to this code largely centered around the degree of comfort that they felt in disclosing their disability to other students, faculty and staff, as well as the stigma often associated with disability. Of the six students who self-identified as having a disability, four explicitly identified stigma and lack of awareness from others as barriers to their perceptions of being included and accommodated at RSPH. (For further discussion, see: (Lack of) Knowledge and Comfort with Disability, Challenges in the Accommodations Process). One student, KO, characterized many of their interactions with currently-abled students as somewhat strained: "I think they meant well, but there definitely were microaggressions. Yeah, [it] just like made me uncomfortable and kind of like [they] pitied me [for having a disability]."

In both focus groups, however, students reported that they felt more comfortable talking about and seeking support for their disabilities when fellow students with disabilities were open and comfortable talking about their own disabilities. As EB stated, "people will say to me, 'I'm really sorry, my ADHD is out of whack today, can we do this another time?' And people are very upfront about that at Rollins. And I really appreciate that honesty and openness. And I find it makes for better group work[…]and it makes me feel more comfortable to say, you know, 'I'm having a bad day, I'm really sorry, please, please bear with me.' And that flexibility and understanding is really important to me, that students can share that with each other."

Code: DEI

This code explored participants' knowledge and attitudes regarding diversity, equity and inclusion concepts and activities that are hosted, funded or facilitated by RSPH (or Emory more broadly). In addition to participants' awareness of and attitudes towards DEI activities at Emory and RSPH, 3 key subcodes emerged from this code: the role of real or perceived "cancel culture" in facilitating inclusive communities; performative activism, language co-opting and virtue-signaling; and the role that disability plays (or, often, doesn't play) in DEI activities.

All participants had strong opinions about how DEI should be incorporated into public health practice and pedagogy. Student participants were especially verbose about the state of current DEI efforts at RSPH and Emory more broadly. One student, KO, shared that they felt a requirement for public health professional should be "[an awareness] of microaggressions, and their privileges and positionality, especially in global health, and [trying] to incorporate intersectional lenses in every aspect of public health." Another student, FN, identified the student body as a source of significant support for meaningful DEI work at RSPH: "I feel like now in an academic setting, we [the students] are raising that awareness and Emory is now realizing the importance of how DEI is really impacting all students at Rollins and they're making their efforts […we've] got to start somewhere. However, we have to consider all of the acronyms and not just one."

Subcode: Cancel Culture

This subcode referred to the real or perceived economic and/or social fears that are associated with "cancel culture," or the concept that others may perceive something that someone has said or done as inaccurate or harmful—even if the comment was not intended to be offensive or harmful by the speaker—and that this negative perception will lead to a loss of social status, online or in-person harassment, or even loss of financial stability.

For faculty and members of leadership, this subcode overlapped significantly with the Effective Communication code, as discussed below—3 out of the 4 faculty and leadership participants alluded to their fears of "not saying the right thing" in some way and facing potential social or economic backlash as a result. One faculty member discussed that fellow faculty members in one RSPH department pushed back against including information about DEI-related work in their annual reports to the department chair because "people are going like, 'but this [report] is our assessment tool of us, right? I get my evaluation, and my pay raise, and all these kinds of things because of what I've done. And now I have these new sections in there, and I might not have done it.' So there's all these tensions that are happening that we're not, I think, talking about." This key informant also suggested that the fear of cancel culture may serve as a barrier to meaningful change, stating that when students bring their concerns to the attention of RSPH leadership, there can be the unintended consequence of a breakdown in communication between students and faculty, staff and leadership: “there is definitely fear of figuring out this new world…and then that leads to sometimes not being open to engaging with the students.” This concept is especially salient in the context of later commentary on recommendations for improvement, as discussed further below (see: Student-Focused, Faculty and Staff-Focused, and Environmental and Administrative Recommendations).

Student participants in the first focus group did not discuss cancel culture as it related to DEI at RSPH or Emory; cancel culture was mentioned only briefly in the second group when discussing recommendations for future improvement, where EB suggested implementing positive cultural norms: “[when setting classroom boundaries] people bring up like, ‘cancel culture is real and we're all learning and we're all going to say stupid things and regret them.’ Point them out when someone says something, but do so gently and in a way that’s educational and compassionate rather than assuming the worst in them.”

Subcode: Performative Activism and Co-Opting Language

This code explored participants’ understanding of performative activism and the co-opting of language related to DEI activities, policies, and programs. Performative activism in this context referred to actions, policies and programs that self-identify or are identified by others as diverse, equitable and inclusive, but don’t actually lead to significant and meaningful change; co-opting language, a similar concept, refers to the use of language that implies inclusivity and respect for diversity without performing actions that support that implication.

As one faculty member perceived the current DEI efforts at Emory, “I think there is a really good intention from a lot of people. I think there is [also] a lot of performativity.” One member of leadership suggested that the co-opting of inclusive language and activism that could be considered performative may be caused by genuine lack of knowledge: “[there] is the richness of [diversity], which is the beauty, and that’s the part that we really, really like. But my goodness, there is such this opportunity to exclude and forget, because there’s just so many identities and so many ways that we can think about who we are, how we present, and how we talk about ourselves.” (For more discussion, see (Lack of) Knowledge About and Comfort With Disability below.)

Student participants also identified performativity as an issue in DEI work on campus in both focus groups. FN, a student in focus group one, asked "are we just trying to fill the box and check? Or are we actually really bringing collaboration among all students and faculty? So the thing that I'm most concerned is like, 'yeah, we can have this presentation on the website, and you know, everybody can fill in the boxes and fill in the spaces. However, what are we exactly *doing?'*" This question was met with significant agreement from the other five participants in that FGD, several of whom felt that there was a lot of talking about DEI and not a lot of "doing."

Subcode: Disability in DEI

The Disability in DEI subcode refers to where disability is (and, often, is not) incorporated into DEI activities, and participants' attitudes regarding the role that disability should play in DEI activities. Across all participants, there was a consensus that current DEI efforts do not adequately include several facets of human diversity; as one member of leadership succinctly worded the issue, "oftentimes when we talk about diversity, equity and inclusion, you know, what's the first thing that comes to mind? Right? Disability is not one of [those first things]."

Students, faculty, staff, and leadership commonly cited race and gender as those dimensions of diversity that get the most focus in current DEI efforts, and, as student TS stated, "although they are important things, they're not the *only* things [we should be including in DEI]." Another student, NJ, had a more positive view of the current state of disability within DEI, saying "five years ago, it seemed like no one was even thinking about disability as a part of DEI. Now, even if it's not Rollins' focus, people will sort of at least acknowledge if you bring it up, like, 'Hey, this is a DEI problem.'"

Student participants were also passionate about disability as an intersectional issue, especially those students who have been marginalized in other aspects of their identity, as exemplified by a statement made by DD: "I know as a woman of color, the way in which my disability will be perceived is going to be completely different from a white person." Two students expressed concern that advocating for the inclusion of disability in DEI activities might lead to the de-prioritization of other important DEI-related issues, with NJ explicitly stating that "if [the leadership of my department] is only gonna pay this much attention to DEI issues[…] it's scary to push for anything else. Because it's like, how much are they going to give? Are they going to, like, start paying less attention to equally or more important issues?”

Code: Emory and RSPH Policies and Programs

This code incorporates discussion of policies, programs, resources, and other services available to RSPH students, faculty and staff as they relate to disability inclusion; relevant services identified include Emory-wide programs and policies like Information Technology (IT), Title IX, and Campus Life, as well as RSPH-housed programs and policies like the Office of Faculty Development & Excellence (OFDE). Two programs were discussed frequently enough to necessitate subcodes: the Office of Accessibility Services and Counseling and Supportive Services.

In addition to these subcodes, IT services were identified as an especially relevant service to explore, particularly given that many people with disabilities rely on technology to accommodate their support needs. Although RSPH’s IT department handles approximately 80% of RSPH’s IT needs, including auto-captioning for lectures using AI and lecture-recording software like Panopto, the staff member interviewed for this project identified several key IT services that are handled by Emory’s central IT department, including Canvas and Outlook email services, which may have significant impact on the educational experiences of disabled students, faculty and staff.

During the COVID-19 pandemic, RSPH IT services has actively pivoted to focus on ensuring that students, faculty and staff have had adequate, easy access to tools to aid communication, learning and connection. The staff participant mentioned that one of the largest changes resulting from COVID-19 “is just the ability to accommodate a whole range of teaching models. So there have been there have been certain cases where instructors have either required or preferred to be on campus more often to do their work, whether or not students are on campus, and the ability to have them record themselves in a classroom environment, or what have you, providing technologies like Zoom and cameras, and you know, Panopto and technologies like that, to help them along in that process.”

Subcode: Department of Accessibility Services (DAS)

This subcode explored participants' interactions and attitudes towards the Department of Accessibility Services (DAS, formerly known as the Office of Accessibility Services). To minimize repetition of information discussed above in Navigating Accommodations, this code focused on direct interactions between students or faculty/staff and DAS.

Generally, participants' perceptions of DAS were positive, identifying DAS as a source of support and helpful guidance. 3 of the 4 faculty and leadership participants reported having positive, helpful direct experiences with DAS staff. One faculty member exemplified what positive interactions with DAS could look like thusly: "if I go in to [talk to DAS with] the question of "I'm wanting to do this, and I'm concerned about how I'm going to do it," they're always really helpful." The fourth participant expressed frustration with DAS regarding unclear communication about a student's accommodations and a desire for DAS staff to have a more active and intentional presence at RSPH to present additional opportunities for face-to-face connection, explaining that "[if I had a question for a faculty member in my department], I would go down the hall and I would stand in the door and say, you know, 'let me ask you a random question.' So that kind of thing, right. How do you ask? Obviously, their FAQ is probably somewhere, but[…]when [an issue arises], it might be pressing at that moment, because you might feel 'I really feel lost right now. And if I could just talk through it with somebody, it might actually dissolve itself.'"

Students' experienced with DAS were similarly mixed; one student who has a visible disability had never heard of DAS before the focus group discussion, an experience sharply different from that of another participant with visible disabilities, who reported that faculty members often approach them during classes to ask if they have gotten connected with DAS services. Three of the five students who were involved with DAS reported that their experiences with DAS were generally positive, including one who shared that when a faculty member initially refused to provide their approved accommodations, their DAS representative advocated for them and handled the issue effectively, causing them minimal stress. FN, another of those students whose experiences with DAS were broadly positive, did report, however, that when they were in the process of seeking a formal diagnosis in their first semester, "I didn't have a good experience, to be honest, as far as my diagnosis journey. And I felt like a lot of this, I had to go through it alone.

So really just establishing that collaboration among DAS representatives and students [during the diagnosis process] is important.”

Subcode: Supportive Services and Physical Accessibility

This subcode explored RSPH-specific or Emory-wide resources and services intended to support students’ emotional, mental and physical health, including Counseling and Psychological Services (CAPS), TimelyCare, Student Case Management & Intervention Services, and Student Health Services but not including DAS. No notable discussion regarding supportive services occurred with any faculty, staff, or leadership participants.

Students’ reported experiences with supportive services were largely negative and mostly characterized by a lack of awareness or capacity to respond to disabled graduate students’ needs, as well as some physical inaccessibility. Four of the eight student participants reported unsuccessfully seeking mental health services through CAPS, while only one student had had generally positive interactions with CAPS and TimelyCare, a virtual mental health service offered through CAPS to help meet demand. Dissatisfaction with CAPS largely stemmed from the perceived inaccessibility of the current screening process. EB’s experience was typical of those reported by student participants; after reaching out to CAPS for services, they found that they would need to go through a potentially retraumatizing screening process “and I was like, ‘Really, I can't just pop in for like a 15 minute check in on my mental health?’ […] after having gone to so many different therapists and psychiatrist for years, I was like, ‘I can't do this. I'm not dishing out the whole hour and a half long story so I can just like, hear some comforting words and navigate through this difficult time’. So I ended up not using them.” Another student shared that their mental health needs were not adequately addressed by CAPS staff until they felt forced to threaten to walk out of the CAPS office with no referral or resources.

Three students identified that the inaccessibility of campus more generally and the Student Health Services (SHS) building specifically made it hard for students with disabilities to effectively and equitably access physical health services. In addition to challenges related to navigating the crosswalk at Clifton and Houston Mill and uneven, broken sidewalks on the SHS side of Clifton Road, one student who attended Emory for both their undergraduate and MPH degrees reported that “there's a ramp [allowing students to access SHS from the main entrance on Clifton Road] but I didn't know that existed until there was a construction in front today and I had to go exploring[…]it is the most ridiculous thing for a student who is coughing themselves to death, or has any sort of thing that would restrict their ability to move to go up all those stairs."

Code: Barriers and Facilitators of Disability Inclusion

This code, which includes a significant amount of subcodes relevant to the stated goals and aims of this project, explores factors that impact faculty, staff and students' perceived and actual self-efficacy and ability to facilitate inclusion of disability at RSPH. Subcodes associated with this code fall into two categories: first, identified barriers and facilitators (i.e., effective communication between faculty, staff and students, contextual factors that may impede faculty and staff's ability to focus on improving disability inclusion, etc); and second, suggestions intended to improve disability inclusion moving forward. These recommendations for change were split according to the social-ecological model from the student perspective, with student-focused suggestions at the micro level, faculty and staff-centered recommendations at the intermediary level, and administrative and environmental recommendations at the macro level.

Subcode: Effective Communication

This subcode emerged as an exploration of the ways in which faculty, staff and students speak to each other about disability, diversity, and accommodations. Relevant concepts associated with this subcode included what kind of questions faculty feel comfortable asking students (as well as what faculty understand about what they're "allowed" to ask) and what faculty/staff need to know to effectively provide accommodations. Although this subcode initially developed in the context of how faculty and students navigate discussing accommodations, in the analysis process an additional dimension emerged regarding how RSPH faculty, staff and students have generative conversations about diversity and other hard topics.

As students have a right to privacy regarding their disability and specific diagnoses which is protected by law, faculty and members of leadership alike reported feeling confused or worried about what questions they were allowed to ask students when negotiating accommodations. All four faculty and leadership participants identified an urge to avoid making students feel uncomfortable or threatened; one faculty member shared that when a recent request for accommodations was confusing, "[the student] said, 'um, you know, I can give you some context.' I was like, 'That would be fantastic. I didn't know how to ask about this, because I know that I'm also [not] supposed to ask about certain things.' But you know, I can't say with how many absences I’m okay if I can’t know how many absences a student might need. I don’t know! What’s the ballpark, right?” Four of the five students who receive formal accommodations reported that they felt pressured to share more information about their disability with professors than they felt comfortable with to implement their accommodation plan.

All faculty and leadership participants also identified having open lines of communication as an essential aspect of successfully supporting disabled students, as exemplified by one faculty member’s observation that, “It's impossible to [communicate with students about accommodations] perfectly, so you need to make sure you're communicating enough that when there are miscommunications, or awkward phrasing, or, you know, wrong assumptions, that you've built up enough trust to address that issue as it happens.” Two students agreed that the professors who took the time to actively keep open lines of communication made their classroom experiences significantly more positive.

Although the faculty and leadership participants interviewed for this project all reported actively taking steps in this process to effectively communicate in these circumstances, three of the five students who received formal accommodations reported that faculty members had not handled the accommodations process with as much grace. Two students reported that faculty had attempted to refuse them accommodations which had been approved by DAS; one student, KO, shared that “one teacher told me that my accommodations doesn't apply to finals. And again, I didn't know, and because this is new to me, like, I wasn't comfortable advocating for myself yet. So that definitely negatively impacted me academically.”

Three of the five students who receive formal accommodations also reported discomfort with faculty who “made it seem like they were doing me a favor” (as KO said) by providing their accommodations or seeing them as objects of pity due to their disabilities. One student, NJ, clarified this point further, suggesting that “whenever I'm accommodated to, it always feels like they think they're doing me a favor rather than just doing like the bare minimum decent human being thing to do.”

Subcode: Contextual Factors

This subcode sought to understand the external factors that could affect faculty and staff’s decision to actively improve disability inclusion in their pedagogy and practice. Although a number of more specific examples like the COVID-19 pandemic, stress associated with research and the “publish or die” academic environment, and personal responsibilities were incorporated into the definition, most participants identified time as the common external factor that may limit faculty and staff's ability to center inclusion. All four of the faculty and leadership participants identified time as the common factor; students in both focus groups also mentioned the time and work pressures that faculty members face and how that may limit their engagement with inclusion activities.

Additionally, this code encompassed discussion of the discrepancy found in the faculty and staff survey between survey participants' belief that students with disabilities can be successful in regular classrooms and their belief that students with disabilities can be successful in regular classrooms because they will not take up too much of the instructor's time. When asked in key informant interviews, some participants suggested that (1) faculty are already pressed for time given their existing professional expectations and requirements and (2) faculty and staff may see providing accommodations as an inconvenience or as time-consuming. As a result of these two factors, key informants suggested, faculty members may be more wary about disability inclusion in the classroom.

One member of leadership explained the issue thusly: "I find that we have very thoughtful, interested faculty who just are pressed. They're just as under pressure as you all are, as students, given all their different responsibilities. I think we have faculty who are also wanting to do a good job, but don't always have all the tools and not the time to get them." For more information on potential solutions related to this barrier, see Administrative and Environmental Recommendations for Change below.

Subcode: (Lack of) Knowledge About and Comfort With Disability

This subcode explored participants' reported knowledge of and comfort talking about disability, as well as perceptions of other Emory community members' comfort with disability. Notably, this subcode was mentioned by all 13 participants as a potential or actual barrier to disability inclusion at RSPH; one student, DD, explained it best when they said, "[in terms of] the lack of sensitivity and the lack of knowledge, amongst just staff or just people in general, when it comes to disability, if we don't simply have an interest in it, we don't simply care much about it." This lack of knowledge and comfort was not unique to disability, however, as several participants noted that positionality can significantly impact a person's ability to identify and consistently remember their "blind spots" (a term used intentionally in the context of disability). One key informant shared that in a recent meeting to discuss future DEI events, “it took someone to say that [we hadn’t included ableism] for me to recognize that, ‘okay, it's not a standalone thing. It's something that really needs to be weaved in everything that we're doing.’”

Students in both focus groups noted that in their classes, “even people in the helping professions who you think would be, y'know, knowledgeable about this topic and want to help, don't know about it, and often just kind of give the impression that they don't want to deal with it. Or maybe they're weirded out by someone with a disability, even though you think they'd be aware of it,” (EB, FGD1). Both faculty participants, on the other hand, reported that although they had at times wanted to include disability in the content of their courses, they did not feel confident in their ability to do so without tokenizing disabled students in the classroom or “saying the wrong thing,” as one participant put it.

Although this code largely explored perceived lack of knowledge about disability, some faculty and leadership participants identified ways that they try to improve their knowledge about and comfort with disability; one faculty member stated that “I'm not going to see the physical space the same way as someone with a disability. But if I interact and, you know, start learning to look for certain things about what's a problem, then, just having enough of that humility that I don't know everything [is a good place to start].” For further discussion of suggested methods to improve comfort with and knowledge about disability, see the three Recommendations for Change codes below.

Subcode: (Lack of) Institutional Support for Faculty and Staff Development

This subcode sought to understand the actual or perceived resources or supports that faculty, staff, and students need from RSPH and Emory on an institutional level to facilitate disability inclusion in curricula and culture. Both leadership participants and one faculty member mentioned that institutional-level support was essential for faculty and staff to feel empowered and capable of facilitating inclusion. One key informant shared an illuminating experience in which they were working with a student on developing a professional development opportunity related to DEI; when they approached leadership at RSPH to seek support and visibility, “I hit a wall. Nothing. Not gonna happen.” They did manage to host the training series through Laney graduate school but, as they put it, “I was just, like, baffled at why that had to happen.”

Student participants shared similar frustrations—three different students had identified institutional barriers to inclusion, including concerns over artwork posted in RSPH buildings that they identified as fatphobic and potential triggers for those students who are currently experiencing or recovery from an eating disorder and efforts to make DEI requirements for student organizations less performative and more impactful. All the students who discussed these concerns reported feeling that the administration did not adequately respond to or support their efforts to advocate for a more diverse, equitable and inclusive environment at RSPH.

Both members of leadership acknowledged the role that administrative and institutional support must play in creating change. As one leader put it, "[the school has] a responsibility to support [its] faculty[…]Because, again, just as much as we're not all trained as psychologists and therapists and physicians, we're also not trained in education and pedagogy. We're trained in specific content areas. And so we cannot assume that people know how to do that [reflect on and improve their pedagogy]. So there is a role for the school to provide that support and the tools, but then I think it's up to the departments to implement."

Subcode: "Non-Mandatory" Faculty and Staff Culture

The Non-Mandatory Faculty and Staff Culture code explored the concept of Emory more broadly or RSPH specifically as an environment where faculty have very minimal requirements and expectations regarding inclusivity or training, but are encouraged to choose how, when, where, and whether they engage with these concepts and professional development opportunities. This subcode emerged largely from interviews with members of leadership, although a number of students did directly or obliquely identify the non-mandatory culture as a potential barrier to inclusion. Currently, the only required training for RSPH faculty and staff as reported by leadership and faculty is the federally mandated Title IX training. As one member of leadership identified, "we're in an academic setting where the culture is traditionally for academics that [they're] kind of that all-consuming professor who is all about the science and the scholarship and the knowledge at the expense of other things. And so I'm not saying we are entirely that, but there's definitely flavors of that in our school, and I think everybody would agree to that."

Both members of leadership and students identified this non-mandatory culture as both a barrier and a facilitator to meaningful inclusion of disability and other aspects of diversity. One member of leadership explained the nuances, saying “there are some basic requirements that we can have. And I think one of the tools again, at the school level, we have is mandating things. You don't like to do that. Because that doesn't create the kind of spirit that you want, when it comes to participation in these kinds of things, right? Um, but, you know, we have to work out ways to make sure that we've done everything that we can to get our community on the same page.” One focus group discussed at length the idea that mandating training or other requirements related to DEI could decrease faculty and staff’s engagement with those educational opportunities; as TS asked, “Are people just viewing that [theoretical required training] as like, you know, ‘this is just another checklist [item] I need to do, or something I had to sit in and listen to[…]’ versus something that's more voluntary?”

Subcode: Challenges in the Accommodations Process

This subcode identified aspects of current formal DAS accommodations process that can be challenging for faculty and students to navigate. These challenges fell broadly into one of three categories: (1) faculty concerns about being expected to lower their standards for coursework; (2) the capacity of the current system to accommodate students with more significant support needs; and (3) students’ potential inability or discomfort with identifying and advocating for their own academic success.

Both faculty participants and one member of leadership identified that some accommodations approved by DAS may pressure professors to lower their expectations for students with disabilities to a level with which they are uncomfortable; one faculty member explained that “sometimes a faculty member might feel there's a flexibility and quality that's being asked for like, they don't have to do the same level of work as somebody else. And I see a distinction there. But sometimes that that can be kind of a fainter line in between, and that could be a stumbling block for the faculty member participating.” A member of leadership also mentioned that there was sometimes “a little bit of a disconnect between [students and faculty about] what [receiving accommodations through] DAS means. And it cannot mean that you're exempt from completing all the course requirements. So sometimes I think the conversations between students and faculty can happen on the fringes of that argument, and never the two shall meet." Interestingly, student participants did not discuss this potential mismatch in either of the focus groups.

Another potential challenge to providing accommodations identified in this research was the potential inadequacy of DAS accommodations for students with higher support needs. One key informant identified an instance in which a faculty member had sought their support when the professor felt uncomfortable with a student's DAS-approved accommodations because the accommodations "bordered on medical assistance" in a way that made the professor uncomfortable; a student in one of the focus groups discussed that a faculty member initially refused to agree to provide their DAS-approved accommodations related to a potential acute episode of their disabling condition and that their contact in DAS had to advocate on their behalf for the professor to agree to their accommodations. Another student, NJ, mentioned that one of their fellow students had had to choose to withdraw when they found that school caused increased symptoms and issues related to their disability, saying that "it feels like we still kind of live in a world where we have a standard nine to five, and if you can't do that, then there's not a reasonable way to accommodate [your needs]."

Finally, faculty and leadership participants all reported that when they initially meet with students to discuss accommodations, they ask the student what they need to be successful in the classroom. As reported by student participants, this approach can be challenging for some disabled students. As KO shared: "on one hand, I feel like some of my teachers were trying to be very accommodating by asking, like, 'what do you need?' But then on the other hand, as someone who had a new disability, I definitely didn't know. And so then the teacher also didn't know. And so I just kind of struggled in that aspect." This sentiment was echoed by three other students who reported feeling unsure of how to advocate for accommodations that would best support their needs.

Notably, one faculty respondent brought up an important point regarding the perception of accommodations by currently-abled students: F2: "students can be—or people in general—can be selfish and so on. If they get the sense that things aren't fair, they might be sympathetic for something that's invisible, or they might not be."

Subcode: Student-Focused Recommendations for Change

This subcodes outlines recommendations for improving disability inclusion which target or focus on students as the intervention population. Broadly, these recommendations focus on intentionally building community for disabled students, connecting students with resources and support services as early in their time at RSPH as possible, equipping currently-abled students with empathy for their disabled classmates, and increasing all students' exposure to disability-related content in various classroom settings.

Student participants in both focus groups identified the need for students to have an intentional space to connect with each other and find additional sources of support as an essential need moving forward. Six of the eight student participants mentioned that finding other students or faculty members who also had disabilities had helped them feel more comfortable with their own disability identity, get connected to resources like OAS, and feel as though they were not alone in the high-stress environment of graduate school programs. Both focus groups ranked establishing a formalized system of support for disabled students as a high priority, whether that was in the form of a student organization, affinity space, or a mentorship program, as suggested by NJ: "we all probably could use a friend or an advisor or a mentor or a faculty member who like has either experienced something [related to disability] or studies it. I think that would also be very beneficial." Although most faculty, staff and leadership participants did discuss the benefits of having a more open, connected student body more generally, none identified a formalized support network as a specific recommendation.

As discussed above in the Unofficial Accommodations subcode, it can be challenging for faculty, staff and students alike when students do not know about or access those resources that are available to them. One student, TS, suggested that to remedy this lack of knowledge about services, "it is important to try to capture people with disabilities so that way they can right off the bat, know what services is available. So I think it'd be great to just [make] sure [to say] like, 'Hey, these are identified disabilities, and these are the services that and accommodations students can receive'[…]I can see that being paired with, like, a session on student services, so it's very much overbroad and making sure that the description includes people with disabilities. Because sometimes people don't even know they have one." Students in the other focus group, however, suggested that orientation can be so overwhelming as it is currently provided that any information they received about disability during orientation would likely be forgotten quickly.

As discussed above (see Challenges in the Accommodations Process), one faculty member identified currently-abled students as a source of potential harm to disabled students if they are not aware of the rights of disabled students and the role that reasonable accommodations play in increasing educational equity for disabled students. Five of the eight student participants also reported that currently-abled students had the ability to act as sources of both support and harm, usually based on their knowledge and awareness of disability. As one member of leadership wondered, “we're saying we want an integrated environment where everybody is able to learn to their fullest potential. And so, while we're working hard on sort of changing norms on the faculty end, I'm wondering what you think is the role of peers and what can be done to inform them better?”

The final commonly-identified student-centered recommendation was increased inclusion of classroom and peer education as a means of improving currently-abled students’ awareness of disability. All 11 student, faculty and leadership participants identified increased disability inclusion in the curricula as an effective method of improving disability inclusion. Student participants had a number of suggestions for how to improve currently-abled students’ awareness of and exposure to disability-related content. One student, EB, shared that one of the options for a required orientation activity for the Class of 2023 cohort required students to choose a marginalized group and educate themselves further on that group, and that they were “surprised to see that because usually it's not on there[…]I thought that was really cool. And I was glad to have that space to say like, ‘I'm interested.’ I'm glad I had the space to learn about this while still accomplishing one of my checklist items.”

Incorporating disability as an option into required orientation activities or other courses and assignments that discuss how positionality intersects with public health was a suggestion supported by students in both focus groups. One faculty respondent suggested that all MPH students be required to take a heavily discussion-based course that focuses on ethics, diverse populations, and/or positionality, specifically referencing a Race, Class & Gender course they were required to take in their own graduate studies program: “I would love for everybody to have some shared understanding, to have done some shared readings, to have done some of these hard conversations, guided by people who have experience in that[…]I think [it should be required] at least for the behavioral sciences, I think also [it] would be essential for everybody, but there will be a fight for, you know, the Biostats and Epi department [to approve those requirements…] it is so fundamental, that I would love in the future to have this as a framing of who we are. And that inclusivity would be the framing [of the MPH program].”

Of particular note with regards to including disability into courses is the inclusion of disability in methods-based classes; the two students who had discussed disability in methods-based courses reported significant positive impact not only for themselves as students with disabilities but for currently-abled students who may not have been exposed to disability as a concept before. One member of leadership provided a laundry list of suggestions for ways that disability could be incorporated into various courses: “what would that look like? It depends on your class[…]readings that address that population, it might be[…]health outcomes that are specifically impacting certain populations with certain disabilities[…] you have examples in your class [including disability], you may bring guest lecturers in your class[…]you can bring in data sets, even if you're in BIOS or EPI, that look at issues that are related to disability so that it becomes more part of our discourse in public health, rather than sort of on the fringe of what we talk about on a daily basis.”

Subcode: Faculty and Staff-Focused Recommendations

This subcodes outlines recommendations for improving disability inclusion which target or focus on faculty and staff as the intervention population. Broadly, these recommendations focus on providing improved disability-related knowledge and skills using strategies like effective trauma-informed and universally inclusive pedagogy, accessibility checklists or handbooks, and expanded utilization of existing services and resources like DAS and the Center for Faculty Development & Excellence (CFDE).

Given the context of the non-mandatory faculty and staff culture as discussed above, students from both focus groups did report concerns about interventions that focused on staff; as one student, TS, put it, “I just think that anything that includes faculty and staff is, I feel like that is just a very difficult thing to tackle, ‘cause, I mean[…]it's like, there's no incentive [to focus on inclusion], really, and there's no disincentive [for not doing it].”

One suggestion discussed by both leadership and student participants was the use of inclusive strategies for pedagogy and classroom management that pre-emptively provide support for all students in the classroom without necessitating that students access formal accommodations. All four faculty and leadership participants mentioned currently available trauma-informed pedagogy workshops as a source of significant faculty growth and learning, especially horizontal sharing of effective strategies between faculty members: “maybe there's a way of working with faculty, because we don't get a lot of training on this—or opportunities to exchange maybe, training is the wrong word. I think training is the the minimum part, but having a space [like the trauma-informed pedagogy workshops…at the last workshop I attended] somebody said, ‘oh, you know, I have the students work out a contract for how they agreed to behave and engage in the classroom, a conduct contract,’ and I said, ‘Oh, would you share that with us, you know, can we share your language of how you're doing these things?’ And I feel the same thing around any issues and work related with students with disabilities. Two students supported a strategy their professors used for helping all students in the classroom succeed, as explained here by NJ: “I wish it was just protocol for like professors to have like an anonymous link at the beginning of the semester, like, ‘Hey, do you have any special accommodations and you don't feel comfortable approaching [me]? Put it in this box!’ And then if it's things like ‘I need image descriptions,’ or whatever it is, [they can provide that without students having to disclose why they need that support].”

Another frequently identified potential solution was the use of some form of accessibility or inclusion-related checklist or handbook. Both members of leadership discussed at length the development of a new DEI curriculum assessment tool which they rolled out to faculty in mid to late March 2022; the self-guided assessment is designed to “[help faculty] to look at their courses during the course preparation phase. [That tool] says we want to be as inclusive as possible, so as you prepare for your course, let's say for next fall or whatever, use this tool to kind of determine dimensions of diversity, equity and inclusion you could emphasize and you can pay attention to your class, depending on what your class is.” Both student focus groups also suggested using similar tools to help set faculty up for success. Members of leadership and students alike did suggest that this approach does have limitations, including the idea that “what I hear back [from faculty] is, you know, ‘it's overwhelming. And it's a lot of extra work.’ And that is the truth. It's the truth. And the truth is that it’s overwhelming and a lot of work—*and* it's also very important if we're going to [make RSPH a more inclusive space].”

One of the barriers identified by all participants was the lack of faculty and staff knowledge about and comfort with disability, as well as a perceived lack of resources (including time and energy) that could help support faculty who want to do that hard work. One faculty participant and both members of leadership identified voluntary sources of information and support, including trauma-informed and Universal Design for Learning (UDL) training opportunities and workshops hosted by the CFDE and the Canvas IT team and an online Canvas course resource for faculty on using Canvas effectively for online courses which includes principles of UDL. One faculty member shared that when they want to check that the way they incorporate disability or other aspects of diversity into their courses, they often reach out to DAS and the Office of Diversity, Equity & Inclusion (ODEI) directly to seek guidance. Potentially, incentivizing or increasing awareness about the existence of these resources may be one effective strategy to improve disability inclusion at the faculty and staff level. That said, all faculty and leadership participants discussed that without administrative support (see below), faculty may not prioritize utilizing these resources.

One final, more minor suggestion, agreed upon by six of the eight student participants, was that faculty actively think about the ways in which they assess students. As YD succinctly put it, “I would like to propose that the professors very critically consider whether time limits on assessments are necessary.”

SUBCODE: Administrative and Environmental Recommendations

This subcodes outlines recommendations for improving disability inclusion which target or focus on an environmental, institutional, or administrative level, including those interventions which directly target all RSPH community members. Broadly, these recommendations focus on improving the built environment, streamlining students’ access to support services through organizational capacity-strengthening, visibility campaigns and events, addressing the lack of institutional support for inclusion activities, and community-building interventions that connect faculty, staff and students.

All eight student participants discussed aspects of the built environment at Emory that could be a source of potential harm to disabled students, from the triggering artwork posted in both the Grace Crum Rollins and Claudia Nance Rollins buildings to the fact that for the two-plus years that the Randall Rollins building has been under construction, the only wheelchair-accessible way that students can travel from the health sciences side of campus to the rest of campus is by going inside of the CAPS building (1462 Clifton Road) and taking the elevator, which creates a significant barrier when that building is closed for any reason. One focus group also spent time discussing the furniture in RSPH buildings; two students with chronic pain agreed that “a lot of times cost efficient furniture [like what is available at RSPH] is really inaccessible[…]I just sometimes want to like sit down and not feel like I'm gonna die[…]it would be great if there were--especially in the classrooms and stuff—some places you could sit that are not just those awful chairs.” Hiring and listening to accessibility auditors who are disabled could help Emory, and RSPH more specifically, improve the built environment to enhance inclusion.

Along with increasing faculty knowledge and use of currently-available supports like DAS, CFDE and ODEI, students in both focus groups identified the need for improved visibility and capacity of those and other supportive services. Six of the eight student participants reported feeling unsatisfied with the current CAPS process and available resources; two students explicitly suggested that disabled students have mental and emotional health needs that are unique, especially during the process of seeking a diagnosis. One mentioned that neither DAS nor CAPS had suggested resources for therapists who hold expertise in supporting disabled people, while another, FN, suggested that “CAPS and DAS [do] need to work together. They should incorporate a representative to where if a student is in process of getting diagnosed, that they could do like a certain check in. That's very important.” In addition, as discussed above, getting disabled students connected with resources as soon as possible was deemed an important recommendation by both student focus groups—this theoretical increase in students who use support resources may require additional funding or support from the institution for those support services to adequately expand.

Another suggestion, identified by two students, one faculty member, and one member of leadership, was increasing visibility of disability at RSPH through promotional events and visibility campaigns. The member of leadership who mentioned this suggested that current DEI efforts are expanding to include disability throughout a larger visibility campaign. A student, TS, suggested that “it'd be great if DAS would once in a while come over to campus and you know, [there are] several different subjects you could do [promotional events] on that you could say like ‘what does a disability looks like? What services are available on campus?’ And also, I think a really interesting [topic] that could be [specific to] public health is like, disability within public health, not only [discussing] it as a subject, but also people with disabilities working in the field.”

A barrier identified by students, faculty and members of leadership alike was the real or perceived lack of institutional support for inclusion activities; one student in particular who had been involved in a successful activism campaign to replace some of the more obviously harmful artwork in CNR and GCR noted that “the things that I heard said, especially after [the campaign] that maybe I wasn't supposed to know about, just made me deeply distrustful of the intentions of Rollins administration, with some exceptions.” The key informant who shared that department leaders stopped meeting directly with students after students brought racism within their department to leadership attention also expressed concern that administrators who are not receptive of constructive criticism from student advocates may do more harm than good.

Both members of leadership interviewed identified top-down support as an essential driver of positive change, with one suggesting that “At the school level, we have a responsibility to support those faculty in the departments to bring that lens to that review, right. Because, again, just as much as we're not all trained as psychologists and therapists and physicians, we're also not trained in education and pedagogy. We're trained in specific content areas. And so we cannot assume that people know how to do [those things]. So there is a role for the school to provide that support and the tools, but then I think it's up to the departments to implement.” The other member of leadership also mentioned that, given barriers like stigma and financial costs associated with diagnosis of some disabilities that may keep some students from successfully accessing accommodations, “[how we accommodate non-diagnosed students with disabilities] a good question for us as a school to really think about, and then devise whatever that response should be in terms of how do we advise other classroom instructors in terms of what we want to do to create a standard [procedure].”

The final recommendation for change, identified as a high priority recommendation by all 12 participants, was the establishment of a formalized structure for building community, understanding, and empathy across all RSPH community members. If faculty, staff and students could find some way to connect and share their experiences without fear of stigma or shame, disability inclusion may be a positive natural consequence, as student NJ suggested: “I might be more honest and forthcoming [about my disabilities] if I really truly thought that people were going to be receptive…maybe we [disabled students] would be advocating for our needs more.”

When asked what might look different if RSPH were truly inclusive of disability, a student, DD, and a member of leadership had almost identical answers. DD suggested that “there needs to be like a bridge for all of those areas in which we feel like we can't connect because in some way, shape or form, we all can connect. Me having a disability is no different from somebody who hasn't identified their disability or just flat out doesn't have one at all. But in some way, shape or form, we can meet in the middle,” while the member of leadership suggested that “if you can ever get to different pockets of people, this is not a hard group to explain the importance of these issues. I think it's more up to us [as an administration] to figure out the best way to be efficient with that, to kind of facilitate this in a way that makes it reachable for [everyone]. And then you give them the opportunity to debrief [those experiences] in a way that makes sense.”

Faculty, staff, leadership, and student participants all agreed that although this work may be hard and some solutions may not be successful, “the message [must be] that everybody has to participate if we're going to build a culture in a community that is diverse, that has equitable features and principles, and also that is inclusive, so that everybody feels like they belong here,” as one member of leadership worded it.

Chapter 5: Discussion

The results of this formative needs assessment revealed a number of concepts and contextual factors that significantly affect the current state of disability inclusion at RSPH. In addition to the themes, codes and subcodes identified in the qualitative results section, important concepts which emerged from the qualitative and quantitative data collected for this special studies project must be further discussed in order to appropriately ground the recommendations for change identified in the conclusion of this document. Important concepts drawn from this data include: the current duality of intent to include disability versus ability to include disability in and outside of the classroom; the role of the medical model in shaping public health professionals' understanding of disability as a social determinant of health; and student participants' perceptions of disability and accommodations.

Additionally, it is vital to further discuss concepts related to strategies directly or indirectly identified by participants as potential solutions, including: the current curriculum approval process and its relationship to disability inclusion; concerns associated with the use of accessibility checklists; and the use of universal design for learning to appropriately address concerns about students who feel uncomfortable disclosing their disability or who are not currently involved in the formal accommodations process. Finally, the limitations and delimitations of this research must be discussed to address the potential validity, rigor and utility of this special studies project.

Duality of Intent to Include and Ability to Include

The most salient results of this formative needs assessment are indicative of two important but competing concepts: first, that all participants report a genuine desire to establish a more diversity-inclusive community; and secondly, that faculty, staff, members of leadership and students alike do not feel well-equipped to build that inclusive community given the current context. Disabled students reported seeking a learning environment which understands, respects, and supports their lived experiences and themselves as whole people, just like any other students. Faculty and staff reported wanting to be perceived by others as supporting inclusion almost unilaterally, both in the survey and in key informant interviews. Students, faculty, staff and members of leadership all identified having what the current evidence base would call "brave spaces," in which community members can speak with each other about their diverse lived experiences without fear of shame or invalidation, as essential to building empathy and community (Ali, 2017). This desire for genuine connection as a method of supporting a culture of inclusion is supported by current research, which suggests that experiential learning and empathy-building are two of the most effective strategies to decrease interpersonal bias and discriminatory behavior (NASEM, 2018).

Although all Emory community members involved in this formative research suggested using some kind of participatory, community-building approach to increase inclusion of disability in curricula and culture, participants did not seem to agree on the exact methods, which may indicate a mismatch of expectations and perspectives. While the majority of faculty and staff alike suggested that training on effectively working with students would be helpful in the survey, key informant interviews revealed major hesitancy regarding expanded training expectations, due in large part to the "non-mandatory" culture and contextual factors related to lack of administrative support. Faculty and members of leadership both identified that faculty members are currently overextended in trying to meet their current expectations, which include but are not limited to: teaching; conducting high-quality public health research; seeking funding for that research; mentoring students both informally and through formal measures like thesis advising; partnering with stakeholders to improve public health efforts in the local community; participating in interdisciplinary andcross-cutting work on campus at Emory; and the responsibilities associated with their personal lives.

Further, faculty and members of leadership identified that the current perception that RSPH (and Emory more broadly) is a research institution and faculty are expected to come into the community primarily as subject matter experts, contributes to a culture where any additional expectations for faculty regarding pedagogy are viewed as unrealistic at best and actively harmful to faculty at worst. All RSPH community members, including students, are aware that faculty are expected to spend little, if any, time focusing on their pedagogical methods; while the students in one focus group unilaterally supported required training for Emory faculty and staff on how to work effectively with disabled students and other Emory community members, the students in the other group explicitly stated that mandating change through required training or curriculum requirements was unrealistic given that there are neither incentives or disincentives for faculty to participate.

Given these external and academic pressures and the "non-mandatory" culture, it is no surprise that faculty do not feel empowered to center inclusion in the classroom through building lesson plans with inclusion in mind, ensuring that their materials are inclusive, or seeking further knowledge about how to discuss disability in the context of their field of study. All these are strategies that could support students' success regardless of ability level (AUCD, 2016; Capp, 2017). Blame for the current lack of inclusion in RSPH culture and curriculum cannot lie exclusively with faculty, however. A major factor in faculty members' disempowerment is the ongoing lack of institutional support.

As noted by several faculty, staff and student participants, changing the culture of RSPH to better include disability into public health practice and pedagogy will require significant administrative and institutional investment and support. Given that RSPH faculty already feel overworked and overwhelmed with existing explicit and implicit expectations, additional expectations for training and or curriculum development will be destined to fail unless the institution increases support measures for faculty and staff in tandem with those increased responsibilities, as supported by existing evidence (Nelson, 2021; Lindsay et al., 2018; Loreman, 2010). Both members of leadership interviewed for this needs assessment identified that faculty and staff need more institutional and administrative support to feel capable of such change, but neither of them identified specific, actionable changes that could help faculty feel more supported.

Further, the current model that RSPH has used to attempt to increase faculty and staff members' exposure to DEI-related content does not appear to include any strategies designed to reduce the impact of external factors on faculty's willingness to participate. Such strategies might include increasing pay rates, less strict expectations for ongoing and consistent publication or research funding requirements, and blocking out specific time in which all RSPH faculty and staff are paid to actively, intentionally engage with evidence-based, participatory experiential training and community-building activities. Additionally, current strategies used to increase faculty and staff exposure to DEI-related content are either completely voluntary—thus decreasing the likelihood that faculty who are already feeling overwhelmed will participate—or centered on the departmental level, a strategy which means that faculty in one department may get better, more accurate, or more in-depth information than another department. The same concerns are likely true with regards to student exposure to ethical or DEI-related content, as departments which regularly discuss social determinants of health as they relate to public health activities and theories, like BSHES and Global Health, may be more effective in helping students understand the important role that diversity plays in public health than departments which are more "hard science" centered, like Biostatistics and Epidemiology.

The Role of the Medical Model of Disability in Public Health Curricula and Practice

Although most participants understood disability as a complex spectrum where ability, social perception, time, and severity of disabling condition all intersect, the shadow of the medical model was evident throughout this formative assessment process and appears to have a relatively significant impact on the ways that public health professionals and students understand the role of disability in public health. The medical model, which pathologizes a difference in physical or mental structure, presentation or ability as a disease or other medical condition, is a common perspective among medical and medical-adjacent professions. Often, students in medical and health-related professions are taught that all disabled people need to be adequately supported by medical and health services is to be seen by a specialist who is an expert in their condition and to gain access to those medications and medical procedures which their disabling condition requires.

This understanding of disability does not, however, explain the social aspects of disability, which often have more far-reaching implications than a disabled person's medical condition(s). Public health interventions are rarely, if ever, designed to be inclusive of disability from the start, and often even federally funded, nationwide public health programs and awareness campaigns intentionally or unintentionally exclude disabled people—a 2017 report suggests that 71% of the programs recommended by the Community Guide, a CDC project aimed at increasing implementation of recommended, evidence-based programming in community public health settings, would need some accommodation to appropriately include disabled people (Hinton et al., 2017).

Although public health professionals and students are generally more prepared to see and understand disability as a social determinant of health than their purely medical colleagues might be, the data collected for this project indicates that the medical model has impacted the public health perspective of disability. Students, faculty, and members of leadership all suggested that disability should be covered more in classes which focus on social determinants of health than in methods-based courses, possibly because their understanding of disability is centered around disabled people accessing healthcare specifically related to their disability and not that our public health campaigns, interventions and research should not exclude the 25% of the population that has one or more disabling conditions.

Disabled people are present in complex humanitarian emergencies, in areas with active HIV prevention campaigns, in areas with ongoing water, sanitation and hygiene (WASH) interventions, in areas experiencing infectious disease outbreaks, in the statistical calculations we use in public health research, and in all topic areas and physical places that public health professionals work and practice. To exclude 20-25% of *any* population targeted for public health intervention would be harmful; to exclude subgroups of the population that are already marginalized and are often at higher risk of associated negative health outcomes is actively unethical. If the public health perspective does not incorporate disability as a relevant, salient social determinant of health in every situation and context, it cannot adequately protect the public, especially those members of the public who are already at higher risk.

Student Perspectives on Disability and Accommodations

Student participants' lived experiences with disability and inclusion aligned closely with evidence from the existing body of research. Although all student participants reported having a condition that qualifies as a disability according to the WHO's ICF criteria, two of the eight students did not identify themselves as having a disability in the quantitative data collection process. This finding was supported by the existing body of literature, which suggests that a person's understanding and identification with disability as a social identity is often secondary to the development or diagnosis of a disability (Forber-Pratt et al., 2017). The potential implications of this finding are especially salient for students who may be forced to reckon with their disability and/or their disability identity while adjusting to graduate school, as well as students whose disabilities are not diagnosed or documented and who may therefore not be able to access DAS services and accommodations.

Even among those students who did identify as disabled or as having a disability prior to the focus group discussion, several participants in this special studies project mentioned that they disclosed their disability selectively and only after feeling comfortable with the people to whom they disclosed. This is also a relatively common phenomenon, as several studies have found that people with disabilities are hesitant to disclose their disabilities and support needs in the academic environment to avoid stigma and shame from others, especially the faculty and staff on whom they may rely for accommodations, mentorship, or research opportunities (Olney & Brockelman, 2003; Smith et al., 2019). Student participants also reported feeling forced to disclose specifics about their disability to justify and fully access their accommodations, a phenomenon well-documented in existing literature (Smith et al., 2019; Lindsey et al., 2018).

Another phenomenon of note identified through this special studies project is the increased likelihood that graduate and professional students may be less likely to seek or effectively navigate accommodations due to factors unrelated to their disability. As these results suggest, students whose disabilities are newly acquired or whose functioning limitations have only been discovered during their postsecondary education experiences may face additional barriers to accessing accommodations due to internalized ableism, lack of familiarity with their rights and/or the accommodations process, and a lack of knowledge about learning strategies that will maximize their success. An additional barrier reported by student participants in this special studies project was the role that time out of school can play in accessing accommodations—three participants explicitly linked the time they had spent working between their undergraduate and graduate studies with feeling less confident in their accommodation needs, often specifically *because* so much time had elapsed since they were last in a classroom environment.

Finally, student participants' understanding of and comfort with their disability identity was significantly affected by the support—or lack thereof—they received from peers. Although in-depth protocols were developed to appropriately support student focus group participants who felt overwhelmed, triggered or upset, these protocols were never used, as all student participants reported that the focus group experience was overwhelmingly positive. Several students indicated that they felt empowered and that they had a real sense of disability community as a result of participating in the focus group discussion. This finding has significant implications for potentially effective interventions, especially when supported by existing research that suggests that formalized peer support systems can be incredibly beneficial for students with disabilities' psychosocial wellbeing (Olney & Brockelman, 2003; Krieder et al., 2020).

Curriculum Approval and Disability Inclusion

The current process for approval of new RSPH curricula is as follows: (1) a faculty member develops a syllabus and curriculum plan for the new course; (2) the syllabus and curriculum plan are submitted to the Education Committee, a group of administrators, faculty and two students selected by the Rollins Student Government Association (RSGA); (3) after a period of review, the Education Committee approves or rejects the course proposal, including any comments or recommendations for improvement as well as any required changes for future approval of the course (RSPH, 2019). This process includes students, which could be beneficial for disability inclusion if one or more of those students were disabled or had extensive knowledge and awareness of best practices for disability inclusion; it also allows for review to include aspects of diversity, an element which one member of leadership reported has become much more relevant to decision-making about approving courses in recent years.

In conjunction with the DEI checklist made public in March of 2022, this curriculum approval process could be a potent source of disability inclusion in curricula, which has been identified in both this special studies project and existing literature as a major factor both in improving disabled students' academic experiences and in increasing disability awareness and inclusion among currently-abled students (Matthews, 2009; Capp, 2017). Based on currently available information, however, it does not appear that this process is viewed by faculty or leadership participants or by Education Committee members as an ideal opportunity to assess disability inclusion in public health. Further, the course approval process is only required for new courses and one member of leadership explicitly stated that there is no ongoing effort to audit or evaluate the presence of DEI in existing classes, although some systemic review does happen every seven years during the Council on Education for Public Health (CEPH) re-accreditation process and individual departments may assess their course offerings more frequently if they choose to do so

(RSPH, 2019). The most recent CEPH re-accreditation of RSPH was confirmed in 2020 according to one member of leadership, meaning that the next time there is any planned systematic review of existing course offerings will not be initiated for at least five years at the time of this writing.

Accessibility Checklists and “Checking Boxes”

While research for this needs assessment was ongoing, RSPH rolled out a “DEI checklist,” as it was referred to by both members of leadership, intended to help faculty self-assess the inclusion of various underrepresented groups and perspectives in their course curricula. Once faculty have identified areas in which they want to improve, both members of leadership suggested, faculty can then move forward, seeking out support as needed, to make any desired changes to their curriculum.

Accessibility checklists and other methods of auditing disability inclusion and accessibility offer a chance for individuals, organizations, and communities to self-reflect and identify areas where they want or need to create change. They can help sensitize those who are not yet aware to the barriers to access that disabled people face, which is often an essential step in increasing empathy and improving inclusion (Piepzna-Samarasinha, 2022).

Aside from concerns about the efficacy and effectiveness of voluntary self-assessment as a source of positive change as already discussed above, such accessibility “checklists” are often criticized in DEI and disability rights and justice advocacy work as a way for those who use them to check off boxes and then determine, once all boxes are checked, that they have “solved” inclusion-related issues (Piepzna-Samarasinha, 2022; Brown, 2021). Checklists cannot possibly include every single access need or potential issue associated with improving inclusion of diverse people and perspectives, but often those who use them assume that so long as all the boxes are checked, there is no ongoing need to revisit current accessibility procedures or ask about access needs.

Further, identifying gaps in current curricula is only the first step—accessibility checklists often do not include resources on what those who use them can do to fill those gaps. Based on currently available information, there does not appear to be a way for faculty who use the DEI checklist to identify resources they can approach with questions or for support. As discussed above, there must be ongoing and institutionalized support for sustainable behavior change associated with improving inclusion of diverse perspectives (including disability).

Universal Design for Learning (UDL) as an Effective Intervention

One concerning phenomenon observed in the qualitative data was that of student participants' discomfort with, avoidance of, or other lack of access to requesting formal accommodations. This phenomenon is not unique to this data, as there is a relatively large and ever-growing evidence base suggesting that disabled students do not feel comfortable advocating for their needs and lived experiences and often avoid disclosing their accommodation needs and their disabilities more generally (Lindsay et al., 2018; Evans, 2019; Matthews, 2009). While decreasing disability stigma and encouraging students who are struggling to connect with support resources and seek formal accommodations can help students feel more comfortable disclosing their disability and support needs, there will almost certainly still be students who do not feel comfortable with disclosure and who will, therefore, not gain access to the accommodations they need or want. Further, several key informants and focus group participants expressed a desire for RSPH instructors to utilize pedagogical strategies that minimize formal disclosure while still providing support to those students who need it, from restructuring curricula to be more inherently inclusive to anonymously asking all students what they need to be successful at the beginning of the semester.

UDL is a framework which aims to "change the design of the [learning] environment" to intentionally minimize barriers to learning by (re)designing curricula to be inclusive of a range of diverse ability levels and cultural and social identities (CAST, 2022). UDL asks educators to consider the ways that students access information, build persistence and understanding, and internalize information and educational empowerment across three main principles: engagement with the material; representation of concepts and materials; and action and expression based on what they have learned (Wakefield, 2018). UDL is a particularly effective intervention strategy for improving disability inclusion because it does not require students to disclose personal barriers to learning—rather, UDL requires educators to plan ahead by creating a learning environment in which students are encouraged to find purpose and motivation, become knowledgeable and resourceful, and think strategically with a goal in mind (Wakefield, 2018). By designing curricula and lesson plans that already include a multitude of options for students to engage, build understanding and internalize what they learn, educators can set themselves and their students up for success regardless of students' support needs and learning styles. Further, postsecondary educators have reported that by using UDL, they minimize the effect that students' formal accommodations may have on their planned curricula and lessons, thus relieving faculty stress and feelings of overwhelm (Edyburn, 2020; Hromalik et al., 2020).

While implementation of UDL can be perceived as overwhelming to educators who feel that they would need to completely overhaul existing curricula to incorporate the guiding principles of UDL, many advocates for UDL—including CAST, the research organization responsible for creating the UDL—suggest that implementation can happen gradually, and that once educators are knowledgeable about and comfortable with UDL guidelines from a conceptual standpoint, it becomes significantly easier for educators to adapt existing content and create new content that aligns with the guiding principles of UDL (CAST, 2022; Capp, 2017; Edyburn, 2020). Although at least two UDL training opportunities are available to RSPH faculty and staff at this time, currently available information suggests that faculty and staff do not have adequate exposure, time, or institutional support to actively engage with these opportunities.

Limitations and Delimitations

Although the initial design of this research included a focus group discussion with currently-abled students, challenges in recruiting currently-abled students for focus group participation and time limitations forced the removal of this group of participants from the proposed research design. Such data would likely have enhanced understanding regarding the role that currently-abled students play in establishing a culture of inclusion at RSPH.

The low response rate of students, faculty and staff to the study surveys presented another limitation of this project. Although it was possible to statistically analyze data from the responses, it is not scientifically sound to make analytic conclusions from the quantitative findings with such a limited sample. Additionally, adaptations that had to be made to survey measures likely have some effect on the quantitative results. This was, unfortunately, unavoidable, as developing survey measures from scratch and assessing their external and internal validity was not feasible considering the scope of this special studies project.

One delimitation of this project was the relatively narrow scope outlined for this formative assessment. A sample which included graduate and professional students throughout Emory University would likely provide results that may be applicable in a wider range of contexts and could explore the experiences of RSPH students as compared to those of graduate and professional students at Emory more broadly. Due to the nature and purpose of this project and the complex relationships between different departments and schools within Emory, it was deemed not feasible to expand the scope of the research beyond the RSPH.

Chapter 6: Conclusion

People with disabilities are a large and relevant portion of the populations with which public health professionals work to improve the health of communities. As the Black Lives Matter and #MeToo movements have facilitated increased awareness of the need for more diverse, inclusive and equitable communities in recent years, societal-level interest in how we can intentionally and effectively improve DEI practices to support diverse communities in the academic sphere has been on the rise as well. In order to support the personal and community health not just of current Emory community members but also the communities with which Emory students, faculty, staff, leadership, and alumni work to support public health, RSPH must ensure that disability is present in curricula and culture.

This special studies project identified several important gaps related to disability-inclusive public health practice in the Master of Public Health curriculum that RSPH currently uses. Two major factors that contribute to this lack of disability inclusion are a systemic lack of knowledge and comfort with disability across faculty, staff, and currently-abled students and the lack of institutional support and expectations regarding disability inclusion. Further, those students at Rollins who have disabilities report facing significant barriers to their emotional, mental and physical health as well as their academic success, including a lack of holistic and/or accessible resources, stigma associated with disability, and challenges in navigating and accessing diagnostic services and/or the formal accommodations process.

Although these findings are broadly in line with the existing body of literature, it is important to understand the unique factors that influence the culture of inclusion at RSPH, including a non-mandatory culture and the high expectations placed on students and faculty alike. Given the results of this assessment regarding the current state of disability inclusion at RSPH and scientific evidence, a number of important recommendations for future change, have been identified.

Implications for Public Health Curricula and Practice

The implications for public health curricula and culture at RSPH include but are not limited to: improved academic outcomes and mental health outcomes for disabled students; increased awareness of disability among RSPH community members, including currently-abled students and faculty and staff; increased visibility of disabled community members; and implications for future public health practiced by RSPH students, faculty, staff, and alumni. The indirect effects are potentially significant, as students who graduate from and faculty who are appointed to RSPH are often found in positions that have significant influence over national and international public health campaigns, interventions and other public health-related activities.

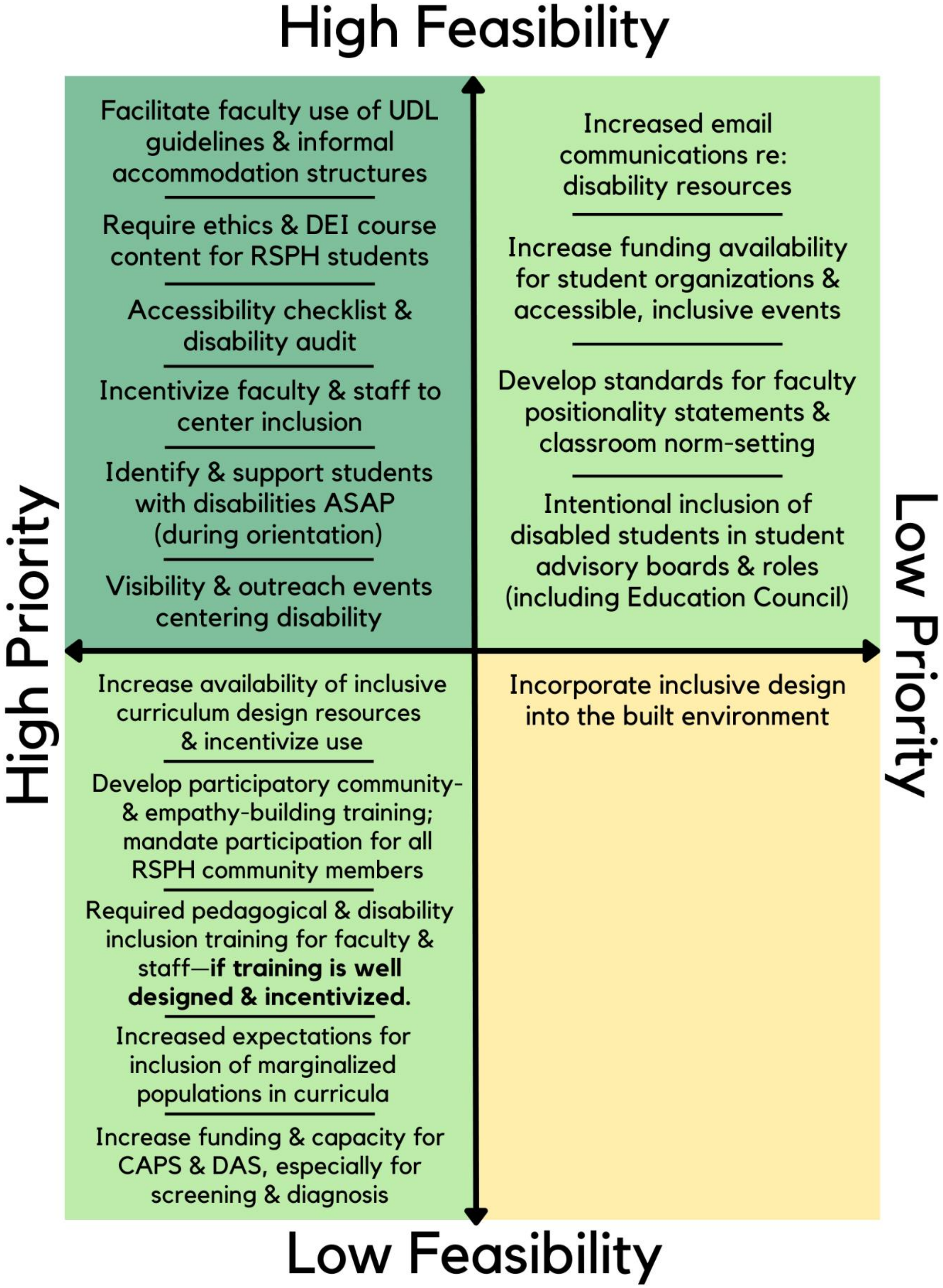
In order to ensure the longevity of RSPH's reputation in the field as a highly respected educational institution and fulfill its ethical responsibility to adequately prepare its students for public health practice in all contexts, RSPH should provide students with the information and skills to successfully navigate challenging conversations about effective interventions that help—rather than harm—underrepresented and marginalized populations, including disabled populations. The information gained from this special studies project can be used to inform changes that will have a direct and key impact on preparing future students to practice thoughtfully and ethically in the real world.

Additionally, the potential negative implications for public health education and practice if changes are not implemented are significant. Until the pedagogy of public health centrally incorporates disability in both curricula and educational praxis, the field of public health practice will lag and people with disabilities at RSPH and beyond may face unnecessary harm and structural violence.

Recommendations for Change

To best present recommendations for change as identified by participants and the author, all suggestions have been organized across two axes: (1) feasibility of implementing the recommendation and (2) priority level as identified by student, faculty, staff and RSPH leadership. Recommendations are thus summarized below in Figure 6.1, Recommendations for Change. Notable observations regarding these recommendations are detailed further below.

Figure 6.1: Recommendations for Change



	High Priority	Low Priority
High Feasibility	Facilitate faculty use of UDL guidelines & informal accommodation structures Require ethics & DEI course content for RSPH students Accessibility checklist & disability audit Incentivize faculty & staff to center inclusion Identify & support students with disabilities ASAP (during orientation) Visibility & outreach events centering disability	Increased email communications re: disability resources Increase funding availability for student organizations & accessible, inclusive events Develop standards for faculty positionality statements & classroom norm-setting Intentional inclusion of disabled students in student advisory boards & roles (including Education Council)
Low Feasibility	Increase availability of inclusive curriculum design resources & incentivize use Develop participatory community- & empathy-building training; mandate participation for all RSPH community members Required pedagogical & disability inclusion training for faculty & staff—**if training is well designed & incentivized.** Increased expectations for inclusion of marginalized populations in curricula Increase funding & capacity for CAPS & DAS, especially for screening & diagnosis	Incorporate inclusive design into the built environment

Among those solutions deemed highly important and highly feasible, the majority of respondents identified solutions that target the present non-mandatory culture of RSPH—including required training for faculty and staff and increased accessibility of resources for curriculum design like curriculum designers—as less feasible than those which did not include mandatory elements. Such suggestions may still require relatively high institutional and administrative support to be fully realized, but as discussed previously, an increase in institutional and administrative support is essentially required for any meaningful culture shift to happen.

The solutions deemed to be of higher priority and higher feasibility largely include ways in which institutional support can be used to facilitate inclusion without increasing expectations or requirements for faculty and staff. Given that both participants who were members of leadership interviewed explicitly stated that the school would prefer to avoid any increased expectations or requirements for faculty, it is not surprising that all RSPH community members have at least some understanding of that institutional preference and rated potential solutions according to that preference. With that said, it is likely that ongoing issues associated with disability inclusion cannot be avoided without some expanded expectations or requirements for faculty. Effective methods that could be used to implement or operationalize some of the less feasible high priority suggestions should, therefore, be considered seriously by RSPH leadership and administration. Considering significant increases in demand for mental health services among the numerous traumatizing events students have faced in recent years related to racialized systemic violence and the mental effects of the COVID pandemic, it is not surprising that student participants reported a very low degree of satisfaction with currently available mental health support services. As a result, it may be necessary for Emory to more heavily and intentionally resource its mental health services.

Lower priority solutions were largely centered around more passive methods of engaging with information and skills related to disability and disability inclusion. While increased awareness of existing resources and incorporating disabled students into ongoing initiatives and student advisory roles within RSPH are feasible and may be useful for some individuals, many participants reported concerns that such changes may not meaningfully contribute to improving disability inclusion in curriculum and culture at RSPH.

The sole low-priority low-feasibility solution suggested, designing inclusivity into the built environment (accessibility of facilities, walkways, and green spaces), would require so much funding and effort on the part of RSPH (and Emory more broadly) that even those participants who identified it as a recommendation agreed that such changes are unlikely if not impossible, especially given the fact that there is currently no centralized or standardized reporting system to which accessibility barriers can be reported. In order to identify current barriers to physical accessibility and appropriately adapt physical spaces to better accommodate all community members, this reporting system should exist and information about it should be publicized in multiple physical and virtual spaces, including Campus Services, Facilities Management, and individual departments' websites.

References

ADA. *Americans With Disabilities Act of 2010,* Pub. L. No. 101-336, 104 Stat. 328 (2010). Accessed via https://www.ada.gov/2010_regs.htm

Akakpo, C.W., Lobianoc, A., & Lollar, D. (2020). "Inclusion of disability content in graduate public health curricula," *American Journal of Public Health,* 110(10), p1509-1511. Accessed via https://doi-org.proxy.library.emory.edu/10.2105/AJPH.2020.305882

Ali, D. "Safe spaces & brave spaces: Historical context and recommendations for student affairs professionals," *NASPA Policy and Practice Series.* National Association of Student Personnel Administrators (NASPA). Accessed via: https://naspa.org/images/uploads/main/Policy_and_Practice_No_2_Safe_Brave_Spaces.pdf

Altschuld, J., & Kumar, D. D. (2009). *Needs assessment : An overview (book 1).* SAGE Publications. https://ebookcentral.proquest.com/lib/emory/detail.action?docID=996658

APHA. 2019. *Public Health Code of Ethics*. American Public Health Association. Accessed via https://www.apha.org/-/media/files/pdf/membergroups/ethics/code_of_ethics.ashx

Association of University Centers on Disabilities (AUCD), National Center for Birth Defects and Developmental Disabilities (NCBDDD), Office of the Director, Centers for Disease Control and Prevention (ODCDC), and the Office for State, Tribal, Local, and Territorial Support (OT). (2016). *Including People with Disabilities: Public Health Workforce Competencies.* Disabilities in Public Health. Accessed via https://disabilityinpublichealth.files.wordpress.com/2016/06/competencies-pdf-final.pdf

Aquino, K. (2020). "Exploring postsecondary administrators' inclusion of disability within their definition of diversity," *International Journal of Disability, Development and Education,* DOI: 10.1080/1034912X.2020.1808951

Bernstein, R.S., Bulger, M., Salipante, P. et al. "From diversity to inclusion to equity: A theory of generative interactions." *J Bus Ethics 167*, 395–410 (2020). https://doi.org/10.1007/s10551-019-04180-1

Berube, M. (2006). “Foreword: Another word is possible,” in *Crip Theory: Cultural Signs of Queerness and Disability.* New York University Press, New York.

Blumsztajn, A. (2020). “The empty form of fairness: Equality of educational opportunity as an instrumentalizing force in education,” *Policy Futures in Education, 18*:7, 834-839. DOI: https://doi-org.proxy.library.emory.edu/10.1177%2F1478210320942072

Bronfenbrenner. (1986). “Ecology of the family as a context for human development: Research perspectives”. *Developmental Psychology, 22*(6), 723–742. https://doi.org/10.1037/0012-1649.22.6.723

Brown, S. (2021). “Diversity, equity, and inclusion--or antiracism? They aren't the same thing. And neither involves quick fixes.” *The Chronicle of Higher Education, 68*(2). https://link.gale.com/apps/doc/A677253364/BIC?u=emory&sid=bookmark-BIC&xid=d61daeab

Capp, M. J. (2017). “The effectiveness of universal design for learning: a meta-analysis of literature between 2013 and 2016,” I*nternational Journal of Inclusive Education, 21*:8, p 791-807, DOI: 10.1080/13603116.2017.1325074

CAST (2022). “Frequently Asked Questions,” *UDL Guidelines*. Accessed via: https://udlguidelines.cast.org/more/frequently-asked-questions

Charlton, J.I. (2000). *Nothing About Us Without Us: Disability Oppression & Empowerment*. University of California Press, Berkeley & Los Angeles, CA. Accessed via: https://vidaindependente.org/wp-content/uploads/2018/07/Nothing-About-Us-Without-Us-Disability-Oppression-and-Empowerment-ilovepdf-compressed.pdf

Cieza, A., Sabariego, C., Bickenbach, J. et al. “Rethinking disability.” *BMC Med 16,* 14 (2018). https://doi.org/10.1186/s12916-017-1002-6

Cho, S., Crenshaw, K. W., & McCall, L. (2013). “Toward a field of intersectionality studies: Theory, applications, and praxis.” *Signs, 38*(4), 785–810. https://doi.org/10.1086/669608

Convention on the Rights of People with Disabilities (CRPD), New York, 13 December, 2006. Accessed via https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx

Committee on the Rights of Persons with Disabilities. (2016). *General comment no 4 (2016) on the right to inclusive education*, CRPD/C/GC/4, accessed via https://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx

Crenshaw, K. (1989) "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *University of Chicago Legal Forum (1)*8. Accessed via http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (2017). “Kimberle Crenshaw on Intersectionality, more than two decades later,” Columbia Law School News Story Archive. Accessed via: https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later

Cullen, J. & Noto, L. (2007). “The assessment of pre-service general education teachers’ attitudes toward the inclusion of students with mild to moderate disabilities.” *Journal for the Advancement of Educational Research, 3,* 1, 23-33.

de Beco, G. (2020) “Intersectionality and disability in international human rights law,” *The International Journal of Human Rights, 24*:5, 593-614, DOI: 10.1080/13642987.2019.1661241

Dusenbery, M. (2018). *Doing Harm: The truth about how bad medicine and lazy science leave women dismissed, misdiagnosed, and sick.* HarperOne, imprint HarperCollins, New York, NY.

Edyburn, D.L. (2020). “Universal usability and universal design,” *Intervention in School and Clinic, 56*:5, 310-315. https://doi-org.proxy.library.emory.edu/10.1177%2F1053451220963082

Evans, H.D. (2019). “’Trial by fire:’ Forms of impairment disclosure and implications for disability identity,” *Disability & Society, 34*:5, 726-746. https://doi-org.proxy.library.emory.edu/10.1080/09687599.2019.1580187

Finlay, L. (2002). “’Outing’ the researcher: The provenance, process and practice of reflexivity,” *Qualitative Health Research, 12*(4), 531-545. Accessed via https://journals-sagepub-com.proxy.library.emory.edu/doi/pdf/10.1177/104973202129120052

Forde, A.T., Crooked, D.T., Suglia, S.F., & Demmer, R.T. (2019). “The weathering hypothesis as an explanation for racial disparities in health: A systematic review.” *Annals of Epidemiology, 33*(1), 1-16. https://doi.org/10.1016/j.annepidem.2019.02.011

Garland-Thomson, R. (2017). *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature, 20th Anniversary Edition*.

Garcia, C. E., Arnberg, B., Weise, J., & Winborn, M. (2020). “Institutional responses to events challenging campus climates: Examining the power in language.” *Journal of Diversity in Higher Education, 13(*4), 345–354. https://doi.org/10.1037/dhe0000130

Gregory, J.L. & Noto, L.A. *Technical Manual for Attitudes Toward Teaching All Students (ATTAS-mm) Instrument*. Accessed via https://files.eric.ed.gov/fulltext/ED537530.pdf

Grimes, S., Southgate, E., Scevak, J., & Buchanan, R. (2019) “University student perspectives on institutional non-disclosure of disability and learning challenges: reasons for staying invisible,” *International Journal of Inclusive Education, 23*:6, 639-655, DOI: 10.1080/13603116.2018.1442507

Guest, G., Namey, E., Mitchell, M. (2013). *Collecting Qualitative Data: A Field Manual for Applied Research.* Sage Publications, Thousand Oaks, California.

Hahn, H. & Beaulaurier, R.L. (2001). “Attitudes toward disabilities: a research note on activists with disabilities,” *Journal of Disability Policy Studies, 12*(1) p 40-46, https://journals-sagepub-com.proxy.library.emory.edu/doi/pdf/10.1177/104420730101200105

Hahn, H. D., & Belt, T. L. (2004). “Disability identity and attitudes toward cure in a sample of disabled activists*”. *Journal of Health and Social Behavior, 45*(4), 453-64. Retrieved from https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/disability-identity-attitudes-toward-cure-sample/docview/201665074/se-2?accountid=10747

Hayes, J., & Hannold, E. M. (2007). “The road to empowerment: A historical perspective on the medicalization of disability,” *Journal of Health and Human Services Administration, 30*(3), 352-377. Retrieved from https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/road-empowerment-historical-perspective-on/docview/199995741/se-2?accountid=10747

Hennink, M., Hutter, I., and Bailey, A. (2011) *Qualitative Research Methods,* SAGE Publications, Thousand Oaks, California.

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). “Code saturation versus meaning saturation: How many interviews are enough?” *Qualitative Health Research, 27*(4), 591–608. https://doi.org/10.1177/1049732316665344

Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? Estimating sample sizes in focus group research. *Qualitative Health Research, 29*(10), 1483–1496. https://doi.org/10.1177/1049732318821692

Hinton, C.F., Kraus, L.W., Richards, T.A., Fox, M.H., & Campbell, V.A. (2017). “The guide to community preventive services and disability inclusion,” *American Journal of Preventive Medicine, 53:*6, 898-903. https://doi-org.proxy.library.emory.edu/10.1016/j.amepre.2017.06.025

Hooks, b. (1994). *Teaching to Transgress: Education as the Practice of Freedom*. Routledge, Taylor & Francis Group. New York, NY.

Hromalik, C.D., Myhill, W.N., & Carr, N.R. (2020). “’ALL faculty should take this:’ a Universal Design for Learning training for community college faculty,” *TechTrends, 64*, 91-104. https://doi.org/10.1007/s11528-019-00439-6

Intercultural Education Advisory Group. (2020). *Emory Institutional Statement on Diversity.* Emory University. Accessed via https://equityandinclusion.emory.edu/resources/self-guided-learning/statement-terms.html

Jackson-Best, F., & Edwards, N. (2018). “Stigma and intersectionality: A systematic review of systematic reviews across HIV/AIDS, mental illness, and physical disability.” *BMC Public Health 18,* 919. https://doi.org/10.1186/s12889-018-5861

Jason, L., & Glenwick, D. (2016). *Handbook of methodological approaches to community-based research: Qualitative, quantitative, and mixed methods*. New York: Oxford University Press.

Lindsay, S. Cagliostro, E. & Carafa, G. (2018) “A systematic review of barriers and facilitators of disability disclosure and accommodations for youth in post-secondary education,” *International Journal of Disability, Development and Education, 65*:5, 526-556, DOI: 10.1080/1034912X.2018.1430352

Lorde, A. (2007). *Sister Outsider: Essays and Speeches*. Ten Speed Press, Random House, New York, NY.

Loreman, T. (2010). “Essential inclusive education-related outcomes for Alberta preservice teachers.” *Alberta Journal of Educational Research, 56*(2), 124-142. Retrieved from https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/essential-inclusive-education-related-outcomes/docview/763130804/se-2?accountid=10747

Kett, M., Lang, R. and Trani, J.-F. (2009), “Disability, development and the dawning of a new convention: A cause for optimism*?”. J. Int. Dev., 21*: 649-661. Accessed via https://doi-org.proxy.library.emory.edu/10.1002/jid.1596

Kreider, C.M., Luna, C., Lan, M., & Wu, C. (2020). “Disability advocacy messaging and conceptual links to underlying disability identity development among college students with learning disabilities and attention disorders,” *Disability and Health Journal , 13*:1. https://doi-org.proxy.library.emory.edu/10.1016/j.dhjo.2019.100827

Kupferman, S.I. (2014) "Supporting students with psychiatric disabilities in postsecondary education: Important knowledge, skills, and attitudes." *All Graduate Theses and Dissertations.* Utah State University 2067, https://digitalcommons.usu.edu/etd/2067

Marks, D. (1997). “Models of disability,” *Disability and Rehabilitation, 19:*3, 85-91. https://doi.org/10.3109/09638289709166831

Matthews, N. (2009). “Teaching the ‘invisible’ disabled students in the classroom: Disclosure, inclusion and the social model of disability,” *Teaching in Higher Education, 14*:3, 229-239, DOI: 10.1080/13562510902898809

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). “An ecological perspective on health promotion programs.” *Health Education Quarterly, 15*(4), 351–377. http://www.jstor.org/stable/45049276

McRuer, R. (2006). *Crip Theory: Cultural Signs of Queerness and Disability.* New York University Press, New York.

Moser, A. & Korstjens, I. (2018) “Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis,” *European Journal of General Practice, 24*:1, 9-18, DOI: 10.1080/13814788.2017.1375091

National Association of Social Workers (NASW). (2022). “NASW Diversity, Equity & Inclusion Committee Charter,” *National Association of Social Workers.* Accessed via: https://www.socialworkers.org/About/Diversity-Equity-and-Inclusion/Diversity-Equity-and-Inclusion-Committee-Charter

National Council on Disability. (2018). *IDEA Series: The Segregation of Students with Disabilities*. Accessed via https://ncd.gov/sites/default/files/NCD_Segregation-SWD_508.pdf.

National Science Foundation (NSF) and National Center for Science and Engineering Statistics (NSCES). (2021). *2021 Women, Minorities and Persons with Disabilities in Science and Engineering Report*. Accessed via https://ncses.nsf.gov/pubs/nsf21321/report

Nagata, D. K., Kohn-Wood, L., & Suzuki, L. A. (Eds.). (2012). *Qualitative strategies for ethnocultural research.* American Psychological Association. https://doi-org.proxy.library.emory.edu/10.1037/13742-000

Nevedal, A.L., Reardon, C.M., Widerquist, M.A.O., Jackson, G. L., Cutrona, S.L., White, B.S. & Damschroder, L.J. (2021). “Rapid versus traditional qualitative analysis using the Consolidated Framework for Implementation Research (CFIR),” *Implementation Science 16*:67. Accessed via https://doi.org/10.1186/s13012-021-01111-5

Nelson, R. (2021). *Teacher and Administrator Perceptions about Administrative Support for Teacher Inclusion, Successful Inclusion Implementations, and Barriers to Inclusion*. Northcentral University, Proquest Dissertations Publishing. Accessed via https://www.proquest.com/docview/2642906332?pq-origsite=primo

Nielsen, K.E. (2012). *A Disability History of the United States*. Beacon Press, Boston.

O'Rourke, J., & Houghton, S. (2006). "Students with mild disabilities in regular classrooms: the development and utility of the Student Perceptions of Classroom Support scale." *Journal of intellectual & developmental disability, 31*(4), 232–242. https://doi.org/10.1080/13668250601050310

O'Toole, C. (2013). 'Disclosing our relationships to disabilities: An invitation for Disability Studies scholars. *Disability Studies Quarterly*, *33*(2). Accessed via https://dsq-sds.org/article/view/3708/3226

O'Toole, C. (2017). "On the importance of community scholars in DS," *Disability Studies Quarterly, 37*(3). Accessed via https://dsq-sds.org/article/view/5896/4687.

Olney, M.F. & Brockelman, K.F. (2003). *"*Out of the Disability Closet: Strategic use of perception management by select university students with disabilities," *Disability & Society, 18:*1, 35-50. https://doi.org/10.1080/713662200

OSERS. (2021). "Legislation and policy," *Office of Special Education and Rehabilitation Services*. United States Department of Education. Accessed via https://www2.ed.gov/about/offices/list/osers/policy.html

Piepzna-Samarasinha, L.L. (2022). *Disability Justice: An Audit Tool*. Northwest Health Foundation. Accessed via: https://www.northwesthealth.org/djaudittool

Piepzna-Samarasinha, L.L. (2018). *Care Work: Dreaming Disability Justice*. Arsenal Pulp Press, Vancouver, BC.

Richardson, K. (2014). Deaf culture. *The Nurse Practitioner, 39* (5), 20-28. doi: 10.1097/01.NPR.0000445956.21045.c4.

Rollins School of Public Health (RSPH). (2022) "Overview of Rollins School of Public Health," Emory University. Accessed via: https://sph.emory.edu/about/overview/index.html

RSPH. (2019). *CEPH Re-Accreditation Self-Study, October 2019*. Accessed via: https://sph.emory.edu/about/documents/accreditation/rsph-self-study_october2019.pdf

Samuels, R. (2013, July 15). "D.C.'s H Street embedded with deaf culture." *The Washington Post.* https://www.washingtonpost.com/local/dcs-h-street-embedded-with-deaf-culture/2013/07/15/efd54732-e3f3-11e2-a11e-c2ea876a8f30_story.html

Schwiek, S.M. (2009). *The Ugly Laws: Disability in Public*. New York University Press, New York.

Shaw, R. M., Howe, J., Beazer, J., & Carr, T. (2020). "Ethics and positionality in qualitative research with vulnerable and marginal groups." *Qualitative Research, 20*(3), 277–293. https://doi.org/10.1177/1468794119841839

Sins Invalid (2019). *Skin, Teeth & Bone: A Disability Justice Primer*.

Smith, S., Woodhead, E. & Chin-Newman, C. (2019). "Disclosing accommodation needs: Exploring experiences of higher education students with disabilities," *International Journal of Inclusive Education*, *25*:12, 1358-1374. Accessed via: https://doi.org/10.1080/13603116.2019.1610087

Smeltzer, S.C., Blunt, E., Marozsan, H. & Wetzel-Effinger, L. (2015) "Inclusion of disability-related content in nurse practitioner curricula," *J Am Assoc Nurse Pract., 27:*4, 213-221. DOI: https://doi.org/10.1002/2327-6924.12140

Snyder, T.D., de Brey, C., and Dillow, S.A. (2019). Table 310.10, *Digest of Education Statistics 2018 (NCES 2020-009*). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education. Washington, DC.

Twardzik, E., Williams, M. & Mesesha, H. (2021). "Disability during a pandemic: Student reflections on risk, inequality and opportunity," *American Journal of Public Health, 111*(1), p 85-87. Accessed via https://doi-org.proxy.library.emory.edu/10.2105/AJPH.2020.306026

United Nations. (1975) *Declaration on the Rights of Disabled Persons* (General Assembly Resolution 3447). Accessed via https://www.ohchr.org/Documents/ProfessionalInterest/res3447.pdf

UNFPA. (2018). *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights.* Accessed via https://www.unfpa.org/publications/young-persons-disabilities

US Equal Employment Opportunity Commission (EEOC). (2022). “Overview,” US Equal Employment Opportunity Commission. Accessed via https://www.eeoc.gov/overview

Wakefield, M.A. (2018). *Universal Design for Learning Guidelines version 2.2 [graphic organizer].* CAST. Accessed via: https://udlguidelines.cast.org/binaries/content/assets/udlguidelines/udlg-v2-2/udlg_graphicorganizer_v2-2_numbers-yes.pdf

Washington Group on Disability Statistics (2020a). *The Data Collection Tools Developed by the Washington Group on Disability Statistics and their Recommended Use.* Accessed via https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/WG_Implementation_Document__1_-_Data_Collection_Tools_Developed_by_the_Washington_Group.pdf

Washington Group on Disability Statistics (2020b). *The Washington Group Short Set on Functioning – Enhanced (WGSS – Enhanced).* Accessed via https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Washington_Group_Questionnaire__3_-_WG_Short_Set_on_Functioning_-_Enhanced.pdf

West, R.M. (2021). “Best practice in statistics: Use the Welch t-test when testing the difference between two groups,” *Annals of Clinical Biochemistry, 58*:4, 267-269. DOI: https://doi-org.proxy.library.emory.edu/10.1177/0004563221992088

WHO (2020). *Fact Sheet: Disability and Health*. World Health Organization. December 12, 2020. Accessed via https://www.who.int/news-room/fact-sheets/detail/disability-and-health

WHO (2002). *Towards a Common Language for Functioning, Disability and Health: ICF*. WHO/EIP/GPE/CAS/01.3. Accessed via: https://cdn.who.int/media/docs/default-source/classification/icf/icfbeginnersguide.pdf?sfvrsn=eead63d3_4

Wolbring, G., & Lillywhite, A. (2021). “Equity/equality, diversity, and inclusion (EDI) in universities: The case of disabled people.” *Societies, 11(*2), 49. MDPI AG. Retrieved from http://dx.doi.org/10.3390/soc11020049

Appendix A: Recruitment Materials

Figure A.1: Recruitment Graphic for Faculty & Staff Survey

RSPH-AFFILIATED FACULTY & STAFF

SURVEY PARTICIPANTS NEEDED!

INTERESTED IN MAKING YOUR VOICE HEARD?

Participants will be offered the chance to win a $25 Amazon e-gift card. Responses will be kept anonymous and participation is voluntary. To participate, click the link below.

Please email nwarre3@emory.edu with any questions or concerns.

PARTICIPANT REQUIREMENTS

- Faculty & staff who work regularly with the Rollins School of Public Health
- Faculty & staff who have regular interaction with RSPH students
- 10-15 minutes of your time

www.surveymonkey.com/r/DIatRSPH-FS

Text of Faculty & Staff Recruitment Messaging:

> All faculty (including Adjunct and Emeritus) and staff who work regularly for the Rollins School of Public Health (RSPH), as well as all Emory faculty & staff who have regular interaction with RSPH students, are invited to participate in an **online survey on disability and disability inclusion**. Data collected from this survey will be anonymous and included as part of an exploratory needs assessment performed by second-year student Nikki Warren, of the Hubert Department of Global Health, in fulfillment of her master's thesis. The survey takes 10-15 minutes to complete. Participation is voluntary, and individual responses will not be tracked.
>
> Participants will be offered the **chance to enter to win a $25 Amazon e-gift card.**

To complete this survey, please click this link by 12/31/2021. Thank you in advance for considering participating, your responses are invaluable!

Figure A.2: Recruitment Graphic for Student Survey

All students who are currently enrolled in classes at the Rollins School of Public Health are invited to participate in an online survey on disability and disability inclusion.

Participants will be offered the chance to win a $25 Amazon e-gift card. Responses will be kept anonymous and your participation is voluntary.

To participate, click here.

Please email nichole.warren@emory.edu with any questions or concerns.

Text of Student Recruitment Messaging:

All students who are currently enrolled in classes at the Rollins School of Public Health are invited to participate in an **online survey on disability and disability inclusion**. Data collected from this survey will be anonymous and included as part of an exploratory needs assessment performed by second-year student Nikki Warren, of the Hubert Department of Global Health, in fulfillment of her master's thesis. The survey takes 10-15 minutes to complete. Participation is voluntary, and individual responses will not be tracked.

Participants will be offered the **chance to enter to win a $25 Amazon e-gift card.**

To complete this survey, please click this link before 2/15/2021. Thank you in advance for considering participating, your responses are invaluable!

Appendix B: Key Informant Interview Guide

Key Informant IDI Guide (MASTER)

Introduction/Consent

Welcome and thank you for your participation in this interview! Before we begin, I would like to let you know that this interview is not intended to judge or to "catch" anyone in relation to disability issues. This research project is seeking to understand the current state of disability inclusion at Rollins **without judgement**, so that any recommendations we may have for change will be contextually appropriate.

You have been identified as a key informant for this research because of your role(s) within RSPH and its potential relevance to disability and inclusion. Disability can be a complex issue, with language that changes all the time, and there is no expectation for you to be a disability expert, so please don't worry about your level of disability knowledge or using the "right" words.

There will not be direct benefits to you from your participation in this research. However, there might be other benefits associated with this research such as improvements to the quality and breadth of public health education, increased support for faculty & staff working with students with disabilities, and social benefits associated with intentionally creating positive culture.

I have and will continue to attempt to minimize potential risks associated with participating in this research. However, while there is no physical risk to participants, there are other risks associated with discussing sensitive topics, including potential psychological distress and social or economic risk as a result of unintended loss of privacy or confidentiality.

Your confidentiality is of utmost importance in this research. Any recordings from this interview will be stored securely in a password protected file on a personal password-protected computer and in a secure cloud location in accordance with existing data security protocols. In addition to ensuring that your responses will be stored securely and as anonymously as possible, I will share the completed transcript of this interview with you for review and approval before I begin the analysis process; further, I will continually work to ensure that my results, discussion, & final presentation and report do not provide any information that could be used to identify any research participant. All interview recordings will be permanently destroyed after the transcription and approval processes are finished. **De-identified** transcripts of this interview may be shared with my thesis committee members.

Your participation is fully voluntary, and choosing to participate in this research should not affect your professional life. Please feel free to let me know if there are any questions that you will prefer to skip answering during the course of our conversation or if at any time you wish to end the interview. If you choose to end the interview, your responses will be destroyed and will not be included in further analysis.

If you have any questions, you can ask them now or later–if you wish to ask questions later, please contact me, Nikki Warren, at nwarre3@emory.edu. For any concerns related to this research project you can contact RSPH's Professor Claudia Ordóñez (thesis chair) at claudia.ordonez@emory.edu [put thesis' chair email address in Zoom chat at this time]

Before we begin, do you have any questions?

If you are ready, we will begin the recording and confirm on the recording your consent to participate in the interview and be recorded.

[Let participants know that you are turning on the recorder]

START RECORDING

"*Do you consent to participating in the discussion today? Are you okay being recorded today?"*

Demographic/Warmup

First, we're just going to talk a little bit about you and what you do at Rollins and your experiences.

Could you please tell me your name and what you would prefer me to call you during this interview?

- What gender do you identify with?
- What is your title at Rollins? How long have you worked with Emory?
    - Probe: Tell me a little more about your role, what is your position responsible for?
        - (which are your responsibilities, student vs faculty/staff-facing, impact on policies at RSPH)

Now, I want to learn a little bit about your understanding of some terms before we move on. These questions really just help ensure that I know your understanding of terms so we're on the same page in this interview.

1) *How would you define disability?*
    a) Follow-up: Can disabilities be invisible?
    b) PROBE: How would you define accessibility?
2) *Have you had any experience with disability in your personal life?*
    a) Follow up: If yes, would you feel comfortable telling me a little more about this experience?
3) *How have you interacted with disability in your work at RSPH?*
    a) PROBE: Direct & indirect; students with disabilities AND disability as concept

Social Interactions Re: Disability

Now, we're going to move to talking about interactions around disability that you may have had with other people at RSPH.

4) *Tell me about any direct/one-on-one/face-to-face interactions you have had with students regarding disability or accessibility.*
    a) PROBE: Directly related to accommodations for SWD?
    b) PROBE: Did those students disclose a disability to you?
5) *Tell me about any interactions you've had with the Department of Accessibility Services regarding students with disabilities or reasonable accommodations.*
    a) PROBE: Was DAS involvement helpful/beneficial?

        i) If not, how could they have been more helpful? If so, what did they do that was helpful?

6) *Tell me in detail about a time that you helped provide accommodations to a student from first awareness/contact through the end of the course.*
    a) Follow Up: Are there accommodations that are harder to provide than others? Why?
    b) PROBE: What points of the process were frustrating, time-consuming or stressful?
        i) How did you navigate them? Was that navigation successful? Why/why not?
    c) PROBE: How was the student (or relationship with student) affected by accommodations/disclosure (from their perspective)?
        i) I.e. helped them understand behavior, created/reinforced/degraded relationship with that student, etc. (as well as student's behavior/presentation during disclosure)
    d) PROBE: What kinds of information or skills would be helpful for a faculty member to know in that accommodations process?
7) *When a student or faculty/staff member reports faculty/staff behavior that seems harmful, unethical, inappropriate, what does the response process look like?*
    a) Is there protocol in existence to address these issues? (If so, what?)
        i) Protocol outside of DTIX/Bias Incidents?
    b) What accountability measures exist for faculty/staff who do not follow the letter/intent of RSPH policies (including DEI, antidiscrimination, ADA, etc.)?

Comfort with Disability

Next, I would like to ask some questions about your feelings of comfort with disability-related topics.

8) *On a scale from 1-10, how confident are you in your ability to support students with disabilities at RSPH?*
    a) Follow-up: What factors would make you feel more comfortable to support students with disabilities at RSPH?
9) *Next I'm going to read you a statement; after this statement, I'll ask you a few questions about it. Students with mild to moderate disabilities should be taught in regular classes with nondisabled students because they will not require too much of the teacher's time. Do you agree with this statement? Why/why not?*
    a) Follow-up: What are some of the barriers that make it harder to provide accommodations/integrate disability?
        i) DAS? Time/other responsibilities?

Disability Inclusion in Curricula & Culture

10) *In your view, how does disability factor into public health curricula and practice?*
    a) PROBE: How can educators incorporate disability into their public health curricula?
    b) PROBE: How/in what area(s) should disability be incorporated into the curriculum at RSPH?

11) *Could you tell me about your understanding and perception regarding current diversity, equity & inclusion (DEI) efforts at RSPH?*
    a) Follow up: Do these efforts include disability issues? (Are they seen as separate issues?)
    b) PROBE: How would you describe the current state of DEI at RSPH?
    c) PROBE: How have you become aware of DEI efforts at RSPH?
        i) (One-on-one? Via email? In staff meetings? Etc.)

12) *What are some solutions that are feasible in the short term ("low-hanging fruit") that could make RSPH more inclusive of disability?*
    a) PROBE: In curricula and/or culture?

13) *How do you engage with the curriculum design/development/approval process?*
    a) Follow-up: Tell me about some of the rules/expectations/guidelines you and your colleagues use to design/develop curricula.
        i) PROBE: Formatting guidelines for PPTs/materials? Frameworks or logic models used?
        ii) PROBE: Any guidelines specifically relating to disability/accessibility?
    b) PROBE: Start to finish, A to Z, where they enter into (or are excluded from) development process
    c) PROBE: Are they content with the current system? What changes might they suggest to make curriculum development easier/more efficient?

14) *In the approval process, which factors are considered when making the final determination of whether a curricula/syllabus/etc is appropriate?*
    a) Follow-up: is there a checklist or set of minimum standards for courses other than those guidelines established by licensing/accreditation organizations?
    b) PROBE: Diversity of content? Scholarship involved? Theoretical frameworks?

15) *How does disability interact with DEI?*
    a) PROBE: Conceptually? Practically at RSPH?

16) *What kinds of DEI activities/continuing education/etc are offered for faculty/staff at RSPH or at Emory more generally?*
    a) PROBE: Which of those (if any) discusses disability?

Training

Let's talk a little bit about disability training now.

17) *Differentiated instruction is defined as a method of education which includes students at all skill and ability levels in the same classrooms and lesson plans. Would you like to be trained in effective differentiated instruction? Why/why not?*

    a) PROBE: What about learning from other faculty who know how to design appropriate academic interventions to create inclusive learning environments?
        i) Follow-up: If no to main, yes to probe: why this and not main?

18) *What are some of the potential challenges associated with increasing training expectations for faculty/staff?*
    a) Time, blowback from busy faculty/staff

19) *Tell me about any training, professional development or continuing education you have received regarding disability in the context of Rollins.*
    a) PROBE: Were any of these trainings part of a larger DEI training?
    b) Follow-up: In those trainings, what was most helpful? Least successful?
    c) PROBE: What kinds of training opportunities for inclusion and disability that you have not had would you find helpful?
        i) Follow up: How often should these opportunities be offered?

20) *What kinds of continuing education, faculty or staff training, or professional development opportunities for inclusion and disability would you find helpful as a staff member?*
    a) Follow up: How often should these opportunities be offered?
    b) PROBE: What other support would be helpful for faculty/staff who are working on including disability more/more completely beyond training and continuing education opportunities?

Wrap-Up/Final Comments

I just have a couple final questions to round out this interview.

21) *In a perfect world where DEI was appropriately and completely incorporated into RSPH (i.e. no funding limit, all the staff/expertise needed, etc.), what would be different than it is now?*
    a) PROBE: How/would DEI incorporate disability into its work?

22) *Is there anything I've missed in these questions? Anything important regarding disability or diversity that you feel like we haven't discussed fully?*

Thank you so much for your participation. Your insights are invaluable and will help me to both understand the current state of disability inclusion at Rollins and offer community-centered, evidence-based recommendations for future teaching, practice, policies and procedures. As a reminder, I will be sharing the interview transcript with you for final approval before including this information in the analysis of research findings.

Appendix C: Focus Group Discussion Guide & Visual Aids

[while participants are still in waiting room, send following message: *Please take a second to change your display name to the name you would prefer to be called during this focus group discussion and your pronouns if you feel comfortable doing so.*]

INTRODUCTION/INFORMED CONSENT (5-7 min)

Hello everyone! First I would just like to thank you all so much for being here! My name is Nikki Warren and I'm a second-year MPH student completing a formative needs assessment on the state of disability inclusion at Rollins School of Public Health in fulfillment of my thesis requirements. Michelle is here to keep us on track and take notes on our conversation today.

This project hopes to identify solutions that RSPH can introduce to create cultural and social change to improve disability inclusion. Understanding the student perspective on this issue is essential, and you [are the experts in what it's like to be a Rollins student with disabilities] OR [are showing solidarity with the people in your cohort who have disabilities. Also, increased awareness of disability in all its forms can help you to become a more reflexive and ethical practitioner of public health.] There are no direct benefits to you as a result of taking part in this focus group, but there may be other benefits associated with this research, like improvements to the quality and breadth of public health education, increased support for students with and without disabilities, and the social benefits associated with intentionally creating positive culture.

I have and will continue to attempt to minimize potential risks associated with participating in this research. However, while there is no physical risk to participants, there are other risks associated with discussing sensitive topics, including potential psychological distress and social or economic risk as a result of unintended loss of privacy or confidentiality.

Your confidentiality is of utmost importance in this research. Any recordings from this interview will be stored securely in a password protected file on a personal password-protected computer and in a secure cloud location in accordance with existing data security protocols. Additionally, I want to take a second now to talk about confidentiality among group participants. In order to ensure that the conversation we have today is as truthful as possible, we have to establish trust among the group about keeping this conversation confidential. Please do not talk to others outside of this focus group about any specific details of another person's experiences or personal information; further, please don't identify other people in this group as participants to anyone else or even to those participants if you engage with them in other settings—for example, it would be inappropriate for me to ask any of you how you felt about participating in this focus group discussion if I were to see you out and about on campus. What questions around confidentiality are there before we move on?

[wait for any questions]

Okay, great. Before we get to the informed consent and the actual discussion, there are a few things it's pertinent for me to discuss. First, when discussing something as personal as disability, it can be especially challenging to feel comfortable sharing with people you don't know well. While I do request that you be as open and candid about your experiences and opinions as is comfortable, I want to make it explicitly clear that there is no expectation that you share any personal medical information or detailed information about any disability you may have. If you do, however, choose to share that information, that is perfectly fine.

Next, I want to acknowledge my positionality and neutrality as a researcher. While I have my own lived experiences with disability and opinions about the topics we will discuss today, it is important for the quality of this project and its eventual report of findings that I remain in my role of facilitator in the context of this discussion.

Finally, I want to tell you about the methods I will be using to share my results; in the interest of transparency and ethical research methodology, I want to be sure that all participants get a chance to see and share their perspective on the results of this project. After presenting my final findings and suggestions to Rollins leadership, I will share both the final report and a summary of that meeting.

Okay, now let's go through a brief formal process of informed consent that I will read to you. After that we'll start the recording, ask you again if each of you to consent to this group discussion and its recording, and get started! Also, I would like to ask you please turn on your camera if possible, if not for the whole time of the discussion at least for when you speak. Thanks!

Your participation is fully voluntary, and participating in this discussion should not affect your personal or professional life. If we get to a question that you don't feel comfortable answering for any reason, you can pass or let me know and we'll move on to another participant or question. In order to most accurately capture the details of our conversation, I will be recording this meeting; we'll talk more about that when I get everyone's formal consent in a few minutes. If you have any questions, you can ask them now or later–if you wish to ask questions later, please contact me, Nikki Warren, at nwarre3@emory.edu. For any concerns related to this research project you can contact RSPH's Professor Claudia Ordóñez (thesis chair) at claudia.ordonez@emory.edu [put thesis' chair email address in Zoom chat at this time]

Before we begin, do you have any questions? *[wait for questions]*

Okay, great. I'll turn on the recording and go around to each of you to record your consent and get your introduction individually.

Start recording

As we do introductions and consent, I'll ask each of you to share the name you want us to use for the recording and the discussion, your age, whether you are a first/second year MPH or a PhD student, and—this last part is totally optional, so only share if you feel comfortable doing so--your gender & ethnic identities.

[notetaker shares screen—see below, figure C.1]

Do you consent to participating in this discussion today? Are you okay with being recorded during the discussion? *[ask each participant to take turns saying out loud yes and turning on their camera when agreeing, if possible]*

INTRO QUESTIONS/ACTIVITIES: [30-35 min]

First, we're going to talk about disability and inclusion at Rollins and some of your interactions with others about disability.

1. *Have you discussed disability in any of your classes at RSPH?*
    a. PROBE: What class was this? In what context did you discuss disability?
        i. i.e. was it talking about accommodations or about disability as it related to a class topic?
    b. PROBE: Was it positive/negative? Why?
2. *What disability and diversity knowledge should public health professionals have before they go into the field?*
3. *What is your perception and knowledge of diversity, equity & inclusion (DEI) activities happening at Rollins?*
    a. PROBE: Does it include disability?
4. *What notable interactions regarding disability have you had with:*
    a. Faculty/staff/ADAPs./admins
        i. PROBE: About accommodations? Talking about disability more broadly?
        ii. PROBE: Positive/negative?
    b. DAS/CAPS
        i. PROBE: context for interactions? (i.e. when/how did they seek accommodations?)
        ii. PROBE: Positive/negative?
        iii. PROBE: Rerouted to TimelyCare? (If so, positive/negative?)
    c. Other students (with/without disabilities)
        i. PROBE: Personal or more general? Were they aware of your disability?
        ii. PROBE: Positive/negative?

ACTIVITY 2(A): PROBLEM TREE [40-45 min]

Next, we're going to talk about a problem tree that has used some of the findings from faculty/staff experiences to explore disability inclusion.

[notetaker shares screen—see Figure C.2]

This problem tree begins with the root cause of ableism & other systemic oppression, which lead to societal deprioritization of disability and suboptimal federal policies re: disability inclusion in higher ed. Those factors contribute to the first intermediate level (blue stickies) which includes a lack of administrative knowledge and comfort with disability & inclusion, a lack of funding for inclusion activities, and contextual factors that de-incentivize disability inclusion. These issues contribute to the second intermediate level (green stickies), minimal culture/expectation of inclusion & disability, lack of meaningful financial and psychosocial support for faculty & staff seeking to improve their practice, and faculty/staff "blind spots" due to lack of knowledge and other factors. The final intermediate level (pink stickies) consists of the co-opting of inclusive language and performative activism regarding disability & inclusion within the classroom, founded or unfounded fear among RSPH community members about "cancel culture," and an accommodations system that can be stressful and challenging for both faculty and students to navigate. The issues in this final intermediate level most directly contribute to the central problem, the lack of disability inclusion in the culture and curricula of RSPH. When disability isn't included throughout public health education, there are significant downstream effects, including direct emotional, mental or physical harm to both students with disabilities and future participants in public health activities that are carried out by RSPH grads.

5. *Do you agree with this problem tree? What should be added/changed?*
    a. *[like 10-15 min for the intro/problem tree discussion, then move on to solutions]*

Now, we're going to work backwards through this problem tree to identify potential solutions.

6. *What should Rollins do to change one (or more) of these stickies?*
    a. Curriculum requirements? Funding?
7. *Are there any other suggestions for how RSPH could better include disability?*

[notetaker records suggestions on sticky notes as participants share them]

These are all great, thoughtful suggestions! Next, we're going to go through and sort/prioritize these suggestions based on what would be most helpful for the most people.

[do that]

FURTHER QUESTIONS/WRAPPING UP [20 min tops]

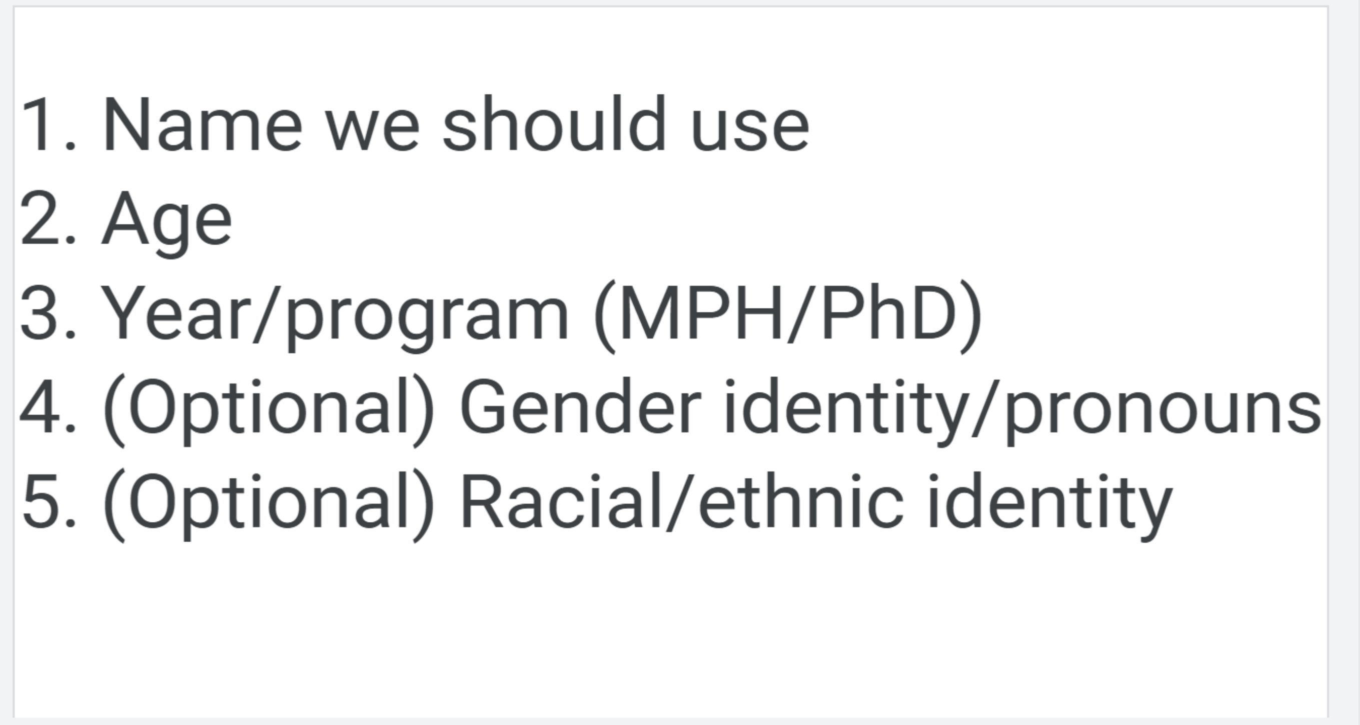
We just have a few final questions and then we'll wrap up.

8. *If we woke up tomorrow and RSPH were truly inclusive of disability, what would be different? What would true inclusivity look like?*
    a. Curriculum, Funding? Resources? Additional support? (If so, what kind of support?)

9. *Is there anything I’ve missed in these questions? Anything important regarding disability or diversity, equity, and inclusion that you feel like we haven’t discussed fully?*

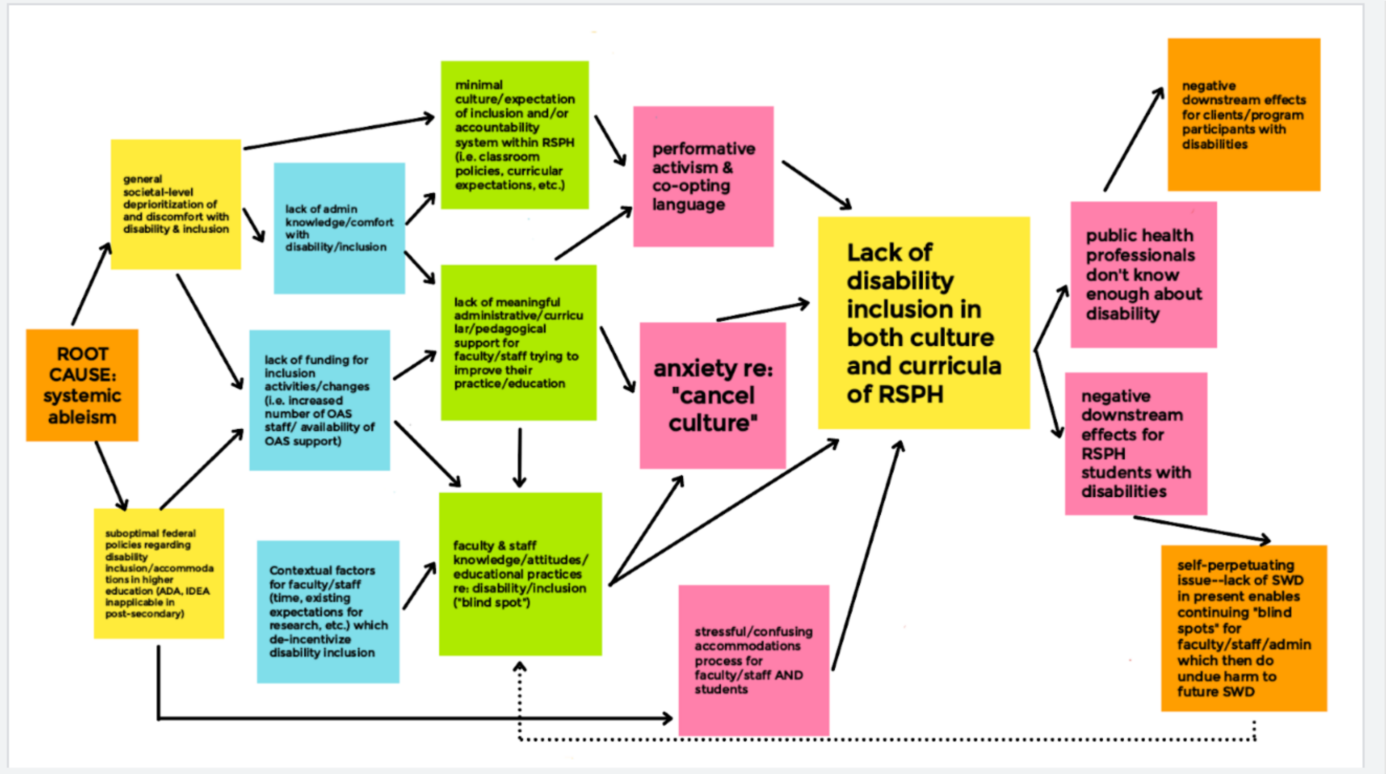
Thank you so much for your participation. Your insights are invaluable and will help me to both understand the current state of disability inclusion at Rollins and offer community-centered, evidence-based recommendations for future teaching, practice, policies and procedures. As a reminder, I’ll be sharing the report of findings & recommendations with you all in early to mid-April!

Figure C.1: Participant Introductions



1. Name we should use
2. Age
3. Year/program (MPH/PhD)
4. (Optional) Gender identity/pronouns
5. (Optional) Racial/ethnic identity

Figure C.2: Problem Tree for Activity


ROOT CAUSE: systemic ableism
general societal-level deprioritization of and discomfort with disability & inclusion
suboptimal federal policies regarding disability inclusion/accommodations in higher education (ADA, IDEA inapplicable in post-secondary)
lack of admin knowledge/comfort with disability/inclusion
lack of funding for inclusion activities/changes (i.e. increased number of OAS staff/ availability of OAS support)
Contextual factors for faculty/staff (time, existing expectations for research, etc.) which de-incentivize disability inclusion
minimal culture/expectation of inclusion and/or accountability system within RSPH (i.e. classroom policies, curricular expectations, etc.)
lack of meaningful administrative/curricular/pedagogical support for faculty/staff trying to improve their practice/education
faculty & staff knowledge/attitudes/educational practices re: disability/inclusion ("blind spot")
performative activism & co-opting language
anxiety re: "cancel culture"
stressful/confusing accommodations process for faculty/staff AND students
Lack of disability inclusion in both culture and curricula of RSPH
public health professionals don't know enough about disability
negative downstream effects for clients/program participants with disabilities
negative downstream effects for RSPH students with disabilities
self-perpetuating issue--lack of SWD in present enables continuing "blind spots" for faculty/staff/admin which then do undue harm to future SWD

Appendix D: Attitudes Toward Teaching All Students Scale (ATTAS-mm) – modified for survey use

Figure D.1: Attitudes Toward Teaching All Students (ATTAS-mm) - modified		
Directions: Indicate the degree to which you agree with each of the following statements.		
Item #	*Statement*	*Response Options*
Q1	All students with disabilities should be educated in regular classrooms with non--handicapped peers to the fullest extent possible.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q2	Students with disabilities can be trusted with responsibilities in the classroom.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q3	I would like people to think that I can create a welcoming classroom environment for students with disabilities	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q4	Most or all separate classrooms that exclusively serve students with disabilities should be eliminated.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q5	Students with mild to moderate disabilities can be effectively educated in regular classrooms.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q6	Students with mild to moderate disabilities should be taught in regular classes with nondisabled students because they will not require too much of the teacher's time.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree

		7. Refused *9. Don't know*
Q7*	I would like to receive professional development from an educator who models effective differentiated instruction (a method of education which includes students at all skill and ability levels in the same classrooms and lesson plans).	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q8*	I want to learn from faculty who know how to design appropriate academic interventions to create inclusive learning environments.	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
Q9	I believe including students with disabilities in regular classrooms is effective because they can learn the social skills necessary for success	1. Completely Disagree 2. Somewhat Disagree 3. Neither Agree Nor Disagree 4. Somewhat Agree 5. Completely Agree *7. Refused* *9. Don't know*
** - Note: Only faculty participants were asked to answer questions 7 & 8.*		

Appendix E: Washington Group Short Set on Functioning Enhanced (WP-SS Enhanced)

Figure E.1: Washington Group Short Set – Extended

Directions: The next questions ask about difficulties you may have doing certain activities because of a **health problem.**

No. - Variable	Question	Response
B1 – VIS_1	Do you have difficulty seeing, even when wearing your glasses/contacts?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B2 – HEAR_1	Do you have difficulty hearing, even when using a hearing aid(s)?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B3 – MOB_1	DO you have difficulty walking or climbing steps?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B4 – COM_1	Using your usual language, do you have difficulty communicating, for example understanding others or being understood?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B5 – COG_1	Do you have difficulty remembering or concentrating?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B6 – SC_SS	Do you have difficulty with self-care, such as washing all over or dressing?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B7 – UB_1	Do you have difficulty raising a 2-liter bottle of soda or water from waist to eye level?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused*

		9. Don't know
B8 – UB_2	Do you have difficulty using your hands or fingers, such as picking up small objects, like a button or pencil, or opening and closing containers or bottles?	1. No difficulty 2. Some difficulty 3. A lot of difficulty 4. Cannot do at all *7. Refused* *9. Don't know*
B9 – ANX_1	How often do you feel nervous, worried or anxious?	1. Daily 2. Weekly 3. Monthly 4. A few times a year 5. Never *7. Refused* *9. Don't know*
B10 – ANX_2	Thinking about the last time you felt nervous, worried or anxious, how would you describe the level of these feelings?	1. A little 2. A lot 3. Somewhere in between a little and a lot *7. Refused* *9. Don't know*
B11 – DEP_1	How often do you feel depressed?	1. Daily 2. Weekly 3. Monthly 4. A few times a year 5. Never *7. Refused* *9. Don't know*
B12 – DEP_2	Thinking about the last time you felt depressed, how depressed did you feel?	1. A little 2. A lot 3. Somewhere in between a little and a lot *7. Refused* *9. Don't know*

Appendix F: Student Perceptions of Classroom Support Scale – as modified for survey

Figure F.1 - Student Perception of Classroom Support (SPCS) Modified		
Directions: The purpose of these questions is to identify the things that help you in academic classes, including things that help you with classwork and things that help you succeed socially in the classroom. There are no right answers.		
No. - Variable	Question	Response
How helpful would this intervention be in getting your work done?		
C1 – PHY1	If I left the class and did my work in a quiet place and a teaching assistant helped me.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C2 – PHY2	If a friend or knowledgeable peer volunteered to sit next to me and help me with my work.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C3 – PHY3	If a friend or knowledgeable peer volunteered to help me and other students.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C4 – PHY4	If an additional instructor was in the class to help students who have problems.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C5 – PHY5	If a teaching assistant helped me and other students as needed.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C6 – CURR1	If the class work was the same for everyone.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C7 – CURR2	If the professor told me exactly what to learn or study.	11) No Help 2) A Little Help 3) Some Help

		4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C8 – PHY6	If the main professor and an additional instructor both help me and other students who have problems.	1. Completely Disagree 1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C9 – PHY7	If I left the class when the work was too challenging and did my work in the library or another study space.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C10 – PHY8	If two co-instructors taught together and helped students who have problems.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C11 – PHY9	If a teaching assistant sat next to me and helped me with my work.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C12 – CURR3	If class assignments and work were changed for me to be easier to understand or complete.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C13 – CURR4	If the instructor gave everyone access to notes that were easy to understand.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C14 – CURR5	If I were able to do other work in class while the rest of the students work on that subject	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C15 – INST1	If there were fewer students in my classes.	1) No Help

		2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C16 – CURR6	If the instructor worked with me and other students who had problems while the rest of the class did individual work.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C17 – INST2	If I sat near the front of the class.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C18 – INST3	If I sat near the professor/instructor.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C19 – CURR7	If assignments and class work were explained simply and clearly.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C20 – INST4	If the instructor was friendly and positive.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C21 – INST5	If the instructor made the subject interesting and enjoyable.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*
C22 – PEER1	If I sat with other students and we worked on projects together	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don't know/ Not Applicable*

C23 – INST6	If everyone followed classroom rules and policies (i.e. masking, no internet browsing)	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C24 – INST7	If the classroom was quiet.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C25 – PEER2	If I sat with other students and we worked together on projects—if given tasks that I can do.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C26 – INST8	If I was taught by an instructor I knew and liked.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C27 – PEER3	If I worked with another student who was good at the subject.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*
C28 – PEER4	If I worked with another student in the class.	1) No Help 2) A Little Help 3) Some Help 4) A Lot of Help *7) Refused* *9) Don’t know/ Not Applicable*

Appendix G: Codebook

Theme	Code	Subcode	Definition	Exclusion Criteria
Public Health & Pedagogy	Curriculum Development		The development, implementation and assessment of RSPH curricula and materials, including where disability belongs in public health curricula, the curriculum development/approval process, including Education Council process;	If mentions training for faculty/ staff — see "Training"
		Tools & Guidelines	Existing documents, checklists, or theoretical frameworks that educators can use to improve disability inclusion in their pedagogy; may include Universal Design guidelines for Learning (UDL), accessibility checklists, Section 508 regulations/requirements, etc.	
	Training		Relevant training and other related opportunities known or participated in by participants; may include professional development, Emory and RSPH faculty/staff training opportunities (related to DEI, disability and pedagogy more generally), external training/education opportunities; may double-code with Tools & Guidelines	
Culture of Inclusion at RSPH	Dimensions of Disability	Spectrum of Disability	Concept that disability exists on a spectrum (i.e. not all physical disabilities are visible all the time, not all mental/developmental disabilities are invisible all the time, not all disabilities are permanent)	
		Dichotomy of Disability	Concept that disability exists as either/or, dichotomous idea (i.e. visible vs invisible, physical vs mental or developmental, obvious to others vs able to be hidden)	

	Professional Experience with Disability	Navigating Accommodations	The ways in which faculty, staff and students navigate the process of gaining formalized access to reasonable accommodations for disabilities in the workplace or classroom environment; may double-code with DAS	If mentions unofficial/ informal accommodations--see "Unofficial Accommodations"
		Unofficial Accommodations	The ways in which faculty, staff and students navigate unofficial or informal requests for accommodations; may include discussions of encouraging people to go to DAS, benefits of getting accommodations through DAS, “fairness” of having to decide of a student “really needs” accommodations; why student's don't want to go to DAS	If mentions students who have gone through official/formal process
		Other Professional Experiences	Disability within the context of participants’ work at Rollins unrelated to student accommodations; may include intersections between disability and participants' professional/research/study areas; research-related interactions (with funders, researchers, participants, statisticians); disability-related experiences with other faculty/staff	If mentions accommodations; if discussing student experiences unrelated to graduate assistantships or teaching positions
	Personal Experience with Disability		Disability impacting participants or their loved one(s) directly and significantly for a period longer than 6 months if impacting their professional/educational experiences	If unrelated to professional/ educational experiences
	Diversity, Equity &		Diversity, equity & inclusion (DEI) activities held, funded or facilitated by Emory or RSPH, as well as participants’ perspectives on those efforts	

		Cancel Culture	Economic or social fears (whether they are justified or not) regarding DEI issues, “political correctness”, or saying the wrong thing; may double code with Effective Communication	
		Performative Activism	Behaviors, policies, programs, etc. that self-identify/are identified by others as diverse/inclusive, but don’t actually lead to significant/meaningful change	
		Disability in DEI	Where disability is/isn’t included in DEI activities (at RSPH, Emory, or more generally); may include narrow scope of current DEI activities, intersectionality of disability with other forms of diversity, etc.; may double-code with performative activism	
	RSPH Policies & Programs		Policies, programs, resources, and other services available to RSPH students, faculty & staff; includes Emory-wide programs & policies like Information Technology, Title IX, Campus Life, Office of Faculty Development & Excellence (OFDE)	
		Supportive Services	Any Emory/RSPH resources or other services intended to support faculty/staff/students' emotional, mental or physical health; may include CAPS, TimelyCare, Student Case Management & Intervention Services, Student Health Services etc.	If mentions Office of Accessibility Services/ DAS
		Office of Accessibility Services (OAS)/DAS	Awareness or knowledge of the Office of Accessibility Services (OAS, aka DAS); direct interactions between students and DAS or faculty/staff & DAS.	If mentions other supportive services
	Barriers & Facilitators to Inclusion		Factors that impact faculty, staff & students' self-efficacy and ability to facilitate inclusion of disability at RSPH; use this code if the barrier/ facilitator/	If one of subcodes accurately describes the facilitator/ barrier/ recommendation

			recommendation doesn't fit into a subcode below.	
		Effective Communication	How faculty, staff and students speak to each other about disability, diversity, and accommodations; may include what kind of questions faculty do/don't feel comfortable asking students (or what they're "allowed" to ask); what faculty/staff need to know to effectively provide accommodations; how to navigate hard conversations about diversity	If mentions interactions between (1) faculty & DAS or (2) students & DAS --see DAS
		Contextual Factors	External factors that can affect a participant or faculty/staff member's decision to actively improve disability inclusion in their pedagogy/practice; may include COVID-19, "publish or die" research pressure, home life, etc.	If related to barriers or facilitators associated specifically with RSPH/ Emory
		(Lack of) Knowledge/ Comfort about Disability	Participants' reported knowledge of and comfort talking about disability; may include how to talk to students about disability (double-code with effective communication), how to use disability as appropriate class example, etc.	
		(Lack of) Institutional Support for Faculty & Staff Development	Resources or supports that faculty/staff need from administration to be more effective at disability inclusion in curricula & RSPH culture; may double-code with Administrative/Environmental Recommendations	
	Barriers & Facilitators	"Non-Mandatory" Faculty/ Staff Culture	Concept of Emory/RSPH as a place where faculty can't/aren't required to do most things, but can choose how/where/whether to engage with those things	

		Challenges in Accommodations Process	Aspects of current formal DAS accommodations process that are challenging to navigate	
		Student-Focused Recommendations	Potential solutions which target or focus on students as the intervention population; may include student-led organizations, community outreach, mentorship programs, etc.	If recommendation would benefit all community members--see Administrative/ Environmental
		Faculty/ Staff-Focused Recommendations	Solutions that focus on providing faculty/staff with improved knowledge, increased skills, etc.; may include accessibility checklists/handbooks, utilization of existing services like OAS/CFDE; may double-code with Tools & Guidelines	If mentions faculty training—see Training; if mentions administrative-level solutions like funding increases/ employee raises
		Administrative/ Environmental Recommendations	Suggestions which occur at the “macro” level or which directly target all Emory community members (faculty, staff, and students); may include additional funding, additional administrative support/expectations/ requirements, visibility campaigns, changes to built environment	If only mentions DEI more broadly without including disability--see "DEI"

Appendix H: Rapid Analysis Summary Form

KII Rapid Analysis Transcript Summary

Participant ID:

Summarized by:

Interview conducted by:

Relevant Personal/Professional Information on Interviewee:

1. Defining Disability [Q1]
2. Personal Experience with Disability [Q2]
3. Social Interactions re: Disability [Q3-4]
4. Navigating Accommodations & Response [Q5, Q6, Q7]
5. Comfort with Disability [Q8, Q9]
6. Disability's Role in Curricula & Culture [Q10]
7. Awareness/Perception of Current DEI Activities [Q11, Q15, Q16]
8. Curriculum Design/Development [Q13-14]
9. Faculty/Staff Training [Q17-20]
10. Potential Solutions [Q21-22]

Identified Barrier(s) to Inclusion	Identified Solutions (if Applicable)

Appendix I: Full Results – Modified Attitudes Toward Teaching All Students Scale (ATTAS-mm)

Figure I.1: Modified ATTAS-mm – Faculty Results

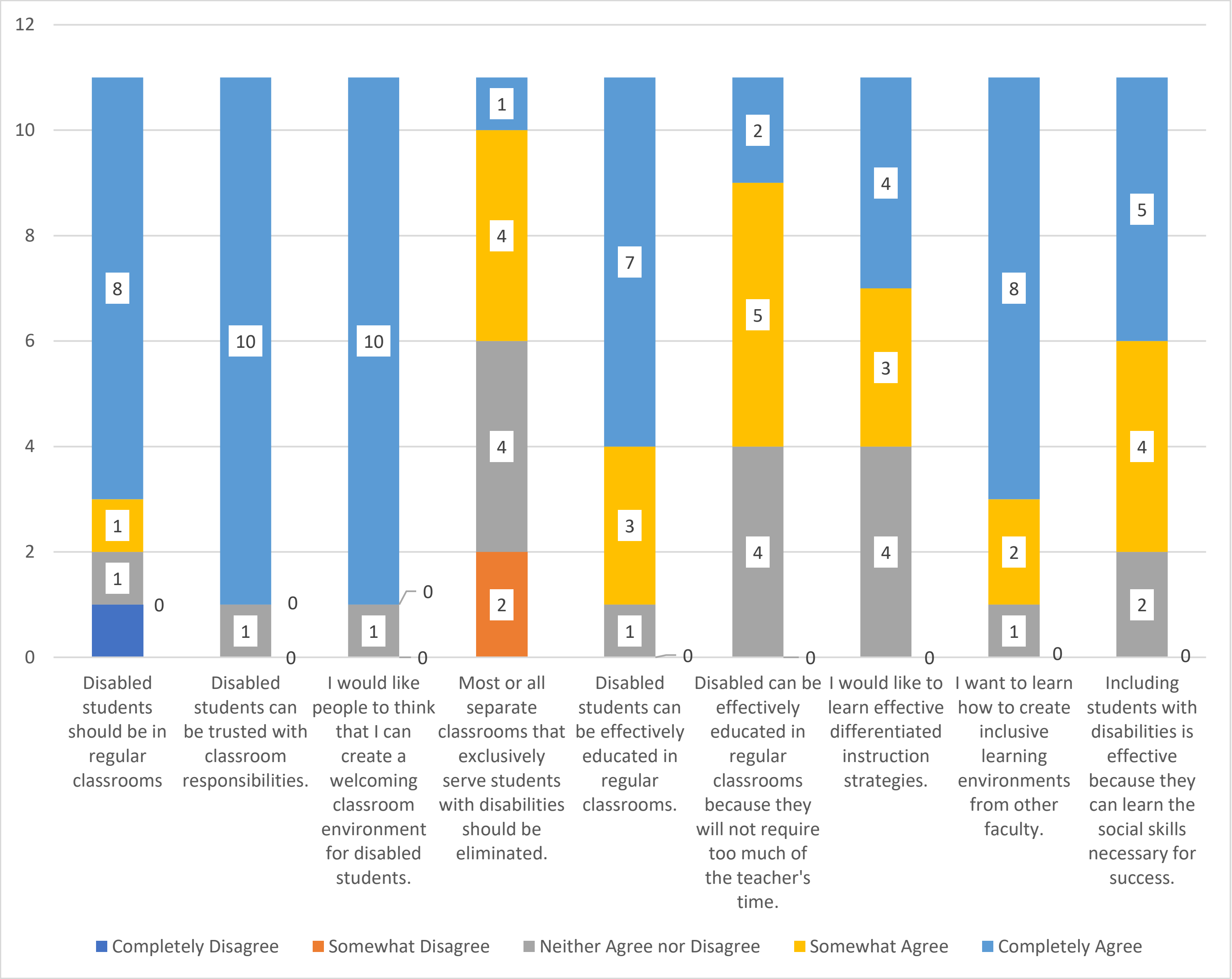
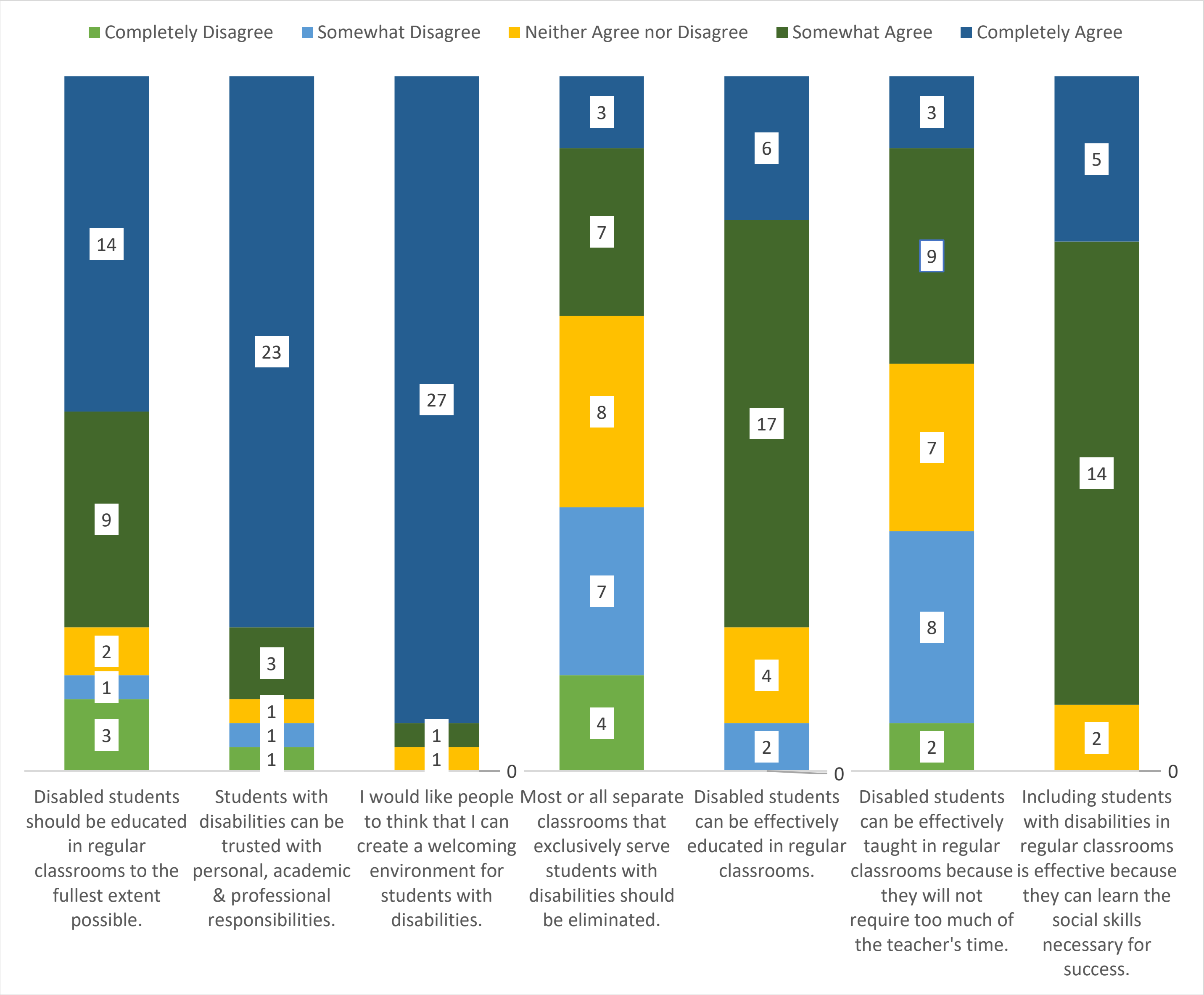


Figure I.2: Modified ATTAS-MM – Staff Results



Appendix J: Full Results – Modified Student Perceptions of Classroom Support (SPCS) Scale

Figure J.1: SPCS Results – Physical Environment Subscale

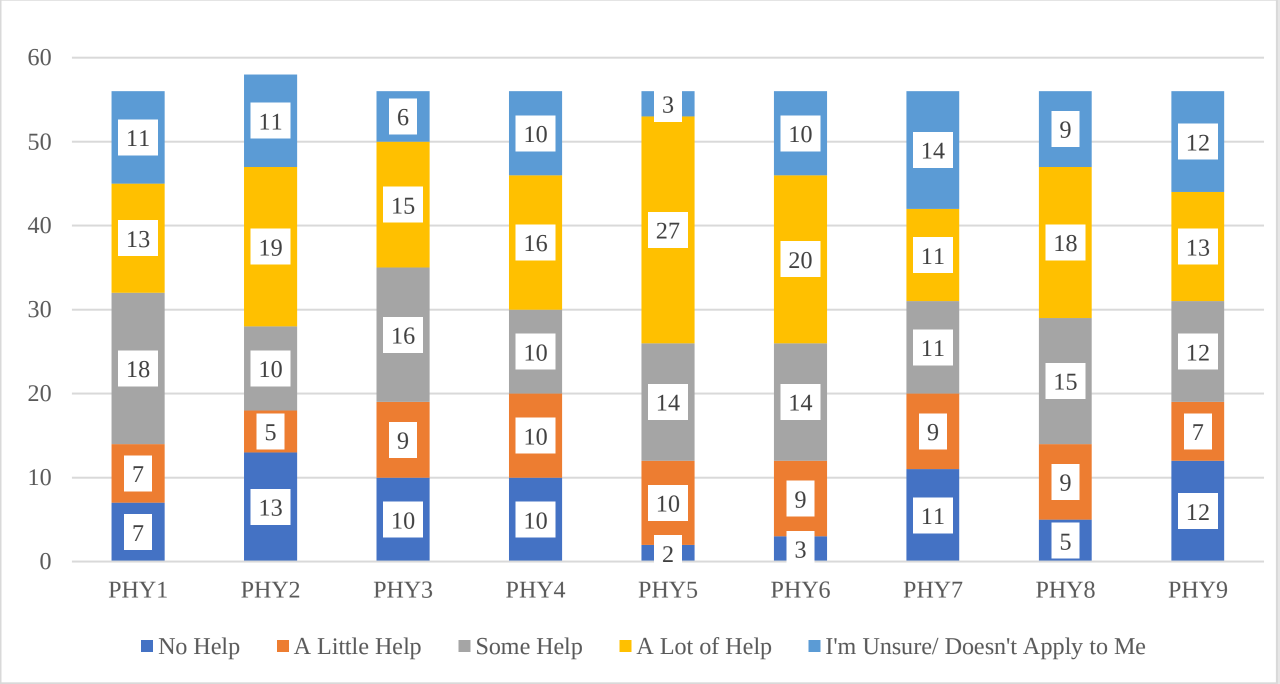


Figure J.2: SPCS Results – Instruction Subscale

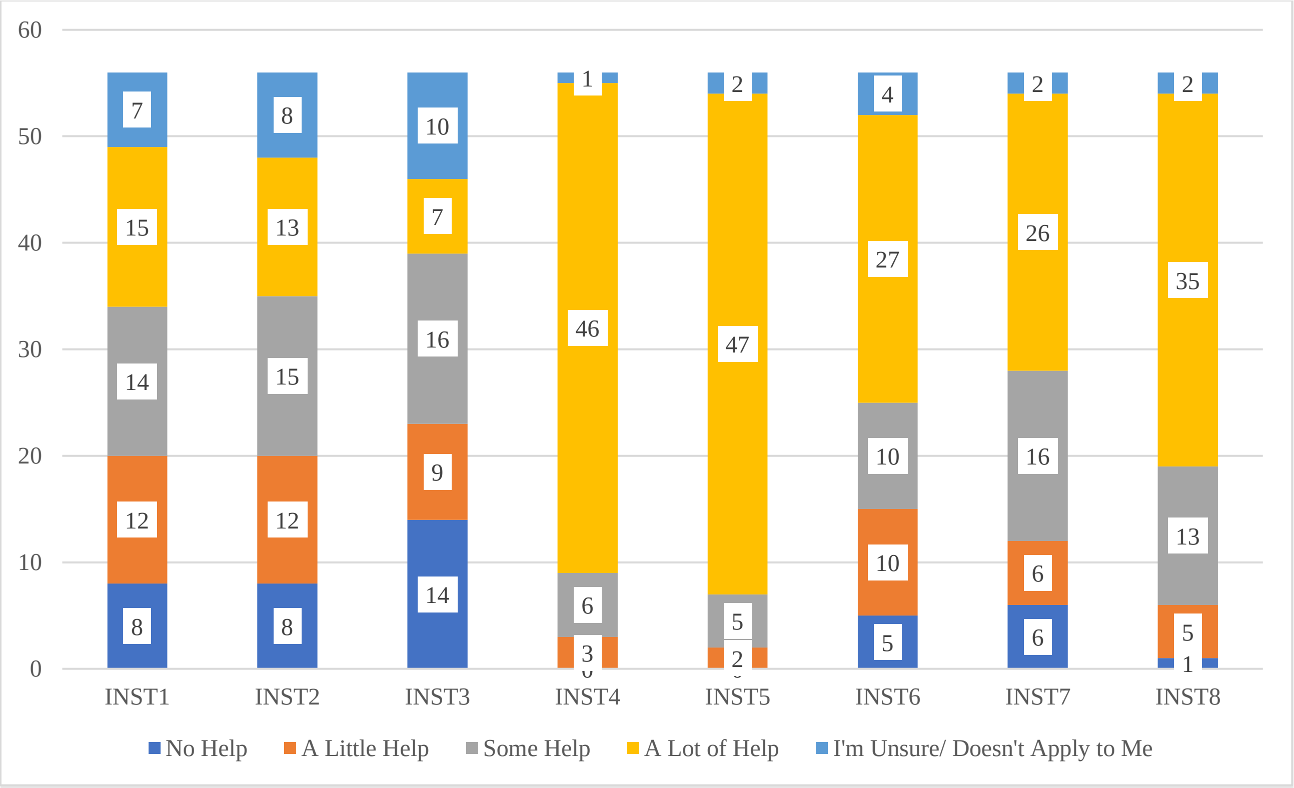


Figure J.3: SPCS Results – Peer Support Subscale

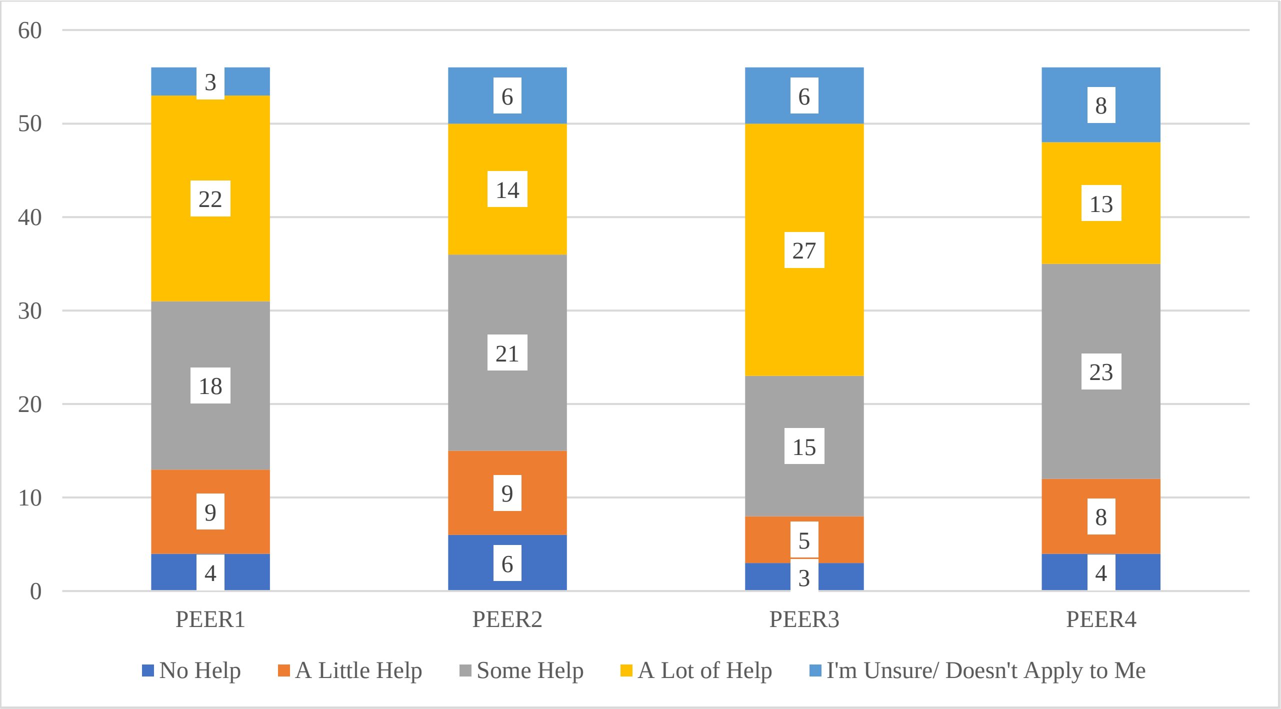
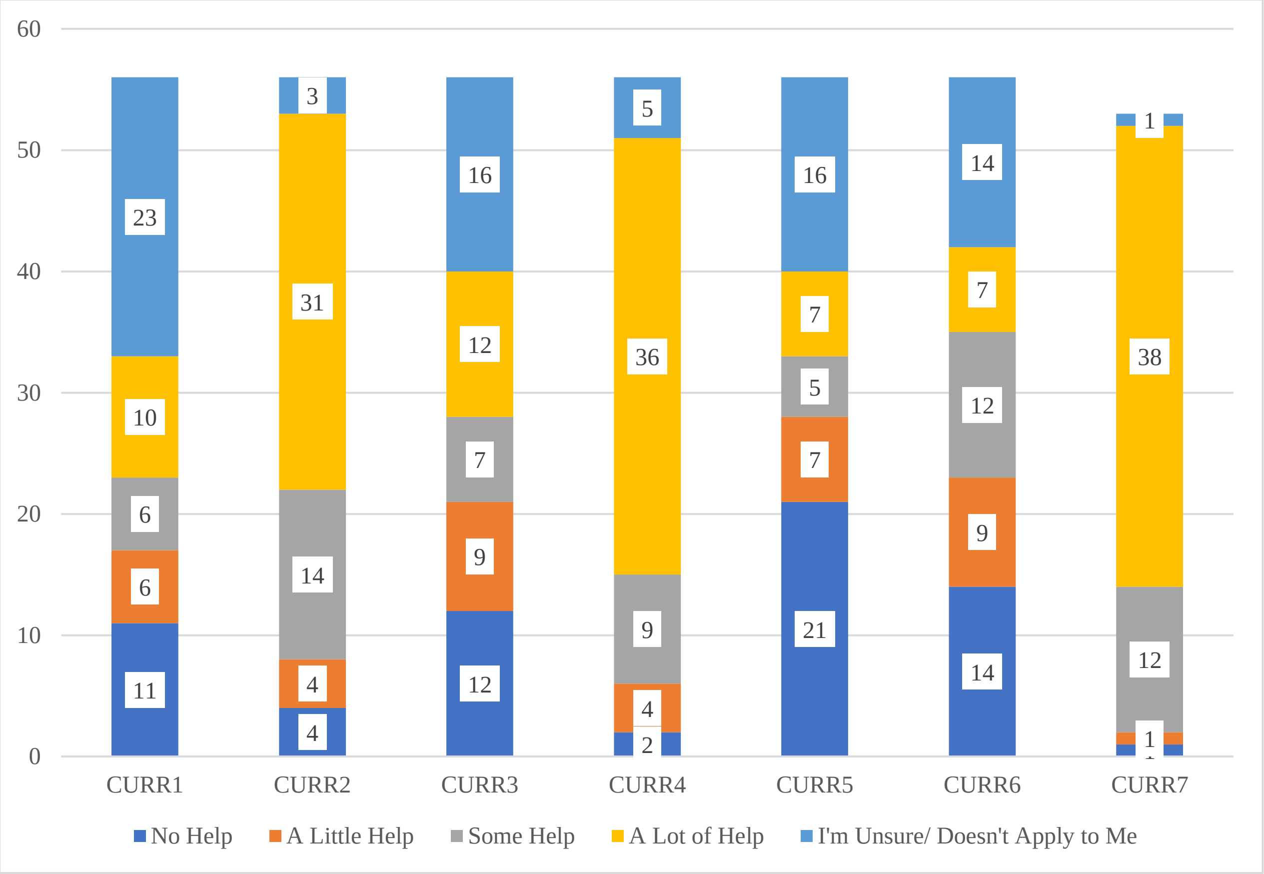


Figure J.4: SPCS Results – Curriculum Subscale



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36
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16
7
5
7
21
14
7
12
9
14
1
38
12
1
1
CURR1
CURR2
CURR3
CURR4
CURR5
CURR6
CURR7
No Help
A Little Help
Some Help
A Lot of Help
I'm Unsure/ Doesn't Apply to Me