“Mental health cannot be the front door”: Deborah Diedricks of EMpower on reframing mental well-being as safety, care, and connection for young people

Ambar Castillo
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Ambar Castillo: Could you start us off by introducing yourself and your work?

Deborah Diedericks: My name is Deborah Diedericks. I'm South African, and I live in Cape Town, South Africa. Before EMpower, I was the director of a nonprofit that specialized in grief and bereavement support for children. In particular, we had a teen girl program that showed less depression. South Africa has one of the highest rates of young women and adolescent girls with HIV infections. There's a link between depression and risky sexual behavior.

That was a lot of my work for 11 years, and then I became an EMpower grant officer. For four years, I was the grant manager for the South Africa portfolio which had 20 organizations at that point. Globally, EMpower has three thematic areas, including safe and healthy lives, economic wellbeing, and inclusive learning. We have two through lines, one is gender inclusivity, and the other is mental health.

In South Africa, because we have insanely high levels of violence, we have similar levels of violence as countries that are actively in civil war. Because of that, we started funding here in 2002, before I arrived. By 2016, we pivoted to focus specifically on mental health in South Africa, and I was brought in to manage that portfolio. That became the backbone of our application to ICONIQ [a global investment firm].

At the moment we are actively funding about 150 NGOs or nonprofit organizations across 15 emerging markets countries. In Latin America, it's Mexico, Peru, Colombia, Argentina, and Brazil. In Africa, it's Ghana, Nigeria, and South Africa. Also there’s Turkey and India. In Asia, it's the Philippines, China, Hong Kong, Indonesia, and Vietnam.

Our argument in the proposal to ICONIQ was that many of our partners wouldn't frame their work as mental health, excluding the South African partners where we've been focusing on mental health, and framing it as mental health. Even though many partners wouldn't frame it as mental health, what we've learned in South Africa, and confirmed by other research we've seen, is that there's something important about safe and reliable adults accompanying young people, and giving them safe spaces. It's also important to have adults who look and speak like the young people, so they're not from a community and class with another accent. Our focus is young people aged 10 to 24. All the projects we fund support this age group.

We found that if you provide a safe space for young people aged 10 to 24, with adults who look and speak like the young people themselves, who accompany them and show an interest, then regardless what your program is, whether you teach math in an after-school setting, or a sports for development program, or different types of programs, having safe and reliable adults in a safe space in and of itself can help young people calm down and help them improve their mental health.

Even though the organizations themselves might not call their work mental health, we'd say the way we frame mental health means all our organizations are improving the mental health of young people, regardless of whether they call it that themselves.

We frame mental health as a positive thing. In the same way that we have physical health, we all have mental health. We know that with physical health, if you eat, sleep, and exercise, you look after your physical health. In the same way, there are ways that you can look after your mental health. We're all on a continuum where we have, for example, better self-regulation some days than other days.

The basic definition of self-regulation is that when you get angry, you want to throw the TV at someone, but you don't actually pick the TV up and throw it at them. We situate our work as mental health promotion and prevention. We don't diagnose and treat. There might be one here or there, but generally we don't support programs that diagnose and treat. We support promotion and prevention programs that sit upstream. It's about helping young people to breathe, to pause, to think before they act, to feel better about themselves, to have hope.

Ambar Castillo: How did you decide on countries or organizations to work with?

Deborah Diedericks: EMpower was started as an organization by emerging markets financiers in 2000. They wanted us to work in the countries where they were investing. They wanted to make it better for young people in those countries because they were already there. It was very much an emerging markets financier's decision. Those groups are also on our boards.

Ambar Castillo: Were the organizations themselves within those countries also chosen by these financiers, or was there a certain process?

Deborah Diedericks: No. One thing that makes EMpower unique is that we have a 10-year intention. In other words, when we start working with an organization, and if

they continue to be compliant, complete reports, and keep good governance, then we are likely to stay with them for 10 years.

We don't do cold call applications, because NGOs spend an inordinate amount of their time writing fundraising applications, and often don't even hear back from people. Instead, we have in-country program officers. In almost all 15 countries, we have people who live in those countries headhunting. They stay connected to the scene, they are continuously putting an ear to the ground, and they visit organizations.

When they think an organization is in alignment with what we do, they invite them to apply. You can't just apply, you have to be invited to apply. Once you're in, it's usually for 10 years unless something goes wrong. It's still an annual process, and you still get your grants annually. You don't get a 10-year agreement, but there's a 10-year intention.

Ambar Castillo: What kinds of characteristics or alignments in organizations were you looking for to partner with in these countries?

Deborah Diedericks: We generally don't do seed funding, so we don't fund organizations that are brand new and just starting out. We generally fund organizations that are at least three years old, and also organizations that have some proof of concept. When I say proof of concept, I don't mean an RCT [randomized controlled trial], but they must convince the program officers that they are making a difference. Obviously, they have to offer programs for young people aged 10 to 24. There must be some link to health, economic wellbeing, or inclusive learning which, if you think about it, encompasses everything about young people's lives.

Ambar Castillo: Can you speak about inclusive learning and how you frame that?

Deborah Diedericks: Basically those three things cover everything. Health is health, and that includes mental health. A lot of health programs are sexual reproductive health and rights work, plus HIV prevention and sex education, and obviously, some of the more distinct mental health work is also in that category. Economic wellbeing is skills training for young people who are either in school and getting ready for what's coming after high school, or they are out of school, or they've dropped out of school, or they've finished school and trying to access the job market.

I can see why the term 'inclusive learning' isn't clear. A lot of our inclusive learning programs include afterschool tutoring programs, so they go to school in the morning, and in the afternoon, to an afterschool center where they get help with math, language or whatever they need. It's education, but it's not formal education in the government school system. It's in addition to it.

If someone dropped out of school and their literacy is really bad, then it could also be education, like learning to read and to write. Some programs are even in school, where teachers give our grantee partners periods to do things during school time. I've seen quite a lot of that.

If you think about it, your brain and your mental health determine everything. All your thoughts and feelings sit in your brain. Good mental health intersects with absolutely everything. Some examples of what are included in mental health are self-regulation, hope, self-worth, and self-confidence.

We get self-regulation from our mothers, typically. If your mother is not self-regulated, then you're not self-regulated, and you regularly beat up kids on the playground, your peers are not going to like you. You're probably going to get kicked out of school, or because you cannot self-regulate you cannot concentrate, which means you will struggle with school.

Hope is a super determining factor. If you have no hope, you're not even going to go to school, because you think, what's the point? If you have no self-worth, you're very likely to engage in risky sexual behavior because you don't think you're worth anything anyway. If you have no self-confidence, you're not even going to try and apply for the job. If you do, you're not going to be able to do well in the interview because you don't come across as confident. Mental health intersects with everything.

One of the biggest challenges is that if we say 'mental health', we can see that people hear you say 'mental illness' [instead]. If I say physical health, you don't think 'cancer.' So why is it that if I say 'mental health,' you think 'schizophrenia'?

Ambar Castillo: You're working with some organizations or countries where they might not frame these things as mental health. Is it because of the stigma? Are there other challenges or reasons why it might be framed differently?

Deborah Diedericks: The ICONIQ grant is a five-year grant, and so one of the things that I am on a mission to do with our 150 partners is to help in-country program officers help the partners they manage to look at their work through a mental health lens. Obviously I can't do all 150 in the first year, so it's a staged approach.

To bring this message of mental health as a positive thing, not a negative thing, the partners are, in all likelihood, already helping to promote good mental health by having safe spaces, and safe and reliable adults who look and speak like the young people. Even if you're teaching them math, you can also ask them, "How are you? What's up today? I see you're feeling a bit sad. Do you want to talk about it?" These are things people naturally do in those contexts.

NGOs are a home away from home. It's the place where disadvantaged, marginalized young people often go. We're working with young people who by definition often come from households that are not the most emotionally supportive households, although sometimes they are marginalized just because of poverty.

Often they find a refuge in NGOs that are based in those communities. It's the place where they go to feel safe, to not be in the streets, to do something. My mission in these five years is to get organizations to look at their work through a positive mental health lens and to integrate more mental health strengthening activities into their programs. We're working in countries with all sorts of different languages, and we're just talking

about English-language stigma. If you start to translate mental health into other languages, the stigma is even worse, as far as I can tell.

Ambar Castillo: Why is that?

Deborah Diedericks: Because mental health has an association with mental illness, and mental illness is such a taboo. In Africa, it's seen as if you're bewitched. It's not just Africa. Often people are completely overwhelmed and don't know what to do with people who have a mental illness. If you're a full-blown schizophrenic, in many countries in the world, you end up on [the streets]. Even in the US, a large percentage of the people who live on the streets are people with mental illnesses because they don't integrate into society, they can't hold down a job, and their families can't look after them. People don't know what to do about them. They can't manage them and they're overwhelmed. That's the association.

Ambar Castillo: When you speak about the importance of having safe and reliable adults with people in that age range, why is it important that the adults ideally look and sound like them?

Deborah Diedericks: Let me give you a real example. Obviously, the country I know best is South Africa. In South Africa, generally speaking, White people are economically better off, because of our history. White people are 8% of the population in this country. 90% of the population are people of color and a large percentage of them are poor, even though there are also many wealthy Black people. I live in what we call the leafy suburbs. If I speak to a class of 12-year-olds, and I want to give them hope, I'm not going to say, "You know what, you can do anything you want to do. You can become anything you want to become. The world is your oyster." Because they would look at me and say, "What? You don't know what you're talking about, lady. You don't know my life."

I grew up poor. I grew up in council flats, but because I'm White, there's a perception that I grew up very well off and had everything I wanted. But comparatively speaking, I still grew up wealthier than many of my contemporary Black peers, and because I'm White, there is a perception of wealth and access, which is often true.

For a Black person who is exactly my age, to give a message of hope when you are someone who grew up in that community, finished school, went to university, accomplished certain things, and now lives a life where they have access to everything, such as better medical care, better schools for their children, having a car, having a driver's license, all that carries so much more weight. It's so much more powerful for them to say if you work hard you can accomplish many things than someone saying that who you think has everything anyway, and didn't have to work for it.

Ambar Castillo: What's distinctive about your approach to mental health?

Deborah Diedericks: Even though we encourage the organizations we work with to frame their own work as mental health, mental health cannot be the front door, because of the stigma. If you say, "I'm running a mental health club," you're not going to have any

kids pitching up to that. If you say, “I am running a group therapy session today so we can have hope for the future,” no one's going to come. It cannot be the front door.

The front door has to be a dance club, a knitting circle, a sports club, or a math class. All our organizations do something [like this], and then on the back end, you plug in mindfulness, breathing, kind and caring adults, plus referral processes. It's a backend approach. It's not the front door. If you say, “I’m doing mental health,” you will not get a single young person. Even if young people want to come, the parents would not allow them, because there's so much stigma.

Ambar Castillo: Even when this is incorporated into everyday speech, is there still an emphasis on intentional language, exercises, and activities around reflection, or pausing before you act?

Deborah Diedericks: It’s true even with adults. If you go to a meeting and the organizer decides to start with a meditation exercise, you're not going to get up and walk out. You're just going to do it. You might roll your eyes, but chances are you are just going to do it. The younger the kids, the more they're just going to do whatever you tell them to do. If you do it well, it will seamlessly become part of the pattern of the work you do. If you have a math class and you start every math class with a five-minute guided breathing exercise, at some point, they'll get used to it. That is life changing.

If you start anything with a breathing exercise, you calm your heart rate down and you put oxygen into your brain, which means you can activate your prefrontal cortex. If you come from a community that's super violent, or a household where your dad's just been hitting your mom, or a taxi where the driver drove like a maniac, or your friend's just been shouting at you in school, or someone just drew a knife and stabbed someone, those are the communities we work in. Or you're a girl in India, and no one thinks you're going to amount to anything because all you need to do is have children and have a husband. If you take that child and put them in a room where they have to learn math, they are not calm. In all these situations that they've just come from, their heart rates are going [up].

A lot of young people in disadvantaged communities have what we call toxic stress. They're continuously exposed to stress to such a degree they almost shut down. If you start with a breathing exercise, it sounds like such a simple thing, but what you're doing is kicking oxygen into their brain and their prefrontal cortex. Then their heart rate goes down and they can focus, and you're going to get more bang for your buck. They're actually going to learn more math than they would've learned if you didn't do it. That’s the drawcard. That's the message.

If you integrate positive mental health reinforcement into your program, it doesn't matter whether you're trying to teach these kids to do better in math, trying to get them employed, or learn to read. Whatever it is you're trying to do, you're going to have better outcomes on the things you want to do if you integrate positive mental health.

Another big thing is attendance. Young people come to programs where they feel safe and cared for, and people actually know them by their names. Otherwise, they won't come. They must feel welcomed and included. If you do that, it makes them calm down. It improves their self-worth. It gives them hope. It gives them an experience of someone caring about them, and that's going to make your program better because you're going to have better attendance.

Ambar Castillo: How do partners make space to talk about situations that might be difficult, such as trauma or incidents that might have led to toxic stress?

Deborah Diedericks: One of the things that we are fortunate to be able to do with the ICONIQ funds is to set three large goals. The overarching idea is to get EMpower as an organization, our staff, and the people we fund, to look at their work through a mental health framework. That's the bigger project. By the end of maybe two or three years, I'd like to have provided training on mental health first aid to all 150 organizations.

If you Google 'mental health first aid', there are lots of different iterations. We break it down as 'look, listen, and link'. You look, you notice, you see the whole child. You take notice of the way they're sitting and their facial expression, by comparing how they were yesterday and today. You can see if they're in distress or if they're okay, or how they feel. You listen. You make them feel heard, and you make them feel noticed, which is a massive thing, and then you link. If you know what to look for, when you see or hear something [off], you know where to go.

Mental health first aid training is cultural. I'm not going to hire an Australian mental health first aid person to train in 15 countries. Each country sources their own people. Again, it's important to speak the language and know the context. It's different variations of the same thing.

The second thing is what I call 'scope of practice'. What I mean is that a lot of people in nonprofits who work directly with young people are non-professionals. They're typically not social workers or psychologists or even teachers sometimes. Nonprofits in most countries typically hire non-professionals. If you give them mental health first aid training, and a clear understanding of what they can do to help build positive mental health, you also need to make sure they know the danger signs.

For example, if a kid is always wearing long-sleeve shirts every day in the heat of summer, you probably need to see if it's a flag that they could be cutting themselves and possibly doing self-harm. Not necessarily, but it could be a sign of that. If you have a child that comes to you and says, "Tomorrow at twelve o'clock I'm going to hang myself," you need to know that this is outside of your scope of practice. What is within your scope of practice, and what is outside?

Third, can we set up referral pathways? This is the "link" part of the mental health first aid training. That is by far the most complicated, because in many countries, theoretically it's there, but if you start scratching a little bit, the phone numbers don't work, or six months later, no one has responded. That's possibly my most challenging

task. I'm trying to determine the way we work in each country and city. What are the best referral pathways? Is it student psychologists at the local university? Is it another nonprofit that provides that service? Is it government?

Then you need to know who to contact in the government, how to access them, and have a relationship with them. Obviously, different things need different referrals. If someone needs to be on a suicide watch, who do you call? What do you do? What form do you fill out? If you think a kid is being beaten up by their father, what's the process?

The vast majority of young people can be helped just by having someone who cares, and having them experience an adult who cares. But you get a few kids who are on the brink of committing suicide, whose home circumstances are so bad that they're actually drowning. You have to make sure that even if your organization doesn't deal with those young people because they don't have the skillsets, they still get the help they need. Then you have to go outside of your organization. That's the plan.

Ambar Castillo: What makes your approach distinctive from what's already out there in the ecosystem of youth mental health?

Deborah Diedericks: Everywhere you will read how anxiety and depression among young people has spiked. If you dig further, you find that in low and middle-income countries it's spiked even more, and also there's no access to professionals. In response to this there are organizations that diagnose and treat depression or anxiety and select these young people for their programs.

But we also know there are not enough therapists, child psychologists, or professional social workers, particularly in low and middle-income countries, and even in wealthy countries, or in poor communities in wealthy countries, to diagnose and treat these kids. We know that access to professional mental health services is limited in poor communities. At EMpower what we do is support organisations who are based in communities that work upstream from diagnosis and treatment, in mental health promotion and prevention.

Your brain and prefrontal cortex only fully develop by the age of 24. If you can have an experience of an adult who cares before then, it becomes part of your neural pathways. That's the reason why we focus on the ages of 10 to 24. At that stage, a negative experience can still be addressed by a positive experience, because your brain is still pliable.

So the organizations that we support work in communities with marginalized youth on health, economic wellbeing and learning with this through line of supporting them across all programmes to have improved mental health.

We also have a ten year intention, which means that we help organisations to grow and learn and to become better and better at supporting young people.

Ambar Castillo: A part of what makes this distinctive is your focus on a youth's current context, and within that, how to incorporate these ways of breathing,

making sure that you have a caring adult in your life, and working within the context you already have, versus the focus on diagnosis and treatment with a provider, when there might be a shortage of them in that community as well.

Deborah Diedericks: Agreed.

Ambar Castillo: How did you decide to prioritize this approach in your role?

Deborah Diedericks: Three other organizations that use very similar approaches are Grand Challenges Canada (GCC), Fondation Botnar which funds Grand Challenges Canada and many other things, and SHM Foundation which has the Ember Project. The Being Project at GCC is also funded by Fondation Botnar**.** The Being Project and the Ember Project are very focused on community-based mental health care approaches, which is all about people who look and speak like those they help.

I've been talking with these people for years. Maybe to some degree independently, we came to the same conclusions that connect us. There's definitely a movement for community mental health. Many papers will say that one solution to the lack of mental health professionals is skilling up laypeople who work at community based organizations. We picked up from there. That's where we've decided to put our energy.

Ambar Castillo: The Youth Mental Wellbeing Co-Lab focuses on resilience, agency, and belonging. Which would you say your work most focuses on?

Deborah Diedericks: It's all three.

Ambar Castillo: Is there one where you see more of a focus?

Deborah Diedericks: Across our 150 partners, some are focused more on one thing, and some more on others. Belonging is a huge thing because it’s about safe and reliable adults. It's a second home away from home, a home that actually works, a place where kids feel safe. Belonging is massive.

I don't always like the word “resilience” because I think it's overused. It's become almost meaningless because it means everything. If resiliency means the ability to recover when something goes wrong, like getting upset with someone and you're not still angry a week later, or you recover and calm down within half an hour, or you try Plan B if Plan A doesn't work, that's what I would call resiliency, and that is baked into all the programs that we support across health, learning, and economic wellbeing.

With agency, you want young people to have hope, self-worth and self-regulation, so they may become agents whose lives don't just happen to them, but they can make their lives happen in spite of their circumstances, in spite of the massive systemic problems we know we have that EMpower can't fix. But we can help people figure out the system in spite of the system, or we can try. So agency is also something that all our partners aim to build with the young people in their programs.

Ambar Castillo: Ideally, your partners have folks who look and sound like the people they help in everyday instruction or activities. Are there other choices in the way partners design programming, or the way you've designed your partnerships, that enhance resilience, agency, and belonging?

Deborah Diedericks: One of the ICONIQ Co-Lab partners is Waves for Change. Their Surf Therapy Program has proven this. Their thesis really resonates for me. They get kids in a group and give them some sort of mastery activity, something they learn to do that's a bit difficult, but not so difficult that they can't do it, so they have to really work at it, like learn to surf, skateboard, play rugby or sing, for example.

If you give kids a group activity that they have to master, and they do it in a group with mindfulness techniques plus caring and supportive adults, the outcomes, particularly for boy children with aggression problems, it just calms them right down and it makes them less aggressive. There's something about that model of group activities where there's some sort of mastery, mindfulness, and physical activity, that I think is quite useful. It's not all the things we do. Not all programs we fund are sports for development.

I just visited an organization in Peru which uses music to teach poor children to play classical instruments. They take them from ages 5 to 18, and the kids end up in the symphony orchestra and youth choirs. The parents say the thing they see the most from this program is self-discipline, because the kids have something they want to do, and in order to do that, they need to stay late or do their homework after hours. They do it because they want to participate. There's something about that group identity that keeps them off the phones. It forges positive friendships and keeps them off the streets. Many poor communities don't have afterschool activities, and NGOs often provide that space. So our partners provide that safe space, safe adults and that shared activity which helps young people to build a sense of belonging, agency, and resilience.

Ambar Castillo: Do you get feedback from parents during your visit, or are there regular surveys or self-reported means from the youth? How do you get feedback on progress?

Deborah Diedericks: Measurement is difficult. It's part of our five-year journey. First, how do we look at our work as mental health work? Second, how do we integrate positive mental health reinforcement more into our work? Third, how do we measure it? We need to keep in mind that nonprofits are not researchers.

There are wonderful things out there, like the 10-point hope scale. That's a wonderful tool, but for a lot of nonprofits, even if they use that tool, chances are they'd have to translate it, which is already going to be difficult to keep it accurate. Then how do they analyze that data? Obviously, bigger nonprofits are on a [different] journey. We try to support organizations where they are. With smaller ones, it's less sophisticated. With bigger ones, it's more sophisticated.

We try to support organizations from their theory of change all the way through to their impact measurements, just to work out what they can do and how they do it, not to just

rely on pre and post-test questionnaires, but also do things like anecdotal evidence, focus groups, and observation schedules, which I think is very underrated. But that's a journey for each organization. One thing with our 10-year intention that has the biggest impact is that we try to help people to come up with ways to prove their work, in a way that is not beyond what they actually have capacity to do.

Ambar Castillo: Can you describe something you tried that didn't work, or didn't work the way you thought, and what you learned from it?

Deborah Diedericks: I used to think that the main thing is about reclaiming the term mental health; it is a positive thing that we all have. Now I realize that the main thing is that mental health strengthening and integration happen in programs, whether people call it that or not.

Ambar Castillo: What helped you realize that?

Deborah Diedericks: Just the reactions of people. If you say, “I'm going to do a breathing exercise with you,” some people might roll their eyes, but at the end of that, they usually say they feel much calmer. They physically experience the difference. If I start by saying, “I'm now going to do a positive mental health reinforcement,” people would be very resistant to that breathing exercise, and they probably wouldn't have done it. It just doesn't work.

Ambar Castillo: What challenges have you faced in your organization or in implementing this approach that you haven't yet been able to solve, or maybe aren’t necessarily solvable?

Deborah Diedericks: It’s the systemic failures. We cannot fix the cycles of poverty. A lot of the young people we work with are trapped in cycles of poverty. We can try to give them what I call ‘traction’, so that they can climb their way out, and we do see young people getting out, but it's a drop in the bucket.

There's a systemic failure in disadvantaged communities that is quite frightening. We can't do anything about it because it’s bigger than us. There's a lot wrong in the world right now, and people don't seem to care about poor people or prioritizing their needs.

Ambar Castillo: Any other issues that are challenging at the organizational level?

Deborah Diedericks: It's almost a year into the ICONIQ grant, but I feel we've just gotten started. We’ve now got traction. What we are about to do is do a survey with all 150 partners to reflect on their framing of mental health, on looking at their programs with a mental health lens, the kind of training and support they give their staff, what the staff might need, and what else we can do. That's going to give us a lot of data that we don't have at the moment, and I'm excited about that.

Ambar Castillo: Any insights or lessons that others inside or outside the field could use from the work you've done so far?

Deborah Diedericks: Not sure. I'd like to see us get to a place where we meet people wherever they're at instead of trying to diagnose them. Kindness is super underrated. It's a super-powerful thing. For a kid who comes from a violent community, kindness can be incredibly life changing.

I'd like to learn more about meeting people where they're at, getting back to the basics, and listening instead of assuming you already have the answer. How do we do that better? How do we train that? How do we train organizations to listen, to meet people where they're at? How do we train funders not to be know-it-alls?

I don't have all the answers. Mental health is a massive subject, and I am going to be learning for the rest of my life. If I stop learning, that's a problem. The day that I think I know it all, I should stop doing this work, because we learn more about the brain every day. Maybe the big thing is that we all need to continue to learn.

Organizations cannot work out a program and then do that for the next 30 years. They continuously need to adapt and check if it's working, meet people where they're at, and respond to what's in front of us, instead of what was in front of us 20 years ago.

Ambar Castillo: What are the most important questions the Co-Lab, or anyone looking into youth mental health, should be asking right now?

Deborah Diedericks: Measurement is challenging. What is too little measurement, and what is too much measurement? What can we reasonably ask organizations to do in terms of proof? Do we need to adapt our expectations? Everyone cannot do an RCT. Do we have to have gold standard evaluations to prove a concept?

Can we relax that standard, and if so, where do we relax to? What are our expectations with donors that want organizations to prove their work? Mental health outcomes are notoriously hard to prove. It's really difficult to have irrefutable proof that young people are more hopeful, for example. You can't do it. You need to be an academic researcher. Where's the middle way between gold-standard RCTs and no evidence?

Ambar Castillo: Thanks so much.

Ambar Castillo reports for Epicenter NYC, covering access and equity in some of the nation's most diverse neighborhoods. A former STAT health equity fellow through MIT's Knight Science Journalism program, her award-winning reporting bridges storytelling and public health. Supported by fellowships like the Solutions Journalism Network, Fulbright and Pulitzer Center, she has carried her reporting across communities from Queens to India.

** This interview has been edited and condensed.*