REDUCING INEQUITIES IN HEALTH & WELL-BEING BY ADDRESSING STRUCTURAL RACISM IN THE U.S.

Partnership for Healthy Communities &
Partnership for Arts and Culture
In collaboration with Delaware State University

PROCEEDINGS OF THE POLICY ACADEMY

April 17, 2019

UNIVERSITY OF DELAWARE
COMMUNITY ENGAGEMENT INITIATIVE

Delaware State University

This document is intended to provide an overview of the content, activities and feedback from the "*Reducing Inequities in Health & Well-being by Addressing Structural Racism in the U.S.*" Policy Academy held on April 17, 2019 in Newark, Delaware. It is the hope of the policy academy organizers that this archival document will provide a foundation for future policy academies, as well as continued momentum for collective, multi-sector health equity efforts in Delaware that address policy, practice and research at the state and community level.

Policy Academy proceedings were compiled by Sydney Rendon, Graduate Research Assistant for Center for Community Research and Service, Joseph R. Biden School of Public Policy and Administration; and Noël Sincere Duckworth, DVS, Program Coordinator, UD Partnership for Healthy Communities.

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I. THE PARTNERSHIP FOR HEALTHY COMMUNITIES

The mission of the Partnership for Healthy Communities (PHC) is to align and strengthen UD research, educational and service capabilities to improve the health and well-being of Delaware communities and beyond through effective community partnerships. PHC seeks to improve the health and well-being of Delaware residents, especially those living in communities that experience social, environmental and economic disadvantages.

PHC is led by Rita Landgraf, Director, and Erin Knight, Associate Director, and is guided by a Steering Committee with leadership and membership from both the community and the university, including all seven colleges within UD as well as membership from Delaware State University.

PHC is a part of the University of Delaware's Community Engagement Initiative (CEI). Following UD's designation in 2015 as a community engaged university by the Carnegie Foundation for the Advancement of Teaching, the UD Office of the Provost launched CEI as a campus-wide initiative to further advance and sustain civic engagement and campus-community partnerships.

PHC considers partnerships to be long-term, two-way mutually beneficial collaborations (with potential for scale); designed to leverage collective resources toward a shared goal; and, guided by jointly defined vision, roles and strategies for achieving that goal. PHC is currently one of six knowledge-based partnerships that have been developed out of the Community Engagement Initiative: Partnership for Public Education (2016), Partnership for Arts and Culture (2018), Wilmington Partnership (2017), Newark Partnership (2018), and the Sustainability Partnership (2018).

PHC officially launched in the fall of 2017 as part of the "*Strengthening Partnerships in Health and Education: Delaware and the Nation,*" conference co-hosted by the UD Partnership for Public Education and the Vision Coalition. The conference brought together over 500 community members, educators, policy makers and students to explore the intersection of education and healthy communities. The day concluded with an action-planning forum for PHC led by Tony Allen, Provost and Executive Vice President for Delaware State University. The forum yielded consistent feedback around two action items: 1) Address racism, discrimination and bias, and 2) Include a focus on early childhood education. Specifically, conference participants urged PHC leadership to address and delve into the history of racism in the U.S., be explicit about place-based disinvestment and inequalities driven by structural racism, focus and reflect on White privilege, and emphasize racial equity and healing needed both off and on campus, recognizing that UD didn't desegregate until 1950.

> *"Not until we address structural racism or inequality or violence does any of this really matter. "*
> *– PHC Action Planning Forum participant, Strengthening Partnerships in Health and Education, October 2017*

II. PURPOSE AND PLANNING

As the Partnership for Healthy Communities entered its second year, PHC leadership, with guidance from the Steering Committee, identified policy academies as core activities of the partnership. Results from the action-planning forum from the PHC launch conference established that the inaugural policy academy would focus on structural racism in the U.S. and health inequities. Consequently, the overreaching goal established for the initial Policy Academy was to raise awareness that structural racism is instilled in policy and perpetuates health inequities. The inaugural policy academy is part of an on-going PHC series aimed at addressing the broad role policy plays in population health, with the ultimate goal of developing an action agenda for policy, practice and research that can guide collective efforts at the state and community level, and among researchers in Delaware. For these purposes, the format of the Inaugural Policy Academy was designed to culminate into a cross-sector focus group where participants' input could guide and inform future policy academies.

The Academy was planned and hosted by the University of Delaware partnerships of the Partnership for Healthy Communities (PHC) and the Partnership for Arts and Culture (PAC), in collaboration with Delaware State University (DSU).

Early planning solidified **Delaware State University's (DSU)** role as a collaborator, thanks to Dr. Tony Allen's commitment to help advance next steps from the PHC Action Planning Forum, and the subsequent appointment and active participation of DSU faculty on the PHC Steering

Committee. Delaware State University (DSU) has been established for 125 years and is one of the nation's Historically Black Colleges and Universities (HBCUs). Founded in 1891 as the State College for Colored Students, DSU has a proud heritage as one of the country's first land-grant educational institutions. Today, DSU is a welcome center of learning for students from many backgrounds.

The **UD Partnership for Arts and Culture (PAC)**, a Community Engagement Initiative, joined as an event partner to help address how art and culture contribute to a healthy community and provide community members with a means of communication and healing. PAC aims to serve as an incubator and resource for artistic and cultural collaborations with a specific focus on global understanding and social change. PAC promotes the engagement of the arts and humanities in designing, implementing and assessing multidisciplinary solutions to areas of critical social concern and needs. PAC also helped plan an *Art Walk* for attendees to view throughout the day that included works reflecting themes of the Academy as interpreted by the individual artist.

Partners and collaborators came to consensus around the Academy title and frame as follows:

"Reducing Inequities in Health and Well-Being by Addressing Structural Racism in the U. S."

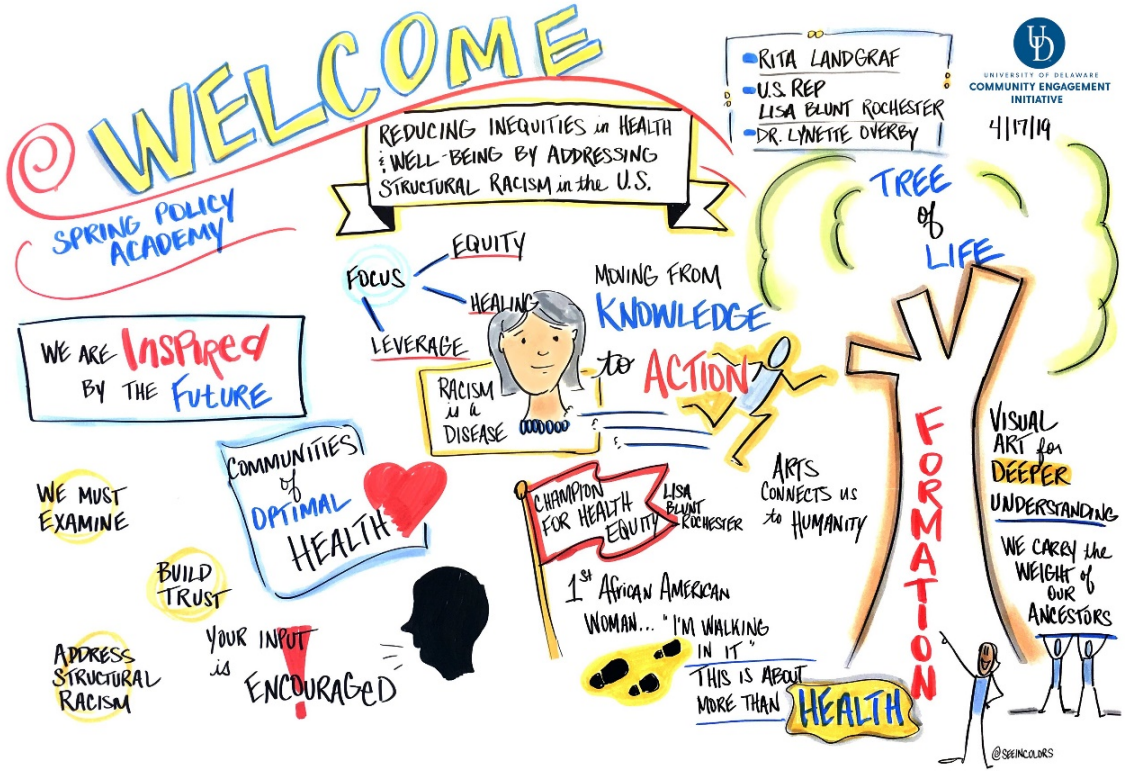
Experts define structural racism as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[1] Despite a growing understanding that structural racism plays a significant role in the poor health of oppressed groups, policy makers, scholars, practitioners and other key stakeholders are reluctant to identify racism as a root cause of health inequities. A more concerted effort to recognize and address structural racism is critical to improve the health of communities and advance health equity in our state.

While health inequities affect many different communities and groups defined by characteristics such as income or education level, gender identity and sexual orientation, or disability status, our focus for this event is on racial health inequities due to their large and pervasive nature. Further, while we recognize the importance of health inequities that exist across various racial and ethnic groups, including Native Americans, Latinos, and Asian Americans, we believe that the historical context of slavery and persistent oppression among Black Americans in the United States warrants particular focus.

[1] *Bailey, Z., Krieger, N., Agénor, M., Graves, J., Linos, N. & Bassett, M. (2017). Structural racism and health inequities in the U.S.A.: evidence and interventions. Lancet, 389: 1453-63*

III. ABOUT THE INAUGURAL POLICY ACADEMY

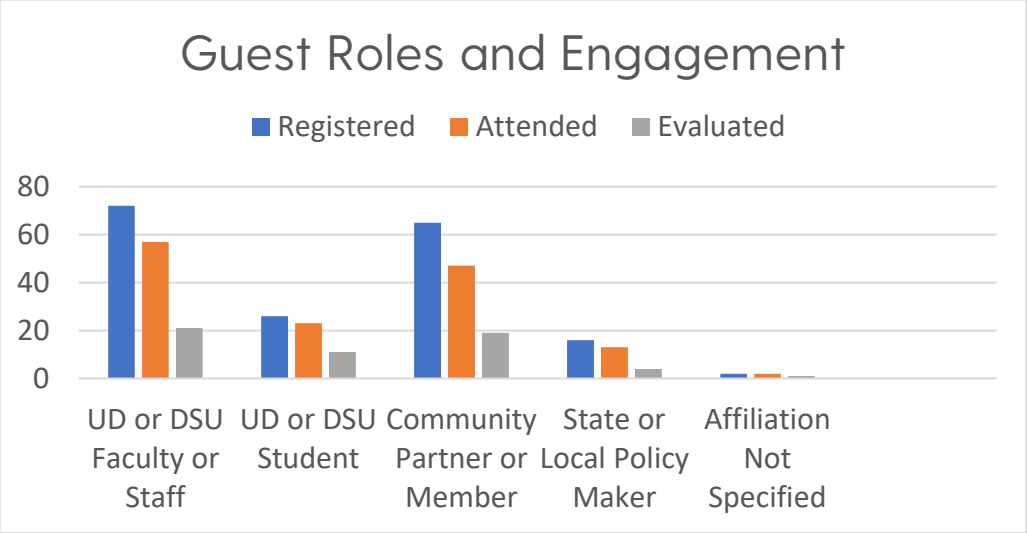
The 2019 Inaugural Policy Academy, *Reducing Inequities in Health and Well-Being by Addressing Structural Racism in the U. S.*, was a one-day event held at the University of Delaware's STAR campus on Wednesday, April 17, 2019 with the goal of gathering cross sector representatives to share in the mission of promoting health equity by addressing structural racism. Opening remarks were provided by Partnership for Healthy Communities (PHC) Director Rita Landgraf and Director of the Partnership for Arts and Culture (PAC), Dr. Lynnette Young Overby. Welcome remarks were provided by U.S. Representative Lisa Blunt Rochester, who shared her experiences as the first woman and the first African-American to represent Delaware in Congress, while reminding participants across the room about their own humanity, interconnectedness, and power as social change agents.



Who attended the Policy Academy?

Recruitment for the Policy Academy was a tiered process. Initially, PHC, PAC, and DSU each identified an approximate equal ratio of students, faculty/staff and community partners to receive invitations to the event in an effort to secure a balanced mix of cross-sector and cross-role attendees. Second-tier registration was then opened up to the broader mailing lists of the respective partners. Finally, registration was opened up to the general public by posting the registration link to the conference webpage. Registration goals were exceeded and a waiting list

was established. However, within one week prior to the event, all wait-listed guests were offered a space at the event. In total, 181 people registered and 142 attended (40% UD faculty or staff, 33% Community partner or member, 16% UD or DSU Students, 9% State or Local Policy Maker). Of the 142 attendees, 59 responded to an evaluation survey administered after the event.



What did the day of the Policy Academy include?

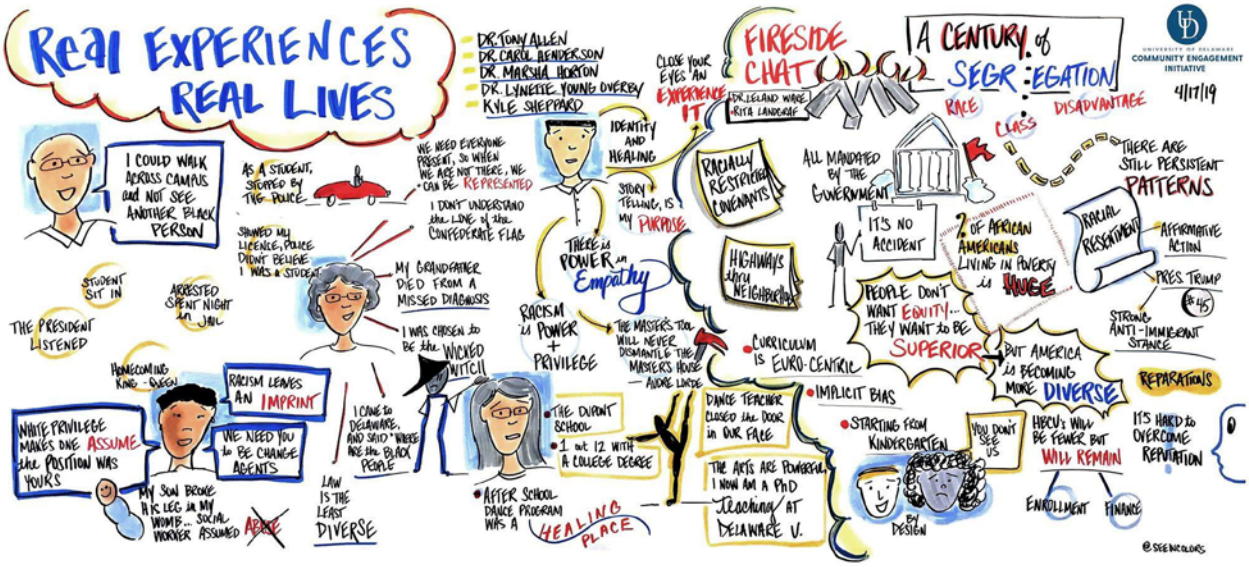
The Policy Academy Organizing Partners worked hard to create a different kind of experience from a traditional conference. In addition to integrating arts and culture throughout the agenda, the Partnership for Arts and Culture, with leadership from the Newark Arts Alliance, sponsored an ***Art Walk*** for attendees to view throughout the day. The exhibits, as interpreted by the individual artist, addressed how art and culture contribute to a healthy community and provide community members with a means of communication and healing.

"We will likely get things wrong today. Language is nuanced and complex so this is a starting point and your input is welcome."
– Rita Landgraf

Organizers also compiled a Glossary (Appendix A) and Suggested Reading and Additional Resources list (Appendix B) as a starting point for the conversation and to facilitate discussion.

Organizers also invested in a graphic recorder to help capture the context of the dialogue through visual notes. Lisa Nelson, from See in Colors, engaged in a process of listening, synthesizing, organizing and drawing what was being said in real time. Using the visuals of graphic recording helps with retention, decision-making and understanding. It can help facilitate collaboration, creative thinking, sustained motivation for action, and bring energy to the group. As the graphic recording progressed through the day, new completed boards were displayed in the atrium for participants to reflect on and further discuss. These storyboards are also featured throughout this document.

IV. REAL EXPERIENCES, REAL LIVES

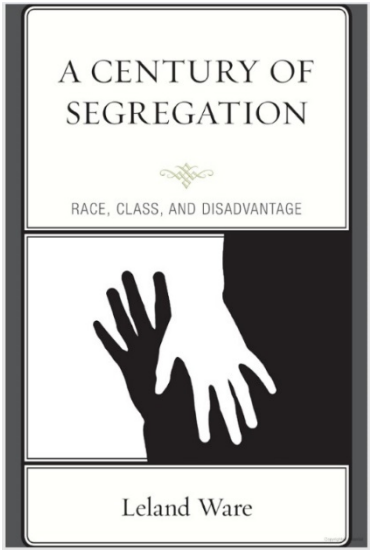


Following a trauma trigger warning and invitation for all participants to engage in self-care throughout the event, the program began with the voices of Black people sharing examples of how racism has impacted their lives in a session titled, "*Real Experiences, Real Lives*." This session aimed to build radical connection and center the work of the Academy on people impacted by racism, while championing the practice of prioritizing, listening to and acknowledging lived experiences. Radical connection recognizes that, "people who are directly impacted by systems of oppression, who are marginalized by those systems, have experience and perspective that is crucial for clearly seeing and understanding the impact of problems that threaten all our humanity, and for leading the whole of humanity toward solutions and alternative futures."[2]

All of the members that participated in the *Real Experiences, Real Lives* panel provided a glimpse of how they have been confronted with and were forced to navigate structural racism. The experiences shared included being arrested for "suspicious behavior" on the University of Delaware campus, being denied entrance to a dance school due to being Black, having physicians accuse a young and low-income mother of child abuse, and having family members' health not be taken seriously to the extent that it ultimately resulted in premature death. Additionally, a powerful speech and experiential exercise was given to engage conference attendees in acknowledging the daily weight and stressors of structural racism, and to charge the group with supporting others in order to lessen, improve, and change the burden. *Panelists: Dr. Tony Allen, Dr. Carol Henderson, Dr. Marsha Horton, Dr. Lynnette Young Overby, Mr. Kyle Sheppard*

[2] Move to End Violence & Movement Strategy Center. (2016). *Movement building practice: margins to center.* [PDF file]. Washington, DC: Author. Retrieved from http://www.movetoendviolence.org/wp-content/uploads/2016/09/Practice-Guide_Margins-to-Center.pdf

V. KEYNOTE SPEAKER: DR. LELAND WARE WITH PARTNERSHIP FOR HEALTHY COMMUNITY DIRECTOR RITA LANDGRAF



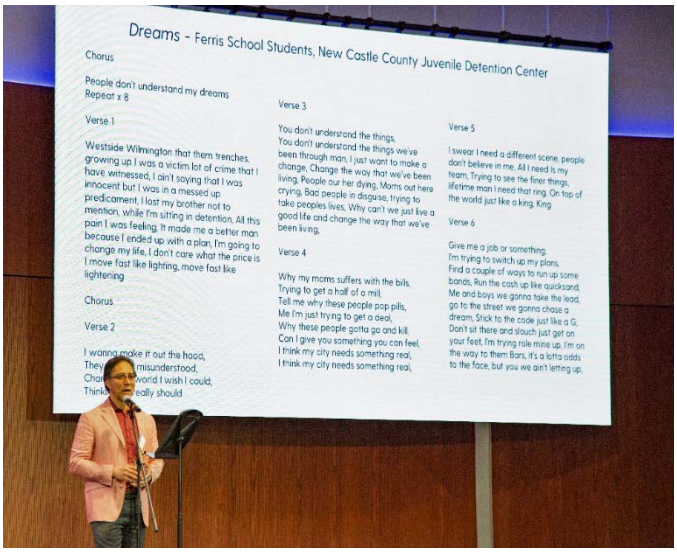
The Policy Academy's keynote speaker was Dr. Leland Ware, University of Delaware professor of law and public policy, Louis C. Redding chair, and author of the recently released book, "A Century of Segregation: Race, Class, and Disadvantage". Rita Landgraf, the Director of the Partnership of Healthy Communities (PHC), led an interview followed by Q&A from the audience with Dr. Ware expanding on structural racism in the United States while emphasizing race, class, and disadvantage. Dr. Ware discussed how these patterns are persistent in the country and that implicit biases are established early in our euro-centric school systems which help create the internal schema that "white is more valuable than black". Dr. Ware also addressed how with America's increasing diversity, there has been more reactivity from people in the country that "don't want equity, they want superiority," including parts of the current political administration.

VI. LUNCH PROGRAM: COMMUNICATING THE LEGACY OF STRUCTURAL RACISM IN THE U.S. THROUGH THE ARTS

Dancers: Amber Rance, April Singleton, Melissa Jones, Rachel DeLauder, Dianna Ruberto, Gabrielle Shubert, 8and Ralph Russell; Choreographers: Dr. Lynnette Young Overby, with contributions from dancers

The Partnership for Arts and Culture (PAC) was able to use artistic expression to showcase the impact of structural racism on Black Americans. First was a video entitled "Field Cotton" from "Dave the Potter" which showed the day of an enslaved cotton worker with Jonathan Green's artwork as the background. A performance of "Dream of Freedom", also from "Dave the Potter", depicted a young enslaved woman about to be sold and her dreams of freedom

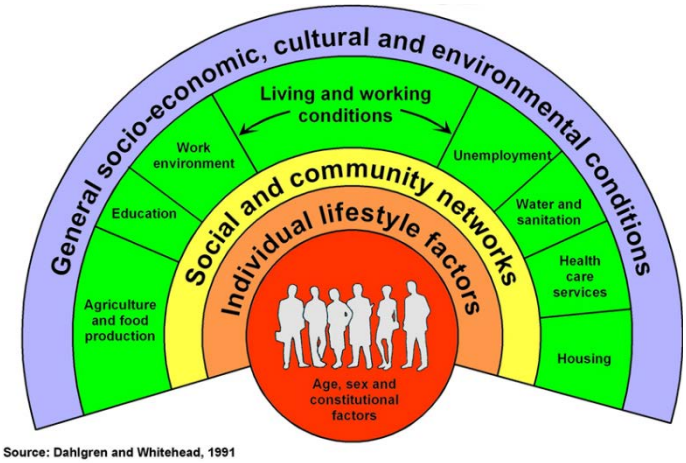
with her family and friends. The final performance was "Nikki, Angela and Me" from "Women of Consequence, Ambitious, Ancillary and Anonymous" which was dance and spoken word poetry based on speeches from Nikki Giovanni and Angela Davis, which told the stories of African American women that had lost their lives to police brutality. Recordings of the performances can be accessed here: https://youtu.be/PObeK9wYWOw .



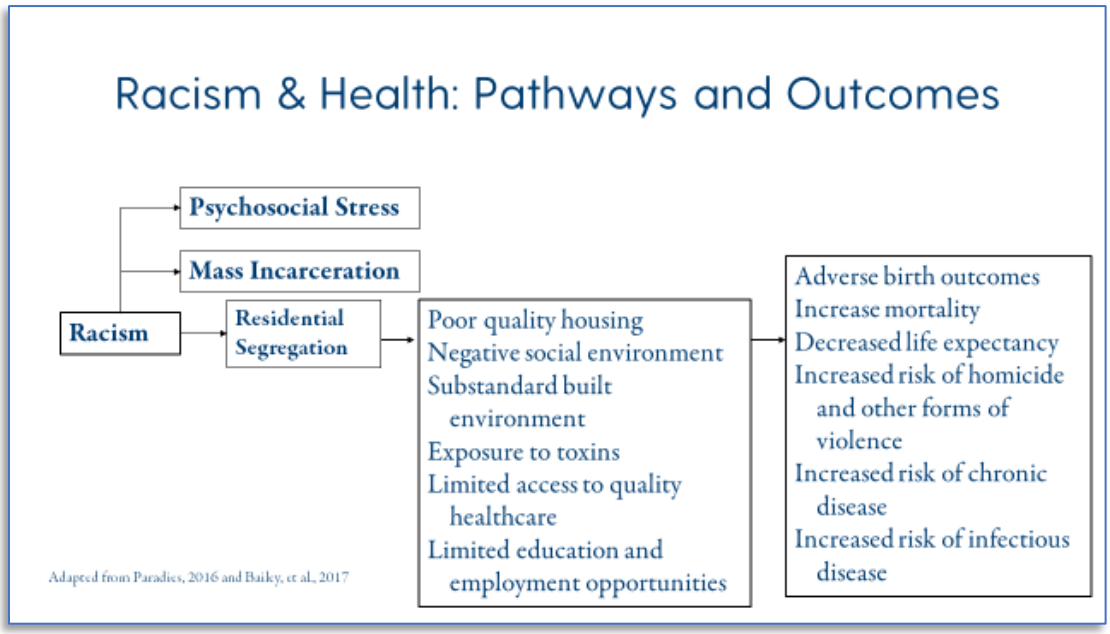
Colin Miller, Director of Global Art, UD College of Arts & Sciences, shared the Prison Music Project, a collaboration with local artist Richard Raw, which showed how music was being used for social change, particularly for young people. The segment entitled "Behind the Bars" featured youth in Wilmington that had used rap music as a positive outlet for their experiences as Black youth in the city. The song "Dream" was from students at the Ferris School and "Lead Me" was created by Kingswood Community Center students. The presentations were followed by an interactive dialogue with the audience and panelist Lynnette Young Overby, Colin Miller, Michael Kalmbach, Founding Director of the Creative Vision Factory, Rachel Delauder, Senior, University of Delaware, and Dianna Ruberto, Ph.D. Student, Public Policy and Administration.

VII. STRUCTURAL RACISM & HEALTH: WHAT DOES THE EVIDENCE SAY?

This portion of the day involved evidence from scientific literature on racial health inequities. Dr. Erin Knight led a general discussion on the social determinants of health and explained the "rainbow" of health, emphasizing how public policy impacts the socio-economic, cultural, and environmental conditions that exist. Dr. Barrett Michalec's presentation provided a sociological perspective on structural and institutional racism as well as a discussion on white privilege and its advantages. Dr. Michalec discussed how white privilege acts like a "knapsack of special provisions" that white Americans have, use, and do not have to think about during their day. Graduate research assistant Sydney Rendon presented evidence from a comprehensive literature review on how racism impacts health outcomes through residential segregation. Doctoral student Kalyn McDonough presented her research on the racial health inequities in Delaware and presented maps showing the impact of residential segregation on life expectancy, with the areas of Delaware with the highest number of Blacks having the lowest life expectancy. Two policy briefs, "Structural Racism as a Fundamental Cause of Health Inequities," and, "Delaware Focus: Health Inequities and Race in the First State," (Appendix C and D) were provided to attendees for additional information.



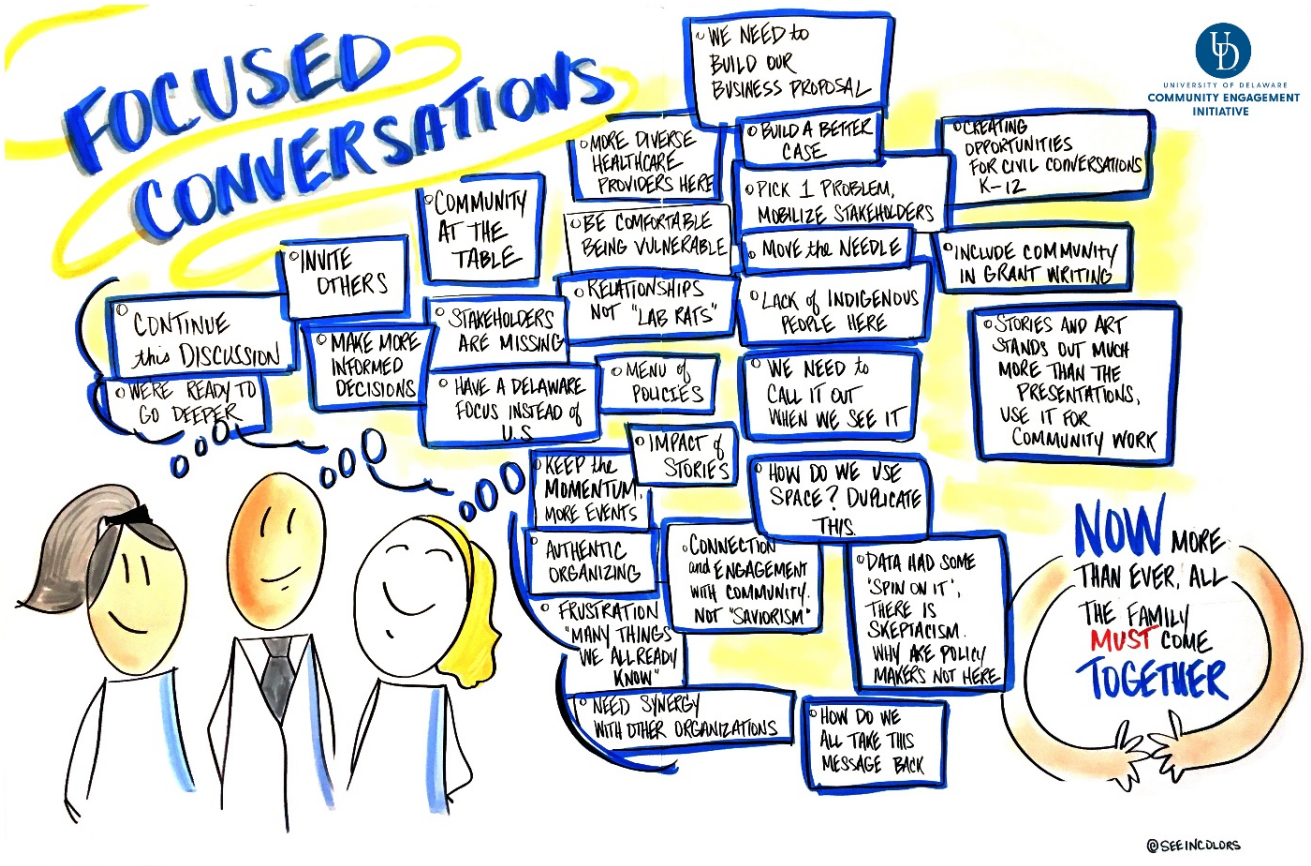
Source: Dahlgren and Whitehead, 1991



VIII. FOCUSED CONVERSATIONS

The afternoon provided an opportunity for participants to connect and engage in focused conversations as small groups. Participants were assigned tables in an effort to have a mix of students, faculty/staff, policy makers and community members. Twenty-two volunteer facilitators were identified before the academy. The volunteers received a guide with sample questions for using the ORID method, which is a focused conversation tool from the Technology of Participation® approach developed by the Institute of Cultural Affairs. ORID is based on the way the brain takes in and processes information through four different stages:

O- Objective	What we perceive through our body and senses	"What"
R- Reflective	Our feelings related to this perception	"Gut"
I- Interpretive	Processing and reflecting on what this means	"So what"
D- Decisional	Making a decision or taking action based on this interpretation	"Now what"



The following themes emerged from the focused conversations:

- **Continue the Conversation**
  - This event cannot just be a "check mark"
  - Discuss the issues in a way that is understandable and compelling to non-academics
  - We all have a responsibility to solve these issues

- **Initiate action**
  - "Actions speak louder than words"
  - To begin, we need to decide what it is that we want, and how we are going to achieve it
  - Policymaking should be *with* the people, not *for* the people

- **Increase Representation**
  - Include other underrepresented minority groups
  - Latino, Native American, Muslim, Creole, and other groups also exist and experience inequities in Delaware and the US
  - There needs to be a balance

- **Power of emotion**
  - Emotions mentioned by guests include: anger, pain, confusion, disgust, shame, guilt, anxiety, concern, eagerness, hope, pride, feeling overwhelmed, heartbroken, and a responsibility to take action
  - These emotions came from hearing and seeing the artistic performances, hearing the real-life experiences, and seeing the scientific data
  - Emotions are a strong agent of change and drive to problem-solve

- **Importance of the arts**
  - Offer a new perspective
  - Arts can inspire and evoke emotion in a unique way, and emotions can evoke change
  - Visuals help us to understand complex problems
  - Art can represent the scientific data in more relatable ways
  - Arts can be used as a creative outlet for those wanting to voice their opinions, concerns, and needs
  - Arts can appeal to a much wider audience than a clinical or academic approach

- **Responsibility to accept and acknowledge inherent white privilege**
  - White people need to hold each other accountable
  - Advocate for people of color when they're not present
  - Think about what you can do on a personal level to lessen these inequities

- The burden cannot be on people of color—white people have a responsibility to listen and take action

- **Scope: Real-life experiences are crucial in understanding the problem**
  - Personal anecdotes and stories of hardships are often more effective than a list of numerical data
  - Elicit emotion in a unique way
  - Help the audience to understand that the numbers presented in scientific data are more than just numbers; they are real people who are affected every day by these issues
  - Varying ages of the panelists show that these issues occurred in the past and still occur in the present

- **Early education is vital**
  - K-12 education curriculum should include multicultural topics to normalize and embrace diversity from an early age
  - Address stereotypes, misconceptions, and stigmas surrounding different racial groups
  - Start the conversation early so these issues are not taboo
  - There is power in youth – young people show hope for change

- **Community Engagement in policymaking**
  - Assess community needs by listening to the voices of the people
  - Create policy *with* the people, not *for* the people

- **Data & Research are important**
  - Data shows that these inequities do exist, and are a call-to-action for policymakers
  - Numerical data demonstrates the disparities of health and economics in racial groups, but how do we understand the data?

IX. HONORING OUR WISDOM/CONFIRMING OUR RESOLVE

After the focused conversations wrapped up, facilitators were invited to come to the front of the room and share out a summary of the "Decisional/Now What?" responses from their tables as part of the *Honoring our Wisdom/Confirming our Resolve* session:

Overall Policy Academy Structure

- Appeal to an even larger and more diverse audience - Engage policymakers and community residents
- Consider what other skills/knowledge to bring in
- Increase diversity on panels & presentations
- Convert to a 2-day event
- Build in more opportunities for participant discussion
- Hold often (quarterly or bi-annually)
- Go deeper- Focus more on building a policy agenda, advancing specific policies and/or calling people to action
- Work on "small p" policy to build changes in "big P" policy
- Be bold (vs "too polite" about content/accountability)
- Policymaking "with" not "for"

Overall UD/CEI Partnership and work to address Structural Racism

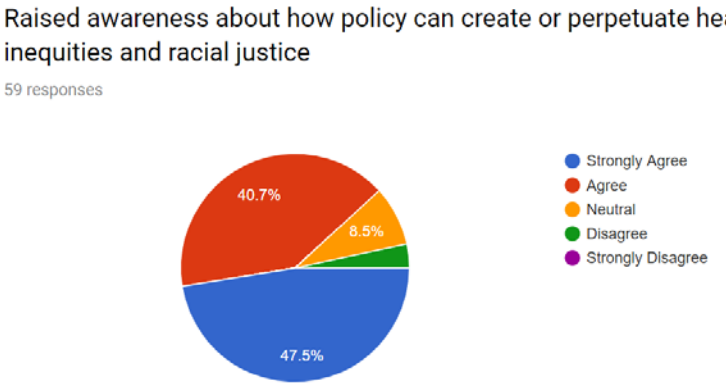
- Engage in efforts to help white people take responsibility and action (i.e. allied training sessions)
- Be more intentional – put conversation into spaces where it isn't automatically there
- Start w/community first (i.e. Coming to the community to help develop the initiative vs. going to them and saying "we have an initiative that will be helpful for you")
- UD to be accountable- create spaces like this in other places, continue conversation, address disparities on campus
- Use arts and culture to communicate, drive information and education, heal, create safe, welcoming & creative spaces, and to bring people to the table
- Build trust (i.e. fund/support community relationship building or authentic community organizing efforts)
- Research- Partner w/researchers to study program effectiveness; Connect UD and DSU research to state initiatives
- Develop sustained mutually beneficial partnerships
- More experiential learning, more engagement with communities

Kim Graham (left) was the final facilitator to report out, and closed with this excerpt from **Peace Go With You, Brother (As-Salaam-Alaikum) by Gil Scott-Heron & Brian Jackson**:

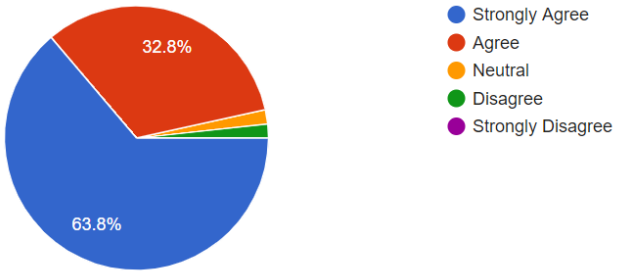
Now, more than ever
All family must be together
Every brother everywhere
Feel the time is in the air
Common blood flows through common veins
And the common eyes all see the same
Now, more than ever
All the family must be together

X. INGREDIENTS OF SUCCESS AND LESSONS LEARNED

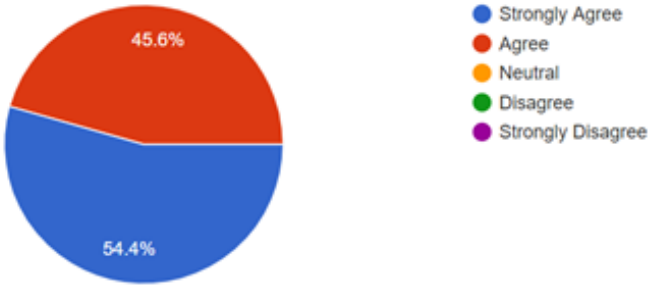
An online survey was distributed to attendees the day after the event that yielded a 39% response rate (n=56). The results suggest that the policy academy goals were met with the majority of respondents agreeing that the event: 1) raised awareness about how policy can create or perpetuate health inequities and racial justice; 2) highlighted the role of arts and culture in healing and promoting equity and health; 3) explored the evidence linking structural racism with poor health; and, 4) fostered a dialogue to advance policies and practices aimed at eliminating racism and promoting health and well-being equity.



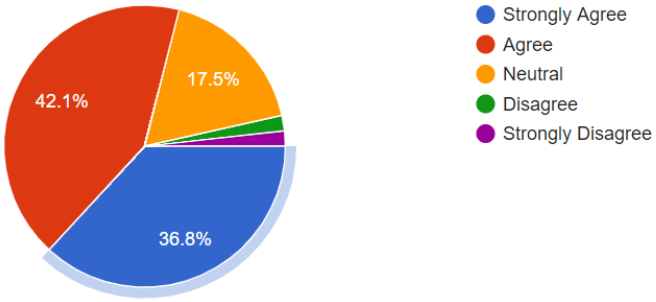
Highlighted the role of arts and culture in healing and promoting equity and health



Explored the evidence linking structural racism with poor health



Fostered a dialogue to advance policies and practices aimed at eliminating racism and promoting health and well-being equity



Feedback

The survey also asked respondents for written feedback and further reflection on what went well and what could be improved for the next event. The responses were overwhelmingly supportive and people most frequently cited feeling connected with the following components: the integration of the arts, the *Real Experiences, Real Lives* session, and the acknowledgement of white privilege in the "Structural Racism & Health: What Does the Evidence Say?" afternoon session.

In order to effectively continue the conversation that was started at the 2019 Policy Academy, both the supportive and critical feedback has to be used moving forward. The following is the feedback of what went well the day of the event and what should be continued in the future:

- "There was nothing that I did not like it was great, but the vulnerability of all speakers struck me most. Additionally, the performances during lunch were AMAZING!"
- "I think the best part of the event was the overall structure. Tying personal experiences to data with the enhancement of the luncheon art, displayed art and visual board helped tie so many pieces of this multi-faceted complex topic together wonderfully. Please thank the speakers who chose to tell their personal stories. I know it took great consideration on their end to be vulnerable."
- "The chat with Dr. Ware and the panel on white privilege and social determinants of health."
- "I liked the combination of arts, data and policy"
- "The audience. The right people were in the room. The opportunity to hear personal stories."
- " Loved the testimonials and art expression; music"
- "The event space was welcoming and conducive to a productive conference. The flow and speed of the program was also good."
- "This was the first time I was in a space with both Blacks AND Whites, having these types of dialogues and conversations, and I really liked this about the event."
- "The "subject" was actually discussed."

While the prior responses are great to hear as feedback, the following responses list suggestions and constructive criticism of the Policy Academy and can be used to inform future efforts:

- "More time for discussion and dialog among participants; more diversity on policy panel (afternoon)"
- "A deeper dive into the conversation--but I realize it is a "first" convening."
- " More focus on action plans, inclusion of indigenous and other community members"
- "Include white panelists on a panel focusing personal experiences w/ individual and structural racism. Doing so shows both sides of the equation for change. What African-Americans must do to overcome structural racism & what white people must do to

acknowledge their role (creators & beneficiaries, i.e., white privilege) in creating race-based inequality & eradicating structural racism.as a characteristic of American culture."

- "There could have been more discussion on explicit policies and innovative policy solutions that address structural racism. There could have been a brainstorming exercise on how to leverage our roles to improve policies"
- "The arts section was too long and did not seem connected as well as I would have liked to the other piece on health inequities."
- "The most important thing will be the follow up. At a subsequent meeting, will there be any outcomes? One idea I liked was the idea of a menu of some policy changes being currently considered and how they would impact racial / health inequity. Property tax increases or raising the smoking age to 21 were both discussed."

XI. FUTURE PLANS AND INITIATIVES

In the weeks following the policy academy, keynote speaker, Dr. Leland Ware, and PHC Associate Director, Dr. Erin Knight, wrote the Op-Ed, "Housing segregation continues. And it is cutting short black Americans' lives" that was published in the Sunday News Journal on May 12, 2019 (Appendix E).

On May 14, 2019, the PHC Steering Committee met and began to review the evaluation results and feedback generated during and after the event. Steering Committee members were asked to reflect on the information and discuss what they believe are the next steps for PHC, including the structure of policy academies as a core PHC activity and their future foci and framework. Committee members discussed how PHC could be a "dot connector" and provide technical assistance (i.e. facilitate and translate research on policies that are detrimental as well as best practices, educate on political process to advance engagement, educate on what policy-making is and how it works- both small "p" and big "P"). Steering committee members from the community encouraged more interaction with communities already engaged in best practice and expressed the need for additional research or evaluation support. Members also discussed interest in connecting UD and DSU research to state initiatives and working together to create joint courses (ex. health disparities) and a co-curricular activity where students engage across colleges and in communities.

Within a month of the academy, state and community partners have already shared exciting details about their plans for next steps:

- Several partners, including health and community development organizations, have followed up with PHC about ways to integrate an explicit focus on structural racism and health inequities in both organizational-level and community-level work moving forward.

- State government, planning agencies, and neighborhood coalitions are using the policy briefs and op-ed to provide context and advance dialogue around place-based solutions to crime and pollution rooted in structural racism.
- UD Faculty have paired up with community activists they met at the Policy Academy and working to evaluate program outcomes in neighborhoods experiencing health inequities.

Promoting equity is a key strategy for the Partnership for Healthy Communities (PHC) and that effort is enhanced through the collective engagement, and the effort of multiple sectors, including those impacted firsthand by inequities. The Policy Academy has increased our collective understanding of key issues that impact the health of communities, gives voice and clarity to why certain communities are most impacted by health inequities, and advances informed decision-making related to the complex nature of health inequities and the policies that impact them. PHC recognizes the importance of this policy work and looks very forward to future academies focused on increasing optimal health for all.

APPENDICES

GLOSSARY

This glossary is intended to facilitate our discussion at the April 17, 2019 policy academy, "Reducing Inequities in Health & Well-being by Addressing Structural Racism in the U.S.". It is not comprehensive, nor are the definitions the only way to explain the various terms. Rather, the definitions presented here reflect our understanding of key concepts related to racism, social determinants of health, health equity, and how art and culture contribute to a healthy community and provide community members with a means of communication and healing. This glossary provides a starting point for our conversation. We welcome your feedback.

Arts-based research: Promotes a deeper understanding and greater access to a topic by transforming the material into an artistic work or creative experience (Leavy, 2015).

Creative placemaking: When partners from public, private, non-profit, and community sectors strategically shape the physical and social character of a neighborhood, town, city, or region around arts and cultural activities (Markusen and Gadwa, 2010).

Health equity: The highest level of health for all people; achieving the conditions in which all people have the opportunity to reach their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance (CDC).

Health inequity: A difference in health status between groups which is considered unnecessary, avoidable, unfair and unjust (Whitehead, 1992); a socially determined difference in health (WHO).

Healthy community: A place where all are free from discrimination and oppression and there is equitable access to the resources needed for optimal health. A healthy community goes beyond quality medical care and is reflected in the social and environmental factors that promote well-being (PHC).

Infant mortality rate: The number of deaths of children less than one year of age per 1,000 live births. Infant mortality is a widely used and important measure of the health of a community, in addition to that of mothers and babies. It is often used for comparisons across regions or communities, and over time. Changes in infant mortality can be attributed to a number of factors, including social determinants of health.

Intersectionality: A theory or framework for conceptualizing an individual or group as having overlapping identities and experiences that may be affected by different forms of discrimination and disadvantage. It is related to various forms of social stratification, such as race, class, gender, religion and disability status and recognizes that these identities do not exist independently (Crenshaw, 1989).

Life expectancy: The statistically predicted (average) number of years of life remaining at any given age; usually reported and understood as "life expectancy at birth" unless otherwise noted. Life expectancy is one of the most frequently used health status indicators, and gains in life expectancy can be attributed to a number of factors, including social determinants of health.

Residential segregation: The physical or spatial separation of two or more social groups within a geographic area; a foundation of structural racism (Bailey et al., 2017).

Social determinants of health (SDH): The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (WHO). SDH are believed to be the primary, or most important, determinants of health and differences in SDH are believed to underlie health inequities.

Structural racism: The *totality* of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice (Bailey, et al. 2017). Alternately, may be defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time" (Aspen Institute, 2004). Structural racism includes both individual racism and institutional racism:

> **Individual racism:** Intentional or unintentional acts of commission or omission based on assumptions that one race is superior to another; can include internalized racism such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth (Jones, 2000).
>
> **Institutional racism**: Differential access to the goods, services and opportunities of society by race, which is often codified in our institutions as customary practice or even law (Jones, 2000); may referred to as "systemic" racism.

White Privilege: A system of benefits, advantages, and opportunities experienced by White persons in our society simply because of their skin color (Donnelly et al., 2005). As described by McIntosh (1989), white privilege may also be conceived as "an invisible package of unearned assets that [a white person] can count on cashing in each day, but about which [they] were 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks."

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Suggested Reading & Additional Resources

BOOKS

Eloquent Rage: A Black Feminist Discovers her Superpower – Brittney Cooper

The Hidden Rules of Race: Barriers to an Inclusive Economy – Andrea Flynn, Susuan R. Holmberg, Dorian T. Warren, & Felicia J. Wong

Race and Social Equity: A Nervous area of Government – Susan T. Gooden

Stamped from the Beginning: The Definitive History of Racist Ideas in America – Ibram X. Kendi

When they call you a Terrorist: A Black Lives Matter Memoir – Patrisse Khan-Cullors & Asha Bandele

The Origin of Others – Toni Morrison

So You Want to Talk about Race – Iljeoma Oluo

Waking up White, and Finding Myself in the Story of Race – Debby Irving

An African American and Latinx History of the United States – Paul Ortiz

Method Meets Art – Patricia Leavy

White Kids: Growing up with Privilege in a Racially Divided America - Margaret A. Hagerman

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WEBSITES

Centers for Disease Control & Prevention on Social Determinants of Health https://www.cdc.gov/socialdeterminants/index.htm

World Health Organization on Social Determinants of Health https://www.who.int/social_determinants/en/

American Public Health Association on Social Determinants of Health http://thenationshealth.aphapublications.org/content/nations-health-series-social-determinants-health

American Public Health Association on Racism and Health
https://www.apha.org/topics-and-issues/health-equity/racism-and-health

Delaware Health and Social Services, Division of Public Health, Bureau of Health Equity
https://www.dhss.delaware.gov/dhss/dph/mh/healthequity.html

Robert Wood Johnson Foundation on the Connections between Race, Racism, and Health
https://www.rwjf.org/en/library/collections/racism-and-health.html

The Boston Public Health Commission on social determinants of health and racism
http://www.bphc.org/whatwedo/health-equity-social-justice/Pages/Health-Equity-and-Social-Justice.aspx

POLICY BRIEF

UNIVERSITY OF DELAWARE
COMMUNITY ENGAGEMENT INITIATIVE

PARTNERSHIP FOR HEALTHY COMMUNITIES

STRUCTURAL RACISM AS A FUNDAMENTAL CAUSE OF HEALTH INEQUITIES

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Purpose & Executive Summary: This policy brief describes the role of racism in creating and perpetuating inequities in health among Black communities in the United States. It defines structural racism within a social determinants of health framework and highlights ways in which residential segregation is connected with poor living, working, and social conditions that threaten good health. This brief concludes with recommendations for advancing health equity through more concerted attention to structural racism.

Health and Health Inequities in the United States (US)

Despite being one of the wealthiest countries in the world with an abundance of health-related resources, the US has poor health compared to other countries. Life expectancy and infant mortality are two important measures used to describe the health and well-being of a community or population. On both indicators, the US ranks poorly: 45th in life expectancy and 170th in infant mortality.[1] Notably, these indicators are also generally moving in the wrong direction, with the US falling in the rankings in recent years.

Differences in health among different groups of people, often referred to as **health inequities**, are well documented, persistent, and even increasing for some health conditions across the US. Health inequities may be viewed in the context of race, gender, sexual orientation, income, education level, disability status, or geographic location, among others. For example, sexual minorities tend to have poorer physical and mental health than heterosexual men and women[2] and individuals with disabilities are likely to have higher rates of chronic diseases, unrelated to their disability, compared to individuals without disabilities[3]. We also see persistent health inequities by socioeconomic status (e.g., income, occupation, and education level) and research documents a social gradient in health, such that as socioeconomic status improves, so does health status. For example, the gap in life expectancy between individuals in the top and bottom 1% of the income distribution in the US is 15 years for men and 10 years for women.[4] The social gradient in health means that inequities affect virtually everyone.[5]

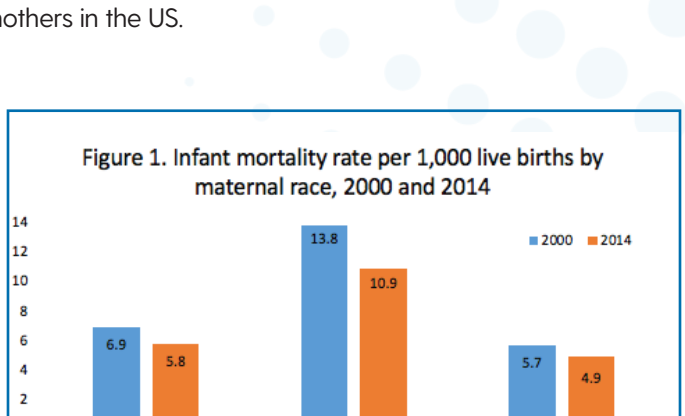
Further, when it comes to health, people are often disadvantaged by more than one type of oppression based on their identity or class (e.g., "black" and "gay"). This concept of **intersectionality**, originally described by Crenshaw[6], is important for understanding how groups of people with overlapping identities and experiences may be discriminated against in many ways.

Because these are socially constructed categories related to social hierarchy, and related differences in health do not derive from biology or genetics, experts consider such health

differences to be socially produced. As such, we can conclude that "health inequities are not only unnecessary and avoidable, but in addition, are considered unfair and unjust".[7]

Among the most pervasive and persistent health inequities are those experienced by people of color in the US. While we recognize the importance of health inequities that exist across various racial and ethnic groups, including Native people, Latinos, and others, we believe that the historical context of slavery and persistent oppression among Black individuals in the US warrants particular focus. Using life expectancy and infant mortality as a snap shot, one can get a sense of the magnitude of health inequities experienced by Black individuals in the US. Figure 1 highlights that while infant mortality rates have fallen among all racial and ethnic groups since 2000, the gap between groups persists, with Black, non-Hispanic women experiencing an infant mortality rate of 10.9 deaths per 1000 live births in 2014, compared with a rate of 4.9 per 1000 among White, non-Hispanic women.

Another way to look at the inequity in infant mortality is to examine the ratio of infant deaths across racial groups. Figure 2 highlights how this ratio (i.e. Black infant mortality divided by White infant mortality) has changed over the past 80 years. As seen in this figure, the Black-White infant mortality ratio reached a low of approximately 1.5 in 1948 and stayed below 2.0 prior to the mid-1980s, when it began to climb steadily until reaching a peak over 2.5 in 2000. This Black-White ratio has remained well above 2.0 in recent years and the most recent data from the Centers for Disease Control and Prevention indicate that the infant mortality rate for Black mothers is 2.3 times that of White mothers in the US.



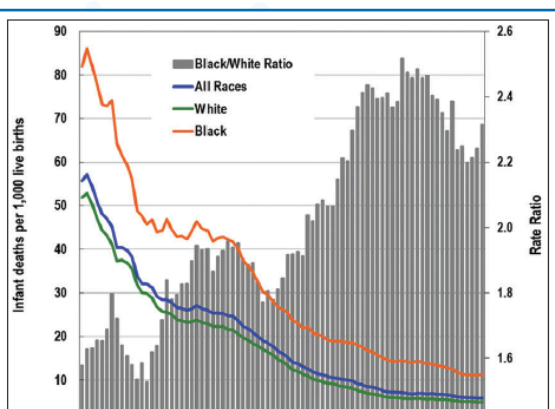


Figure 2. Infant Mortality Rate by Race, United States, 1935-2015
Source: Singh GK, van Dyck PC. Infant Mortality in the United States. A 75th Anniversary title V Publication. HRSA. 2010 (updated data) and CDC/NCHS.

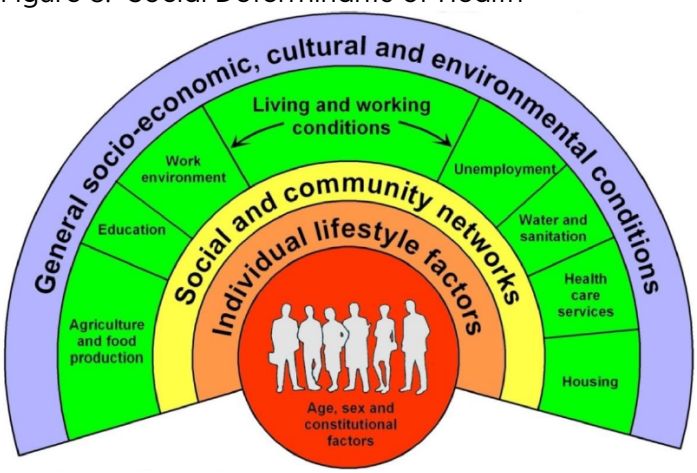
Health inequities experienced by Black individuals in the US can be seen across a range of other health indicators. Despite recent progress, especially among Black males, the gap in life expectancy between Blacks and Whites was still 3.4 years in 2015.[8] Further, a recent analysis of health status and outcome measures across different racial and ethnic groups found that **Blacks fared worse than Whites on 24 out of 29 indicators**, including rates of asthma, diabetes, heart disease, HIV, and cancer.[9] Among these findings is evidence that Black children also have higher rates of asthma, teen pregnancy, and obesity.

The Importance of Social Determinants of Health

Health is a result of a complex web of influences, including social, economic, political, physical, behavioral, and biological factors. Figure 3 is a model often used to illustrate how various factors operate on different levels to influence health and health inequities.[10] As seen in this figure, health is influenced at a fundamental level by our innate constitutional factors, such as age, gender and genetic predisposition or family history (red circle). Health is also influenced by individual behaviors and lifestyle factors, such as tobacco use or physical activity (orange band). However, we know that lifestyle choices are made within the context of one's social and community networks (yellow band) as well as the broader social, economic and physical environment (green band). Often referred to as the "social determinants of health (SDH)", these are widely understood as the conditions in which people live, learn, work, play and pray. **SDH are believed to be the most important determinants of health; and differences in these conditions result in health inequities.**

Communities often experience cumulative health burdens grounded in inequities in these social determinants. For instance, communities that experience low economic and employment opportunities, may also have underfunded education systems, inadequate access to health and social services, lack of healthy food retailers, unstable housing, and a lack of safe recreational spaces. Finally, these conditions are themselves influenced by larger structural forces, such as economic, education, and political systems, social norms, culture and power (purple band).

Figure 3. Social Determinants of Health



Source: Dahlgren & Whitehead, 1991

Structural Racism as a Fundamental Cause of Health Inequities

Racism is a complex social phenomenon that can be defined in many different ways and is frequently expressed on different levels. It involves individual and collective attitudes, actions, processes and unequal power relations.[11] On an **individual** level, racism can be expressed as intentional or unintentional acts of commission or omission, based on assumptions that one race is superior to another. For example, a restaurant owner who refuses to serve a Black patron is committing an intentional act of racism, while a doctor who neglects to recommend the same surgery for a Black patient that is recommended for a White patient with identical symptoms may be unintentionally committing an act of omission. On an individual level, racism may also be internalized, such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth.[12] Internal racism may be expressed by Black individuals dropping out of school or referring to themselves using negative stereotypes.

Institutional or systemic racism can be defined as differential access to the goods, services and opportunities of society by race, which is often codified in our institutions as customary practice or even law.[12, p1212] The historic practice of redlining, such that Blacks were systematically denied mortgages in certain neighborhoods, or charged higher insurance premiums, are expressions of institutional racism. A subtler, but potentially just as serious, form of institutional racism may be seen in the content of public school curricula, or images in the media, that are biased towards the culture and experiences of the majority population. Institutional racism in one area or sector may reinforce or interact with racism in another, such as the ways in which discrimination in housing perpetuates problems with underfunded schools and limited educational opportunities for Black children living in segregated neighborhoods.[13]

Institutional racism is interconnected with individual forms of racism and often serves to reinforce discriminatory beliefs and values.[14] For this reason, the concept of **structural racism** has been suggested as a way to reflect the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice".[14, p1454]

Another way to think about structural racism is as:

"A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time".[15]

Conceptually, we can think about this definition of structural racism in the context of the determinants of health rainbow (figure 3). Specifically, we can see how negative aspects of living and working conditions in Black communities are largely the result of structural racism, where historical and contemporary policies, practices, beliefs and attitudes have resulted in an unequal distribution of resources across communities. More specifically, structural racism has led to many Black neighborhoods characterized by a lack of employment opportunities, underfunded public schools, substandard housing, inadequate access to health insurance and healthcare, lack of greenspace and recreational opportunities, as well as high concentration of poverty, pollution, and violence—all of which threaten health directly and indirectly.[16]

While social networks may be strong and promote health and well-being in communities of color, policies and practices in our criminal justice system disproportionately incarcerate Black men, women and children, with direct health impacts on those who are incarcerated and potentially dismantling what would have otherwise been strong social support and community networks.[17,18] In addition, the stress of racial discrimination is associated with coping behaviors that are detrimental to health, such as smoking, and alcohol and drug use.[16] Ongoing stress associated with racism can also have direct physiological impacts on the body (i.e. allostatic load) and is associated with mental health problems such as anxiety and depression.[16]

All of these negative influences and exposures can accumulate over time and across generations.[14] An understanding of how structural racism shapes the determinants of health for Black communities leads us to conclude that structural racism is a fundamental cause of health inequities.[19,20]

A Focus on Residential Segregation

"Residential segregation is a foundation of structural racism".[14, p1457] **Residential segregation** is the physical or spatial separation of two or more social groups within a geographic area. It is a fact of history in the US and has long been identified as the root of many social and racial inequities in American cities. While different racial and ethnic groups and immigrants have experienced segregation in the US, African Americans have been victims of an unparalleled level of deliberate segregation that is perpetuated today through individual actions, institutional practices and public policy[21] and patterns of segregation among Blacks in the US remain the highest across all racial/ethnic groups[22]. According to Dr. David Williams, a leading scholar on racism and health, "the single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans is residential segregation".[23, p177] Further, residents of segregated neighborhoods continue to be politically alienated and lack power such that conditions often remain entrenched.[24]

Importantly, segregation is a contemporary problem that persists in the US, despite the myth of integration.[25] While the latter half of the 20th century saw an end to explicit policies aimed at keeping Blacks from White neighborhoods (e.g. the Fair Housing Act of 1968), "such practices continue to be realized by purportedly color-blind policies that do not explicitly mention 'race' but bear racist intent".[14, p1454] For a detailed historical analysis of segregation, including its roots in law, public policy, and public and private institutions, and its contemporary manifestations and enduring impacts see *A Century of Segregation: Race, Class and Disadvantage* by Leland Ware[13].

An estimated 176,000 deaths were attributable to racial segregation in 2000[26], and there is a growing evidence base linking segregation to a range of indicators of poor health status of Blacks living in segregated communities. Health inequities are "largely a function of the separate and unequal neighborhoods in which most Blacks and Whites reside".[22, p179] Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities, and that health inequities remain even after income and education levels are accounted for. Rather, the places themselves and the nature of the social, political, built and physical environments affect health directly and indirectly in myriad ways.[14,16,17,27] For an overview of the pathways through which residential segregation impacts health outcomes with strong supporting evidence see figure 4.

Figure 4: Pathways and Outcomes through which Residential Segregation Harms Health

Pathways through which segregation is believed to contribute to health inequities

- Poor quality housing, including dampness, inadequate heat, noise, overcrowding, and presence of environmental hazards and allergens[e.g.,14,19,27]
- Negative social environments, including exposure to violence, crime, and systematic differences in policing and incarceration[e.g.,22,27,28]
- Substandard built environment, including higher exposure to fast food outlets and alcohol retailers, reduced access to supermarkets with fresh fruits and vegetables, and lower access to recreational facilities[e.g.,19,29,22,30,31]
- Exposure to pollutants, toxins, and other environmental hazards[e.g.,22,32,33,34]
- Limited educational and employment opportunities and earning potential[e.g., 17,19,27]
- Limited access to quality health care[e.g.,19,22,35,36]

Health Outcomes with Evidence linked to Segregation

- Adverse birth outcomes, including low birthweight, pre-term birth and infant mortality[e.g.,17,37,38,39]
- Decreased life expectancy and increased mortality[e.g., 19,40,41]
- Increased risk of chronic diseases including CVD, heart disease, cancer, hypertension, asthma, and mental health problems such as anxiety and depression[e.g.,16,22,33,42,43,44]
- Increased risk of homicide and other forms of violence[e.g.,45,46]
- Increased risk of infectious diseases, including tuberculosis and HIV[e.g.,47,48]

Policy Recommendations

According to the Centers for Disease Control and Prevention, "**health equity** is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances".[49] Given the discussion presented above, it is evident that achieving health equity requires action on multiple fronts to dismantle structural racism.

Improving neighborhood conditions – Addressing social conditions through policy change has long been recognized by experts as the best way to improve health and advance health equity. Place-based and cross-sector policy strategies are recommended to address the multitude of ways in which the housing market, education system, job market, and the built and physical environments interact to produce health. Investments in communities can have direct benefits that reduce health threats (such as crime and pollution) and indirect benefits that promote healthy behaviors (such as sidewalks, green space, and healthy food establishments). High quality, equitable education and safe, affordable housing are fundamental to health improvement, as are promoting living wage jobs and access to quality health and social services.

Shifting power and decision-making – Improving neighborhood conditions is insufficient, however, if the underlying structures and processes that determine the distribution of resources are not fundamentally changed. The evidence cited above suggests that conditions in Black communities have roots in historical and contemporary racism. Therefore, we must confront structural racism if we are to have a meaningful impact on health inequities.[20] This means, among other things, a fundamental shift in power and decision-making with respect to public policy and distribution of resources from the local level to the federal level.

Further, while improving conditions in Black neighborhoods is critical for health improvement, "the issue of separation that remains so pervasive and endemic to the American way of life that we rarely even question it."[25] We must debunk the myth that integration has been achieved and continue the unfinished work of the civil rights agenda.

Training and professional development – It has been argued that training for health professionals should more systematically include content related to SDH and specifically racism and health.[14,50] However, the need to work across sectors to address underlying neighborhood conditions to improve health calls for broadening the scope of such training to other sectors and disciplines. Just as there can be an accumulation of burdens and risks when racist policies and practices are perpetuated, dismantling such policies and practices in one sector can have a positive ripple effect in other areas.

Research – There is much we can still learn about the ways in which racism impacts health, including for instance, the ways in which racism can be mediated, how racism interacts with other forms of oppression, or for understanding generational health impacts of racism. There is also a need for improving the ways in which both racism and health are measured, and for using multilevel analyses to capture the complexity of factors in the racism and health equation. These and other research activities can improve our understanding of this complex issue and may be particularly important for addressing criticisms and skeptics. However, it seems evident that **we know enough about racism as a determinant of health inequities to act**. Further, where research may be most useful is in evaluating policy and practice changes meant to address racism and its consequences. Similarly, research is needed on the most effective strategies for building public and political will for change, such as research on framing and social movements. Findings from these kinds of applied studies can help to further our collective efforts to advance equity in health.

Conclusion

For those with a social justice orientation, addressing structural racism is a moral imperative. Those with a more practical world view may approach this work from the understanding that "racism undermines the realization of the full potential of the whole society through the waste of human resources".[20,p9] Both perspectives are relevant to efforts to advance health equity given that health is both a human right, as well as a resource for living and working. Addressing structural racism requires efforts on multiple fronts and on many levels. The evidence suggests there is good reason to be optimistic that changing underlying structural conditions will lead to improved health and well-being.

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Our Vision: Healthy, Thriving Communities for All

The Partnership for Healthy Communities is inspired by the possibility of this reality for all Delaware communities; as well as being inspired by a vision of equity in health. This prompts our work so that all of our residents can live in communities with the resources that are necessary to promote optimal health, and the burdens or threats to good health are minimized. We focus especially on communities currently experiencing social inequities.

The mission of the UD Partnership for Healthy Communities is to align and strengthen University of Delaware research, educational, and service capabilities to improve the health and well-being of Delaware communities and beyond through effective community partnerships.

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We are grateful to the following individuals who contributed to the development of this brief and served as reviewers: Isaac Botchey, Noël Sincere Duckworth, Carol Henderson, Rita Landgraf, and Barret Michalec.

UNIVERSITY OF DELAWARE
COMMUNITY ENGAGEMENT INITIATIVE
PARTNERSHIP FOR HEALTHY COMMUNITIES

DELAWARE FOCUS: HEALTH INEQUITIES AND RACE IN THE FIRST STATE

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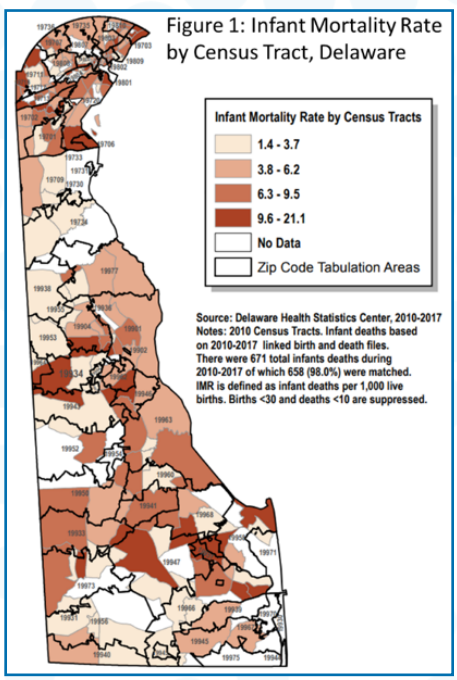
How healthy are Delawareans?

Health is often defined as a state of physical, mental and social wellbeing and not merely the absence of disease. It is a positive concept emphasizing resources and capabilities[1] and at a population level, is only marginally impacted by the delivery of healthcare[2]. Rather, experts agree that social circumstances and our living and working conditions—referred to as social determinants of health (SDH)—are the most important drivers of health.

America's Health Rankings (AHR), an initiative of United Health Foundation, has been tracking determinants of health and health outcomes across the US for nearly 30 years. AHR assigns a score to each state based upon a composite of indicators, with health determinants accounting for three-quarters and health outcomes accounting for one-quarter of each state's overall score. In 2018, Delaware (DE) ranked 31st among US states, which is down one spot from 2017.[3] DE does well compared with other states in terms of childhood immunization rates (#6) and in the percentage of the population that is uninsured (#11). We are challenged by other factors such as air pollution (#41), children living in poverty (#30) and violent crime (#38). Further, DE ranks in the bottom half of states for overdose deaths, cancer deaths, diabetes, physical inactivity, deaths from cardiovascular disease. Finally, we rank 48th in the country in infant mortality.

Social Determinants of Health & Inequities in Delaware

The DE Department of Health and Social Services has long recognized the importance of SDH. Its most recent state health assessment argues that "quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents"[4, p5]. Differences in these social conditions drive health inequities in our state, such that many DE communities—those that lack employment opportunities, have poor quality schools and low graduation rates, lack healthy food retailers but have an abundance of alcohol and tobacco establishments, unstable housing and a lack of safe recreational spaces—have poorer health than communities with more resources.



Infant mortality is an indicator often used to describe the overall health of a community, and to make comparisons between communities. Differences in infant mortality are often attributed to differences in SDH. Figure 1 shows infant mortality rates by census tract across the state, suggesting differences in underlying community conditions and resources.

Racism & Health

Researchers, Gee and Ford, remind us that "over a century ago, W.E.B. Du Bois recognized the connection between societal inequities and health inequities, raising several central arguments related to racism, poverty, and other social problems".[5, p2] More recently, attention to structural racism as an important determinant of health inequities has grown in the academic literature. **Structural racism** is defined as the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice".[6, p1454]

Structural racism is believed to underlie many of the health inequities experienced by Black communities in our state. For instance, Blacks have an infant mortality rate that is approximately two and half times that of Whites; the homicide rate for Black men increased 116% between 2012 and 2016, and is seven times higher than for White men; although the death rate for HIV/AIDS has decreased in recent years, it is still 11 times higher for Blacks than Whites in DE.[7]

Delaware's history of residential **segregation** and its lasting impact on health is apparent in the ways in which health inequities can be viewed geographically. Table 1 provides estimates of segregation across DE counties and the city of Wilmington according to the dissimilarity index, which is a commonly used measure of residential segregation.

Table 1: Dissimilarity index by geographic area in DE

Geographic Area	Dissimilarity Index*
New Castle County	45.2
Kent County	28.0
Sussex County	37.5
City of Wilmington	49.7

*Calculated using 5-year population estimates, 2013-2017, US Census

Values of the index between 0 and 30 are considered low segregation; 30-60 are considered moderate; and >60 are considered highly segregated[8]. Wilmington has the highest level of segregation, and if we look across neighborhoods in the city, we can see how health varies dramatically by place and race. In figure 2 of Wilmington, the darker shaded areas have the highest percentage of Black residents. **Life expectancy varies by approximately 16 years across Wilmington neighborhoods** with Black communities generally experiencing the lowest life expectancy. Although not as dramatic, Dover sees approximately an 8-year gap in life expectancy across neighborhoods.

Investments in communities can have direct benefits that reduce health threats (such as crime and pollution) and indirect benefits that promote healthy behaviors (such as sidewalks, green space, and healthy food establishments). High quality, equitable education, and safe, affordable housing are fundamental to health improvement, as is promoting living wage jobs and access to quality health and social services. Importantly, improving neighborhood conditions must be coupled with building local capacity and changing the ways in which decisions are made and resources are allocated, such that communities of color have more power in those decisions.

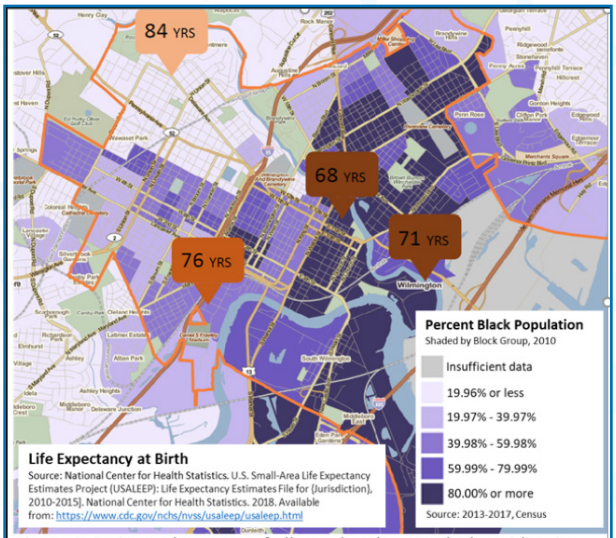


Figure 2: Estimated percent of all people who are Black residing in Wilmington neighborhoods and life expectancy

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[i] See UD PHC policy brief on "Structural Racism as a Fundamental Cause of Health Inequities" for more information about the relationship between racism and health.

OPINION

Housing segregation continues. And it is cutting short black Americans' lives (opinion)

Leland Ware and Erin Knight Published 12:09 p.m. ET May 8, 2019 | **Updated 3:49 p.m. ET May 8, 2019**

Leland Ware is the Louis L. Redding Chair and a professor in the Biden School of Public Policy and Administration at the University of Delaware. Erin Knight is Associate Director of the Partnership for Healthy Communities at UD.

Where you reside determines how long you live.

The average life expectancy of a person living in a low-income neighborhood in Wilmington's East Side is as low as 68 years. In some wealthy enclaves in Greenville, a mere 4.5 miles away, the life expectancy is 84 — almost two decades more.

Why is this?

There are many factors in a person's health, ranging from innate physical factors such as age, gender and genes, to behavior and lifestyle choices, such as tobacco use and physical activity. But lifestyle choices are made in the context of a person's social and community networks — and their social, economic and physical environment.

What public health researchers refer to as the "social determinants of health" are the conditions in which people live, learn, work and play. Their research has shown that these conditions are the most important determinants of health.

Neighborhoods that experience low economic and employment opportunities are likely to have underfunded education systems, inadequate access to health and social services, a lack of healthy food retailers, unstable housing, and a lack of safe recreational spaces. These conditions are influenced by larger structural forces, such as economic, education, and political systems, social norms, culture and power.

The negative aspects of living and working conditions in inner-city communities are largely the result of policies, practices, and attitudes that have caused an unequal distribution of resources across communities — both in the past and in the present.

Segregated neighborhoods were perpetuated by the federal government after World War II when insured mortgages from the Department of Veterans Affairs and Federal Housing Administration allowed middle class families to purchase homes in suburban communities. Blacks were kept out because the government required racially restrictive covenants in mortgages.

Leland Ware *(Photo: University of Delaware)*

In the 1950s and '60s the construction of the interstate highway system displaced people from their homes, sliced communities in half and led to abandonment and decay in city after city.

The history and legacy of structural racism has resulted in many black neighborhoods suffering from a lack of employment opportunities, underfunded public schools, substandard housing and inadequate access to health care.

Residential segregation is the legacy of the nation's history and has long been identified as the root of many social and racial inequities in American cities. While different racial and ethnic groups and immigrants have experienced segregation in the U.S., African Americans have been victims of an unparalleled level of deliberate segregation that is perpetuated today through individual actions, institutional practices and public policy.

Patterns of segregation among African Americans in the U.S. are the highest across all racial and ethnic groups.

Today at least 1 in 4 minority home seekers will encounter some form of racial discrimination. African Americans are “steered” away from white neighborhoods by real estate agents. African-Americans are turned down for mortgages and charged higher interest rates and charged for points at disproportionate rates.

According to Harvard University professor David Williams, a leading scholar on racism and health, residential segregation is the single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans.

Health inequities are largely a function of the separate and unequal neighborhoods in which most blacks and whites reside. Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities.

Health inequities remain even after income and education levels are considered.

Erin Knight is Associate Director of the Partnership for Healthy Communities at UD *(Photo: Courtesy of the University of Delaware)*

Pathways through which segregation contributes to health inequities include poor quality housing, inadequate

heat, noise, overcrowding, and the presence of environmental hazards and allergens. Segregation perpetuates negative social environments that include exposure to violence, crime, and systematic differences in policing and incarceration.

Residents live in a substandard built environment with features including higher exposure to fast food outlets and alcohol retailers.

As President Barack Obama observed in 2008, “The biggest problem that we have in terms of race relations …is dealing with the legacy of past discrimination, which has resulted in extreme disparities in terms of poverty, in terms of wealth and in terms of income."

Obama concluded: "Our inner cities are a legacy of what happened in the past."

This opinion piece was originally published by the News Journal.

https://www.delawareonline.com/story/opinion/contributors/2019/05/08/housing-segregation-shortens-black-americans-lives/1140476001/

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