

# ADVOCACY BUILDERS PROJECT

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# INTRODUCTION

## ABOUT US

Research on child development, racial identity, and family socialization demonstrates that bias formation begins at a young age and that white families tend to discuss race much less frequently than families of color. Based on these findings, Laura Horwitz and Adelaide Lancaster founded We Stories in 2016. We Stories sought to build a more equitable and inclusive future through the creation and implementation of its core offering, the Family Learning Program (FLP). Its grounding framework is in our **Getting Started** document.

The program was designed for white caregivers with young children (ages 8 and under) in the St. Louis region who wanted to start and strengthen conversations about race and racism with their families. In each cohort, or group of participating families, caregivers were provided with diverse children's books as well as strategies for minimizing and deconstructing bias formation. The program endeavored to foster mindsets and build skills toward lifelong learning and advocating for change in spaces where these families lived, worked, and played. This program is now captured in our self-guided **Family Learning Program** document.

At the end of the facilitated 12-week program, the families in the cohort joined an ongoing learning community of a growing group of fellow FLP families. Together they received continued support in extending, processing, and implementing their learnings. Rich collaborations with schools, libraries, community organizations, parent groups, and a robust social media presence quickly followed. We engaged in teacher training opportunities, research partnerships, and curriculum design and development. The **DEI Themed Lessons** document represents many of the resources developed to support these partnerships, as well as our FLP families.

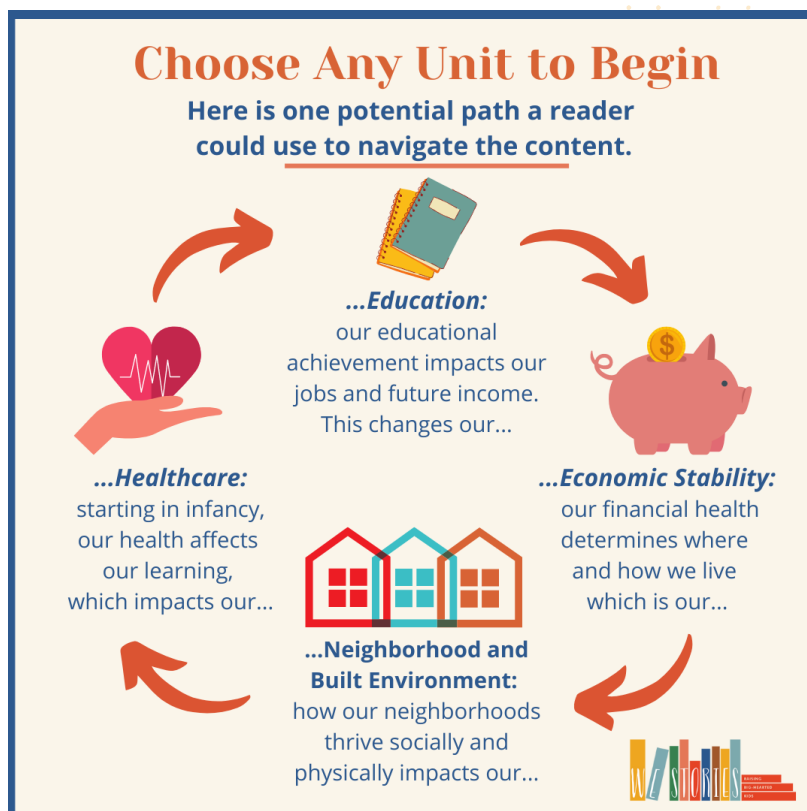
Clear that meaningful change required intentional actions to address root causes of disparities, we developed the Advocacy Builders Project for FLP caregivers to move beyond family conversations to deeper discussions of systemic racism. To support learning, this program focused on four social determinants of health and challenged participants to see how systems are designed to help some groups of people, while simultaneously designed to hurt other groups of people. We Stories piloted this project with FLP families in 2021. This content has been consolidated and now exists as this document.

To increase the accessibility and impact of our programs and resources, our board and staff made the decision to culminate and refine these assets into resources that could be utilized and shared broadly. We hope to bolster changemakers as they lead our collective effort for a more equitable and inclusive future.

## WHAT'S INSIDE

The Advocacy Builders Project aims to illuminate systems and demystify advocacy utilizing the framework of social determinants of health, the non-medical factors that influence health outcomes, to explore systems and to demonstrate how they interact with each other. ABP explores four domains: Healthcare, Education, Economic Stability, and Neighborhood & Built Environment. These domains are organized into non-sequential, interconnected units intended to be navigated in order of the reader's preference.

As the authors explain in the opening letter, the specific aspects of the social determinants this project explores only represent pieces of the larger systems. They were selected to serve as accessible entry points that build on the habitual nature of the Family Learning Program and foster nuanced conversations about intersectionality and the systems in which we interact.



Every **Unit** has three sections of content synthesized from curated resources. Each **section** includes the following components:

- A **Closer Look** provides insight into how the outlined social determinant of health and overlapping social identities of race, gender, and class work together to oppress, dominate, or discriminate while allowing privilege to other identities.
- **Disparate Outcomes** discusses the disproportionate harmful impacts on historically marginalized groups caused by policies or practices.
- **Engagement Guide** is a framework to extend learning and understanding:
  - **Reflection** encourages participants to consider possible problems and solutions to systemic oppression by reflecting on their own roles and responsibilities within the systems themselves.
  - **Family Discussion** is an opportunity to connect the learning with adult family members in an accessible and meaningful way.
  - **Group Discussion** is a deeper dive into the given subsection to provide rich discussion opportunities with fellow Advocacy Builder Project learners.
  - **Explore More** is a list of resources you can listen to, read, or watch to further grow your understanding of the topic.

## Navigate the Engagement Guide



**Step 1:** After sitting with the section's content and seeing what comes up, respond to the Reflection prompts.

**Step 2:** Spark conversation with family (or friends) with the Family Discussion prompts.



**Step 3:** Expand your understanding using the Group Discussion prompts with a small group of fellow readers.

**Step 4:** Check out Explore More to further grow your understanding of the topic.



## *Dear Reader:*

We compiled this resource while occupying stolen Indigenous land.

Crafted around the social determinants of a health framework, Advocacy Builders Project (ABP) not only illuminates core determinants that dictate health outcomes, but it also models the predictable nature of systems—healthcare, education, economic stability, and neighborhood and built environment—interacting and compounding one another. These systems and their patterns are what we truly hope we make visible and relatable to you. What you see here in this project isn't close to the full scope of what is possible to highlight. Instead it is a reflection of our collective expertise and what we found most timely and important to understand the core of the systems.

No matter how practiced you are, ABP is meant to be a starting (or stimulating) place for you. Developing your ability to envision each of these systems individually AND as they interconnect with each other will take time. As you move through the project, you will have opportunities to take stock of all of the identities you carry; to see where you have been and still are complicit in the oppression of others; and to recognize your resilience for withstanding the oppression you yourself may face. We are the sum of our parts, and when we take the time to examine each facet of ourselves critically, we can be better advocates for others. And building better advocates is an urgent matter because people are dying from our inequitable systems.

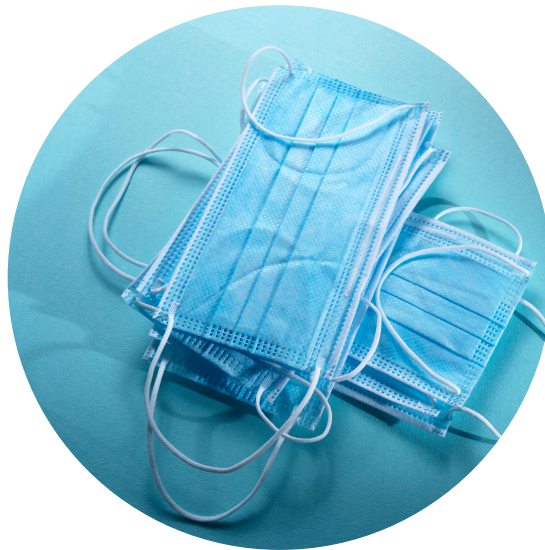
Undertaking this researching, writing, and contemplation was a unique opportunity—one that was a labor of great pain and deep sadness and a marvelous love. And that love—for our communities and their people—was our primary motivating factor. A myriad of other emotions emerged over time while the love remained constant; always underscoring the importance of moving forward. Of learning more. Of seeing learning as a meaningful action, but not the only action we should take. Of knowing that we will make imperfect actions. Of learning from mistakes and attempting to make them right. Knowing that we could not create a project that was without flaws, bias, or problems, we endeavored regardless because of our collective responsibility to one another. We hope that you, dear Reader, can find the love in this project, and in doing so, discover your potential to disrupt the status quo.

*With Love,*

*Maleeha Ahmad, Rhema Anazonwu, & Jasmine Winter*

# UNIT 1

# *HEALTHCARE*





# HEALTHCARE

## 1.1 History of Medicine as an Oppressive Force

Medicine would be nothing without the contributions, and oftentimes, forced sacrifices, of oppressed people groups, most especially Black, Indigenous, People of Color (BIPOC). **Access to healthcare** constantly challenges these groups of people because of the power dynamics inherent in our healthcare system.

To make a connection read Healthcare 1.3.

They've been viewed as a "near-human" stand-in, never given the full recognition of being human. They were and are thought to experience less pain, and to be generally, "biologically different" from "actual" human beings (read: white people). Time and time again, this disregard for the humanity of BIPOC and people without **power**\* has been demonstrated in the medical system and has created lasting damage in their ability to trust in medical providers. BIPOC, women, and other oppressed groups unfortunately know to expect providers to not treat their pain as "real enough" or "severe enough" to warrant the medical interventions they would give to privileged groups. As such, due to the history of medicine taking advantage of these oppressed groups, they navigate the healthcare system with the knowledge that they cannot put their full trust in medical providers.

### **\*power**

*Power is the ability of a person or system to influence the actions or beliefs of others around that person/system. Ways that we will often see power show up throughout this project are through the influence of the system of white supremacy and capitalism acting on our collective ideals (named and unnamed) that we hold as members of U.S. culture. As an example, power can equate to access. For U.S. passport holders, this manifests as the ability to travel anywhere in the world with that passport.*

This learned distrust BIPOC have when encountering the medical care system is no accident. Going as far back as the 1800s, when America was in the process of standardizing its medical practices, J. Marion Sims, “the father of modern gynecology,” made a name for himself off of the pain and suffering of Black, enslaved women. He performed countless surgical procedures on Black women without anesthesia.<sup>1</sup> Arguments exist that the advancements and discoveries he made experimenting on Black, enslaved women more than justified the means. Even today, he’s still known primarily by the positives of his career, with rarely any nuance to include the fact that his contributions to his field came at a steep personal cost to Black women. In fact, the conversation surrounding him oftentimes goes straight to a defense of his actions,<sup>2</sup> instead of acknowledging that operating on an enslaved person in an experimental fashion, without an anesthetic is not treatment that we would consider acceptable on any person today. Because the horrendous behavior happened against Black women, we’re already conditioned to use different standards of acceptability.

The creation of the birth control pill brings another example of a population of vulnerable women targeted for experimentation because of these differing standards. Scientists John Rock and Gregory Pincus made their mark on history by developing an oral pill contraceptive. When their trial moved beyond the rats and rabbits stage, they needed to find human women to develop their drug further, and they first tested their prototypes on mental ill patients.<sup>3</sup> Ultimately, with the support of Margret Sanger and financial backing from Katherine Dexter McCormick, the drug trials were brought to Puerto Rico’s<sup>4</sup> (a US Commonwealth Territory<sup>5</sup>) poor women and female medical students. Puerto Rican women were easy targets because they were poor and their skin brown—they bore the brunt of experimentation that was deemed too unsafe for white women, despite white women being the more readily available test subjects in the United States. Puerto Rican women also had fewer legal protections than women in the contiguous United States, and therefore had to experience the brunt of severe adverse side-effects of the pill as it evolved. The end result was FDA approval for the birth control pill; however, all of the Puerto Rican women who made the pill possible were unable to obtain the contraception because of its inaccessible price.

Unfortunately, the examples only abound from here. Black men were withheld vital information about their health and treatment while researchers tracked the progression of syphilis in the Tuskegee trials.<sup>6</sup> The Havasupai tribe’s DNA was researched without their knowledge or consent to provide researchers with answers to questions, at the detriment of their tribe<sup>7</sup> (for more about Indigenous People, see the Critical Intersection down below). Dozens of medical discoveries were made using HeLa cells—cells stolen from a Black woman dying of cervical cancer, cells that are still being sold and used today with no compensation given to her family in the aftermath.<sup>8</sup> It all amounts to the same thing—people of oppressed groups aren’t thought of as full people in the eyes of the healthcare system. And when that same system has a history that teaches through the lens of “the end justifies the means” and

offers lackluster attempts at acknowledging the complicit nature of the system as a whole, those people won't be guaranteed any kind of safe harbor when seeking medical attention.

## *A Closer Look: Native American Cultural Harvesting*

In the United States, from the first moment of interaction with colonizers, Native Americans have felt the effects of “formalized” or “scientific” read Western—medicine undermining and undervaluing their own ways of treating sick people.<sup>9</sup> Viewed as primitive people, who couldn't possibly have any knowledge worth that of the white colonizers who stole their lands and did their best to strip all Native identity from them. Four hundred years later, this stereotyped view has not changed. In the 1980s, “plastic shamanism” emerged, heaping insult onto grievous injury. Under the guise of “New Age Enlightenment,” plastic shaman or “plastic medicine people... [are] typically Euro-Americans claiming mentorship by ‘authentic Native American medicine people’ [who] write best-selling books and lead expensive workshops.”<sup>10</sup> This underscores the same pattern of taking advantage of Native People, only executed differently by plundering knowledge from their cultural practices and putting the profits of that information far beyond their reach.

## *Disparate Outcomes*

**RACE** As the previous examples demonstrate, so much of the history of medical advancements have come directly at the expense of BIPOC (Black women, Latinx women, transgender people of color, Black men, Indigenous people—the list goes on). While most of the consistent devaluing takes place with Black and brown people, if a person's race doesn't fit squarely within the boundaries of white, they will be open to scientific exploitation too. Since the very history of the healthcare system is steeped in the understanding that Black and brown people are thought to be less, their lives must not actually be as important. And while there are a plethora of barriers related to BIPOC being able to **access the healthcare system**, the attitudes that created the environment that BIPOC face when encountering healthcare professionals have their roots in devaluing a person based on their race. The American College of Physicians found that “racial and ethnic minorities tend to receive poorer quality care compared with nonminorities, even when access-related factors, such as insurance status and income, are controlled.”<sup>11</sup>

To make a connection read Healthcare 1.3.

**GENDER** Also contributing to the attitudes targeted people groups carry into medical situations is how their **gender will affect the perception of the healthcare worker providing care**. Women have long been thought of as overly emotional.<sup>12</sup> This has translated into an insidious gender bias in which women are understood to be unable to correctly articulate their own experiences.<sup>13</sup>

To make a connection read Healthcare 1.2.

Women voicing their concerns are often disregarded, in part because the bulk of medical research has excluded them from its studies. Rather it looked at men and how disease and ailments affect their male bodies. “Coronary artery disease, Parkinson’s disease, irritable bowel syndrome, neck pain, knee joint arthrosis”<sup>14</sup>—the list goes on—but the majority of what we know of the hallmarks of these conditions comes from research and treatment tested on men. Thus, the **male\*** experience is the roadmap for all people’s healthcare. To this day, male anatomy is the default anatomy in the majority of medical schools across the country, leaving intersex people and women by the wayside.<sup>15</sup>

**\*male**

*The limitations present in our medical systems currently equate sex and gender identity as one and the same, and in some instances throughout this project, we’ll also be replicating some of those imperfect, confusing practices. This is primarily due to the data available to any given domain content. Where we can, we are more precise and separate sex and gender identity to our best ability.*

**CLASS** Socioeconomic status (SES) further compounds the disparities. To start, women are 35 times more likely than men to be poor,<sup>16</sup> which puts a large portion of the poor population at risk of harm associated with women in the healthcare system. Increasingly, the medical training field is teaching healthcare practitioners to see the systems that hinder people from being part of the healthcare system. Take SES for example. Despite “teaching hospitals bring[ing] students face-to-face with poor and uninsured patients on a regular basis...this contact does not result in students’ greater understanding and empathy for the plight of the poor...[but may] lead to an erosion of positive attitudes toward the poor.”<sup>17</sup> Furthermore, about 50% of medical students come from households earning more than \$100,000 annually, while households earning under about \$20,000 a year only contribute up to 5% of medical students nationally.<sup>18</sup> One way forward is to increase the SES diversity of graduating medical classes.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. When we talk about the history of how things are discovered or invented, there are always certain people that get uplifted more than others (usually white, usually men). What are some questions that you can ask to make sure that you're approaching historical knowledge critically?
2. Which of the disparate outcome sections resonated or stood out the most to you?
3. What identities do you carry that make you vulnerable at one (or more) of those intersections? Can you recall a time when an identity made you feel particularly vulnerable in a healthcare setting?
4. What identities do you carry that make you especially powerful at one (or more) of those intersections? What surprised you when thinking through the extra burden targeted groups shoulder when in healthcare settings?
5. The sources that were chosen for the main content section came from a variety of perspectives, sometimes choosing to omit parts of the larger story, or the systems impacting the oppressed people. How often do you question how full or thin the information that you take in is? What is the consequence of that action, especially as it pertains to attitudes concerning those oppressed groups?

## *Step 2: Family Discussion*

1. Talk about family experiences with healthcare in the past (trips to urgent care, times when bones were broken, or more involved and extended stay times in hospitals for family members or friends.)
  - a. What were the emotions involved for everyone: How did kids feel in those situations? The adults? Spend time talking about things that made those experiences easier or harder for the adults to navigate—having sufficient health care insurance, being able to call other adults for advice, being alone to figure out the system while also being scared for the person in care, etc. Talk about how the doctors and other professionals made you feel during the experience.
2. Have you ever gone into a situation in which you knew you would need to stand up for yourself against another person (teacher mismatch, friend conflict, etc.)? How did you feel about interacting with them in that moment and afterwards?

# ENGAGEMENT GUIDE

## *Step 3: Group Discussion*

1. How present was the healthcare system in your childhood? Your adulthood? In hindsight, did you have similar experiences or vastly different ones?
2. What feelings did you/do you carry when entering healthcare spaces?
3. What other instances in healthcare history (past or near present) can you think of in which oppressed groups aren't thought of as full people?
4. How can you see disregard for the humanity of other targeted groups showing up in other programs you know about?

## *Step 4: Explore More*

1. Take a look at *The Immortal Life of Henrietta Lacks* from HBO,<sup>19</sup> and then read *The Legacy of Henrietta Lacks* on the John Hopkins website.<sup>20</sup> What differences do you notice in how each describes Henrietta's treatment in the hospital?
2. View the birth control episode of *Sex, Explained* on Netflix<sup>21</sup> for a more in-depth history on the pill and realities facing women using the pill today. Pay attention to how women of color are treated consistently throughout the various histories of contraceptives they present—do you see any similarities to the major themes of this subsection?

# HEALTHCARE

## 1.2 Maternal and Infant Health

No matter a person's gender identity or parental status, maternal and infant health impacts all of us. When talking about maternal and infant health, the conversation centers mostly talking about mothers and babies. We all came from a womb, and who that womb belonged to impacted our health. Sometimes that womb belongs to a woman, sometimes it doesn't. However, not everybody is impacted equitably. Our social and economic well-being starts from birth.

What is maternal and infant health?<sup>22</sup> Maternal and infant health are all aspects of a woman or **birthing person's\*** and the baby's health during prenatal (before birth), perinatal (22 weeks of gestation to 7 days after birth), and postpartum/postnatal (up to 6 weeks after birth) periods. Also, depending on the country and context, the term infant can be used to describe newborn infants (up to 28 days after birth) or a child up to two years of age. This section will be referring to the health of an infant up to one year old.

### **\*birthing person's**

This is gender additive language recognizing that not all individuals who give birth identify as women. Simultaneously, it does not erase issues that are specific to women.

The health of a childbearing person starts well before they can have children;<sup>23</sup> for instance, the chronic stress and lack of resources a four-year-old girl endures throughout childhood can impact her health during pregnancy<sup>24</sup> as an adult. Some demographics have a higher prevalence of maternal and infant health complications. As such, we will be focusing specifically on Black moms and babies.<sup>25</sup>



Access to resources is an indicator of increased risks for maternal and **infant mortality**\*, but an even bigger indicator is racism.<sup>26</sup> Not race, but racism. Studies have proven that it's not about genetics,<sup>27</sup> because African Black mothers who have immigrated to the United States have children with birth rate outcomes (<5.5 lb) closer to those of U.S.-born white mothers compared to U.S.-born Black mothers.<sup>28</sup> Some studies have indicated a low birth weight rate can increase for the generation of Black immigrant children due to racism and stress. It may appear that low birthweight is not a big issue, but it can negatively impact a child's trajectory for a thriving adulthood.<sup>29</sup>

**\*infant mortality**

*According to the CDC, "Infant mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births."<sup>30</sup> The difference between morbidity and mortality is that morbidity is related to acute or chronic illnesses and mortality is related to death.*

Further evidence that racism contributes to infant mortality can be found by looking at the educational background of the mother, as infants born to college educated Black parents are twice as likely to die as infants born to similarly educated white parents.<sup>31</sup> It is important to not confine ourselves to one narrative and for us to see all systems at play. For instance, there are Black celebrities who have publicly talked about their maternal complications<sup>32</sup>—such as Serena Williams and Beyoncé.<sup>33</sup> Many Black women, regardless of education and socioeconomic status (SES), face maternal and infant health complications due to racism. This is the medical reality most prevalent in the real world, but it's also one of the least reported.<sup>34</sup>

For instance, tennis star Serena Williams talked about how her insistent self-advocacy with medical professionals saved her life during childbirth.<sup>35</sup> She felt something was wrong immediately following the birth of her child and pushed through the exhaustion of post-partum to demand life-saving medical attention from the staff who neither noticed the symptoms on their own nor believed her initial pain.<sup>36</sup> Then there's the story of Shalon Irving,<sup>37</sup> a woman who worked for the CDC and died shortly after childbirth due to complications from medical neglect. It is common for Black women to not be heard within healthcare, even if they have financial wealth and/or a higher education. It is also important to understand the meaning of **financial wealth and how that differs from being rich**.

To make a connection read Economy 3.1.

There is an uneven burden of maternal mortality in the US.<sup>38</sup> In St. Louis, Black babies are three times more likely to die than white babies, no matter the mother's socioeconomic status (SES) or level of education.<sup>39</sup> Even when SES is controlled for, low birth weight is higher amongst non-Hispanic Black infants compared to other racial groups across the United States. Infants with a low birth weight are at a higher risk for health problems, motor and social development, and, by proxy, financial and social well-being. Although many infants with a low birth weight may live a healthy life, in the U.S., it is the leading cause of infant mortality for Black babies.<sup>40</sup> In addition to low birth weight being a risk factor, preterm birth (less than 37 weeks gestation) can also negatively impact the infant and mother's health.

Black mothers die at almost three times the rate of white mothers in the United States due to pregnancy-related deaths.<sup>41</sup> During childbirth, Black mothers are three to four times more likely to die compared to white moms.<sup>42</sup> They often aren't given quality care, adequate services, the ability to choose, and above all, space to thrive. As we continue to dive into the statistics and the heart wrenching reality of racism and its effects on Black moms and babies, remember that there are many opportunities for Black women to experience joy in motherhood.<sup>43</sup> Focusing solely on trauma is a grave disservice to Black women, as it can whittle them down to a statistic and a trope and does not allow for them to tell their own stories<sup>44</sup> or create spaces for healing.<sup>45</sup> It's possible to learn about systemic racism as it pertains to Black women while acknowledging and leaving room for their joy.

## *Disparate Outcomes*

**RACE AND GENDER** It's extremely important to focus on gender and racial intersections. Studies have shown that gendered racial identity is more important than separate gender identity and race identity for young Black women (ages 15 to 21).<sup>46</sup> Black women simultaneously experience racism and sexism, and highlighting singular identities within marginalized populations (e.g., women or transgender people vs. transgender women) can limit a full understanding of an issue and its solutions. In some cases it is possible to discuss singular identities and implications while also understanding the layers when multiple marginalized identities intersect. However, in regard to maternal and infant health, it is impossible to discuss inequities without the layering of gendered racial identity. This is not to say that other races do not have significant maternal and infant health complications—they do—but the gap is so wide for Black moms and babies that it is imperative to address this first.

Another aspect to consider is the lack of research in regards to people's gender identity; the majority of the data available presumes female<sup>47</sup> mothers. This shows the need for more accountability in academic institutions, higher community participation in research, and lifelong learning.

**CLASS** Even when Black mothers have a higher education and/or access to resources, they still have a higher rate of maternal complications. When looking at class, race also comes into play. For instance, if a white mother from a lower SES did not have access to transportation, missing her baby's checkup would be seen as a sociocultural factor. On the other hand, for a Black mother from a lower SES in the same circumstances, missing the appointment would be seen as a result of individual behavior and not due to transportation barriers. This emphasizes the need for 1) Black physicians and other people of color in medicine and 2) radically changing the medical education for white physicians. When a Black mother calls the doctor's office to reschedule, she might be seen as difficult instead of given the resources to overcome those barriers (i.e. organizations that provide transportation, connections to social workers, etc.). Individuals (e.g., healthcare professionals) exist within a system, and they have a choice to actively not abide by that system. This example is painted with a generalized brush (there are white mothers from a lower SES who also face perception issues), but the fact is racism is so entrenched in our society the Black woman's identity or personal choice is seen as the barrier versus the systems of power. If the systems of power (i.e. white supremacy and capitalism) also influence education, then the people offering services will be limited in their worldview and quality of treatment due to the systems. Once again, social narratives are important to deconstruct and understand. Many social workers, for example, are not given a racially trauma-informed education, unless it is their specialty. Most social work schools offer a handbook or three-hour training on cultural competency and claim that's enough. It is common for social workers to report a POC caregiver from a lower SES with neglect without any understanding of the caregivers' culture (lifestyle, norms, expectations, communication style, etc.).<sup>48</sup> There have been reported complaints of white social workers claiming neglect<sup>49</sup> because a child's hair is "nappy" or in locs.<sup>50</sup> Also, if the caregiver does not speak English and is from a lower SES, they face subpar treatment.

Regardless of race, mothers of a lower SES have limited access to healthy foods and a limited choice of healthcare providers, also known as maternity deserts.<sup>51</sup> Studies have indicated that women living in food deserts, areas with limited access to grocery stores or affordable healthy foods, have higher rates of morbidity (i.e., preeclampsia, preterm labor, gestational diabetes).<sup>52</sup> In some areas there are no obstetric options within a two-hour radius. Maternal or fetal complications, can be fatal. Women in rural areas experience higher rates of complications and hospitalizations than women who live in metropolitan areas.<sup>53</sup>

Finally, it is important to increase nontraditional pregnancy care options.<sup>54</sup> Telehealth, doulas, midwives, birthing centers, and community support, among others can provide medical, emotional, and informational support during a pregnancy, birth, and postpartum period. Although some of these options are not medical, the support and outreach helps families understand their pregnancy journey and helps them cross structural barriers. Advocates accompany the individuals to a hospital, conduct home visits, develop birth plans, and provide parenting education.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. Did you have access to preventative care that helped best prepare you and your family ahead of time? Did you have any concerns about this access?
2. If you were pregnant and had access, what was the quality of care you received from healthcare providers?
3. If you delivered a child at a hospital, were your concerns or symptoms heard by healthcare providers? Did you have to have one or multiple representatives advocating on your behalf?
4. What is another barrier that may come up for a mother pre- or postpartum?

## *Step 2: Family Discussion*

Watch the Focus Features documentary *Babies*<sup>58</sup> with your family, or if you can't commit to a movie, then try watching the trailers and clips together.

1. Engage your family in a discussion about the differences you see as it relates to the maternal, prenatal, and infant experiences. Imagine the variety of differences that exist across the globe and also within our nation. Some differences are a matter of choice or culture or tradition. But what about when they aren't?
2. Consider that some of the most resourced systems have the most unfairness built into them, resulting in some huge differences within our nation. How does it feel to know that the same system is safe for some families but not for others? Supportive and affirming for some but not for others? What kinds of experiences do you think all mothers and babies need?

## *Step 3: Group Discussion*

1. Black women are commonly diagnosed with postpartum depression, which may be due to the lack of quality care they've received from healthcare institutions, specifically during pregnancy. Do you feel holistic mental health is prioritized for all mothers?
2. If the checks and balances within systems like social work don't protect marginalized populations (i.e., Black moms are judged unfit more than other races<sup>55</sup>), how can we hold the systems and decision makers accountable?
3. If an extensive plan on improving maternal and infant health already exists,<sup>56</sup> what are the barriers for implementation and reducing the astronomically high rates of mortality and morbidity?
4. How do social supports play into a mother and infant's health? What does that look like in regards to race and class?

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5. What are the cultural expectations of what is acceptable and unacceptable in regards to maternal and infant health? For example:
  - a. Now it is slowly coming to mainstream to have a midwife and doula, when decades ago that was seen as uneducated and a class symbol.
  - b. Breastfeeding vs. formula (marketing and capitalism)
6. What makes some prenatal and postpartum programs successful over others? Take a look at the examples of successful programs that the Center for American Progress compiled.<sup>57</sup>

### *Step 4: Explore More*

1. Look up the March of Dimes Report Card by state.<sup>59</sup> Once you download the report, you can view the results by county
  - a. Discusses a few social determinants of health (e.g., insurance, poverty, quality of care, etc.)
2. Read the Lost Mother series on ProPublica<sup>60</sup>
  - a. “While social media allowed us to find many women whose stories would have been lost in the past, this method falls short at capturing women who live and die on the margins, including homeless [unhoused] women and undocumented immigrants. Black expectant and new mothers, who die much more often than whites, are less likely to have their stories told on social media.” If this limitation were not stated, would you consider why there were fewer stories about Black women although they have a higher rate of maternal mortality? Why or why not?
3. Watch the short film *Stories of Black Motherhood*,<sup>61</sup> in which Black moms share their stories of motherhood.
4. Contact your representatives<sup>62</sup> and ask for expanded Medicaid coverage; most states’ Medicaid maternity coverage ends sixty days after birth
  - a. Take a look at the options listed on the Association of Maternal & Child Health Programs (AMCHP) website.<sup>63</sup>
5. Connect with organizations fighting for maternal and infant health, such as:
  - a. FLOURISH St. Louis<sup>64</sup>
  - b. Black Mamas Matter Alliance (Atlanta)<sup>65</sup>
  - c. Jamaa Birth Village (St. Louis)<sup>66</sup>

# HEALTHCARE

## 1.3 Access to Healthcare

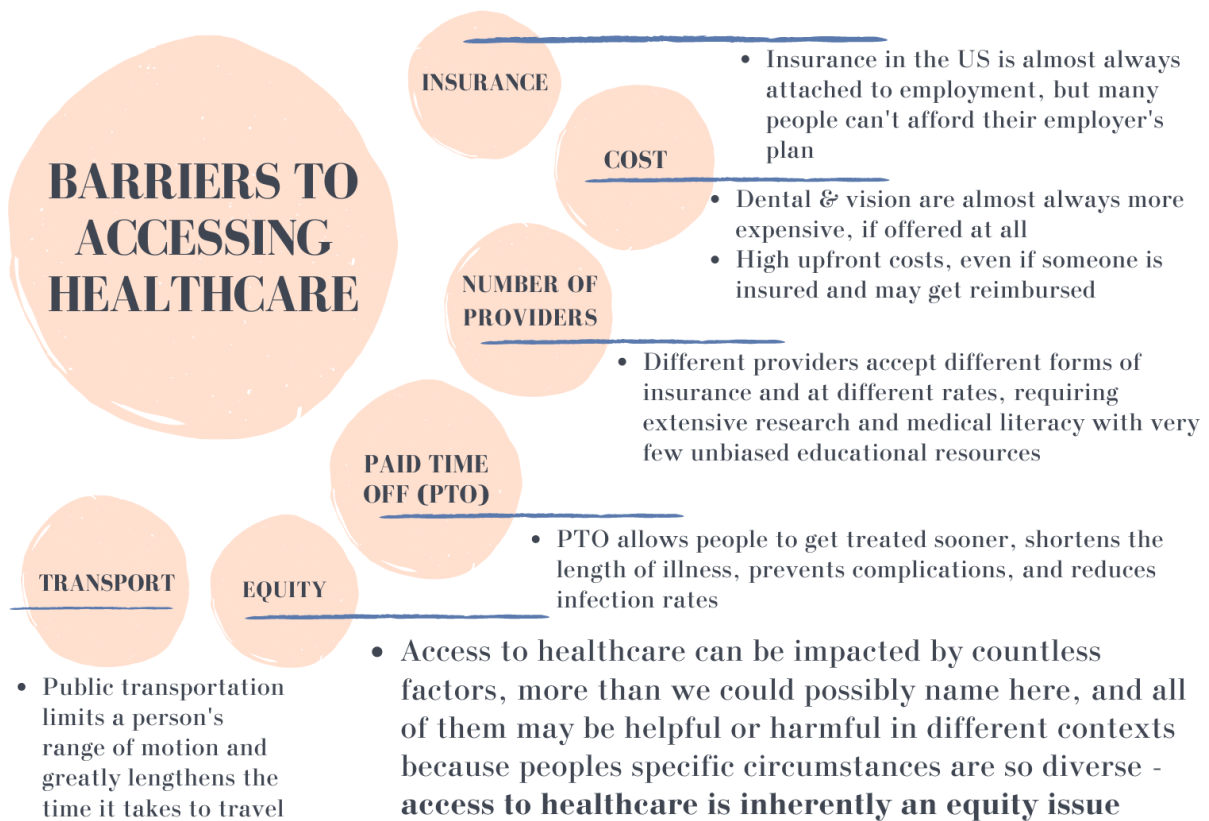
Measuring access to healthcare stretches far beyond the doors of hospitals and primary care physicians (PCP). Conversations about access to healthcare need to encompass the social, physical, and systematic factors that impact how and if a person is able to receive meaningful care. The definition we will use for “access to healthcare,” with these considerations will be “the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled.”<sup>67</sup>

Many factors impact this access, and all of them intersect with race, class, and gender. The cost of medical care, access to affordable and sufficient insurance, the number of providers in an area (including specialists), employment packages with paid time off, the accessibility and affordability of transportation, and **the equity of our healthcare institutions** are all factors that directly influence our abilities to foster healthy bodies—for ourselves and our families. If you want to start with some basic grounding in the economic fundamentals of the U.S. healthcare and insurance system, start here.

To make a connection read Healthcare section 1.1.

The Institute of Medicine defines disparities in access to healthcare as “differences in access that are not justified by underlying health status.”<sup>68</sup> The Institute of Medicine is a powerful governing body that oversees the entire medical industry, yet this definition is the only explicit wording to which their professionals are held accountable. Rewriting this definition with equity, justice, and accountability in mind would change it to something like this: Differences in access to the sociopolitical factors that enable someone to seek quality and effective care. All of these factors heighten racial, class, and gender inequities that have deep historical roots in the healthcare industry and often create chronic and comorbid conditions that make accessing quality, effective care even harder.





To reiterate, access to healthcare can be impacted by countless factors, more than we could possibly name here, and all of them may be helpful or harmful in different contexts, because people's specific circumstances are so diverse. However, these near-endless possibilities still exist within a dynamic socially constructed sociopolitical system with key intersections that we always need to be looking for: race, class, and gender. Because these countless factors have potential to be helpful or harmful for different people based on our combinations of identities and positionalities, access to healthcare is inherently an equity and systems issue.

Before discussing and challenging ourselves to build deeper knowledge and compassion for how racist, sexist, and classist disparities play out when accessing healthcare, we need to talk about individualism. In short, individualism is the socially constructed norm that trains us to prioritize our own individual needs, wants, goals, and beliefs over those of other people and over the majority rulings of our communities. It's not exactly the same as selfishness, which is more about interpersonal connections and lacking a sense of responsibility to those around us; individualism is a social construct that teaches us to see the world and its resources as a commodity that certain people have a right to if they follow XYZ rules. Individualism in the United States is indivisibly reliant on this nation's capitalist and **neoliberal history**.\*



**\*neoliberal history**

*Neoliberalism is generally associated with a set of policies implemented in the 1980s by the International Monetary Fund (IMF), the World Bank (WB), and the United States of America Treasury Department, in an effort to help crisis-stricken developing countries by prescribing a series of reforms, the so-called “Washington Consensus” policies. Such policies aimed at achieving macroeconomic stabilization, reducing governments’ role in the economy, privatizing public assets, and reducing public expenditure. While neoliberalism has acquired many economic, social, political, and philosophical definitions, it is usually associated with a general orientation towards a strongly market-based approach, which emphasizes deregulation, minimization of the State, privatization, and the emergence of individual responsibility.<sup>69</sup> For more historical context and discussion, check out the podcast Scene on Radio—specifically season 4, episode 8: The Second Redemption.<sup>70</sup>*

When we teach children to measure their success based on whether they have achieved their personal goals and if they are happy with their jobs, families, social lives, and neighborhoods, we are teaching them to center themselves in their understanding of the world. Individualism is not an inherently good or bad thing—in many ways it is central to American culture and a way of life that can create a bold, colorful, resilient society; however, when we allow this individualism to develop a comorbidity with capitalism (in a nutshell, this is neoliberalism), we find ourselves steeping in the false and inhumane rhetoric that individual people are alone in their responsibility for their well-being, regardless of **state-sanctioned violence\*** and systemic failures.

Neoliberal policies have led to an individualization of the right to health and a reconceptualization of health care as a private good for sale rather than a public good paid for with tax dollars.<sup>71</sup>

**\*state-sanctioned violence**

*State-sanctioned violence, in this context, refers to physical, psychological, and/or emotional trauma enacted against specific people or groups, especially BIPOC, by ...agents of the state such as police, court systems, social workers, ICE, etc. Some examples of state-sanctioned violence are glaringly obvious, such as police brutality, while others rely on gaslighting, such as the racial and class discrimination trackable through which families are offered support by social workers and which are separated citing “abuse” and “neglect” (see **Healthcare 1.2** for more). Still others are silent, such as the active erasure and denial of attempted genocide against American Indians, Alaska Natives, First Nation peoples, and Indigenous communities throughout “American” history. All of these acts of state-sanctioned violence build off one another to create a culture of discomfort and a social narrative that simultaneously victimizes and victim-blames (the “blame-and-shame” cycle). Radio—specifically season 4, episode 8: The Second Redemption.<sup>70</sup>*

By individualizing healthcare, we have seen “fewer, more expensive, less controlled, and lower quality healthcare services;”<sup>72</sup> however, it is very important to note that this decline in quality is NOT the product of inability. If a patient has money upfront or other forms of social capital (most commonly a “well-respected” or “deserving” job with farther reaching insurance), they could relatively easily gain access to state-of-the-art care. The U.S. is at the global forefront of medical research and treatment innovation, yet we also have the **highest maternal and infant mortality** rating in all of the **colonizing world**\*

To make a connection read Healthcare 1.2.

### **\*colonizing world**

*Sometimes called the “developed world,” “first-world,” or “global north,” the term “colonizing world” and its alternates primarily refer to the histories of the modern nation-states of the United States, Canada, and western Europe. We make the distinction of calling them “modern nation-states,” because we are not referring to the entire histories of these lands—Indigenous and Black histories are not included in narratives of the “developed world” nor the “global north.” What we are actually talking about is the white, heteronormative, capitalistic, imperialistic, ...colonizing patriarchies that violently control these lands today. All of these terms are inexact, but “colonizing world” is, by our assessment, the most literal and active language choice we can make.*

As you continue through this section and into the rest of the Advocacy Builders Project, carry the tension of how individualism may simultaneously be a way to enhance autonomy by amplifying voices and communities that are actively (and historically) being silenced in the healthcare industry, while also creating a social mindset hand-in-hand with capitalism that is directly harmful, exclusionary, and violent. Cultures are dynamic and fluid, which means we have the power to shape a version of individualism that maintains our outspoken, vibrant, and bold society while also dismantling the distortions that do harm.

## *A Closer Look: Community Health Workers*

There are already conversations happening in the field of public health about groups of organized and trained healthcare workers who are well positioned to spearhead an equity-focused and strengths-based approach to shrinking disparities in access to healthcare. Community Health Workers (CHWs) is an umbrella term used to categorize a broad range of public health professionals working to reduce racial, gender, and class health disparities through increasing access to and education on all forms of healthcare. CHWs can help to address the issue of access to care by linking patients to needed services and by providing education and needed assistance to patients as they leverage available community resources. Typically, CHWs are members of the communities in which they work, providing a context by which they can facilitate greater patient engagement.<sup>73</sup>

CHWs have a wide variety of responsibilities depending on their organizations and the communities in which they live and work. Most commonly, CHWs provide some combination of supporting enrollment in Medicaid and social services, providing mental health support and therapeutic skill-building, assisting families in finding the right providers, facilitating psychoeducation on managing chronic illnesses or timely public health concerns (vaping, sexual health, accessing fresh foods, homelessness, etc.), and increasingly they may offer mental health/peer counseling and life coaching services. In collaboration with primary care clinics, CHWs can assume tasks that otherwise might place a strain on clinical staff, or tasks that a trusted member of the community may perform with greater success, and thus expand and enhance the workforce at a time when health care systems are experiencing strain on resource availability.<sup>74</sup>

## *Disparate Outcomes*

**RACE** Anti-immigrant policies and rhetoric supported by the Trump administration have caused immigrants and their families, especially those of Hispanic/Latinx descent, to withdraw from public assistance programs en masse. This drastically limits their ability to regularly see a healthcare provider. Hispanics, who made up approximately 18% of the population of the United States in 2016 (nearly 59 million people), have faced a disproportionate share of these politically-driven barriers.<sup>75</sup>

In 2016, Hispanics represented:<sup>76</sup>

- 33% of uninsured residents in the United States as a whole
- 56% of uninsured residents in California
- 62% of uninsured residents in Texas

Permanent resident immigrants are only eligible for public health insurance like Medicaid and CHIP after five years in the United States,<sup>77</sup> which leaves very few options for “legal immigrants” who are not insured through their employer to access healthcare without paying out of pocket. Well over half of the insurance plans in the country are private and employer-sponsored, but part-time and service industry positions, for example, almost never offer these benefits to anyone outside of their top managerial staff. Even for people who do have the option of getting insurance through their employer, it is almost always an extra expense that many people cannot afford. In the United States, undocumented immigrants are not eligible for any government run health insurance programs. Instead, they must rely on “a patchwork ‘system’ of safety-net providers, including public and not-for-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers” for health care services.<sup>78</sup>

Immigrant families under the Trump administration reported feeling like they are being forced to choose between seeing a doctor and getting themselves and/or their families deported.<sup>79</sup> For many, this means staying sick longer and with a much higher chance of complications—and for almost all, it means preventative care such as regular check ups, vaccines, and testing are not an option. In the current heightened climate of fear, even when immigrants do seek out care, they are learning to avoid certain clinics through word-of-mouth. This is creating a cycle of misinformation connecting health-seeking behavior to immigration notifications.<sup>80</sup>

In Texas, from 2008 to 2017, the number of certified CHWs grew to over 4000, a 600% increase over that time period, highlighting their growing influence in modern health care.<sup>81</sup> CHWs may be able to act as a crucial bridge between local healthcare resources, immigrant rights and legal supports, education and childcare resources, and other government assistance programs that, when used in tandem, could preemptively counteract the unconstitutional policies that allow deportation for seeking medical care.

However, immigrant communities, especially those who are Hispanic/Latinx, have tremendous reason to be distrustful of government workers, public health professionals, social workers, researchers, self-identifying advocates and allies, and the institutions we serve. Social services and research ethics are robust and long-standing sub-fields that are historically and immediately in need of greater community involvement. Thinking back **Healthcare I.I**, white people and people with substantial privileges are responsible for grappling with this history.

**CLASS** Having a disability, defined according to limitations in activity or functioning related to a health condition or impairment, is conceptually distinct from having a preexisting condition, which could be anything for which one had previously sought treatment, but there is a substantial overlap between the affected populations.<sup>82</sup> Mental health disabilities are associated with the most severe access barriers among disability groups; this population has substantially greater risk of uninsurance, much greater likelihood of delayed or forgone care, and less likelihood of having a regular provider.<sup>83</sup>

Having a disability is expensive. People often need expensive equipment in order to function or stay alive, and people with disabilities are rejected, charged more, or offered limited coverage because of “preexisting” health problems and impairments that are often part of their disability or occur as secondary conditions related to having a disability.<sup>84</sup>

For many people with disabilities, access to employment-based coverage is limited because of low workforce participation and employment in low-skill jobs not offering benefits.<sup>85</sup> Systemic poverty (meaning upfront money, net worth, and belongings, as well as social capital such as education and prestige) intersects starkly with disability, making it very rare for people to find affordable individually purchased insurance with worthwhile, comprehensive benefits.

People with disabilities who are unable to work and receive cash benefits are usually eligible for Medicare/Medicaid. However, for people who do not qualify for cash benefits and without another disability-related pathway to public coverage, multiple barriers have long made it difficult to obtain comprehensive, affordable private coverage.<sup>86</sup>

Stigma around disability, mental illness, unemployment, government-funded social services, the Affordable Care Act, and Medicaid expansion are all showing up in this example. Public policy initiatives need to address the remaining disability-related disparities:<sup>87</sup> higher uninsurance among people with mental health disabilities and across the disability population are much greater delayed or forgone care. Large gaps remaining (post-Affordable Care Act) with respect to income could be further reduced if more states were to expand Medicaid coverage and subsidized private policies were to be further promoted and more widely purchased. Consider the Five A’s for Access framework<sup>88</sup> to structure advocacy efforts:



Data Source: 5 A's of Accessing Healthcare Services (Arvind Kasthuri, 2018)

**GENDER:** Transgender is a term used to describe a large and diverse group of people whose **gender identities\*** (who we are and where we fit into the world) and/or **gender performances** (the external gendered signals we send through clothing, makeup, hair, etc.) do not align with the binary assignments they were given at birth.

**\*gender identities**

*Gender identities are distinct from sexual orientations, but they can often overlap. For more information about the important differences between these and other related terms, visit the Sex and Gender Identity page on Planned Parenthood's website<sup>89</sup> to explore their vast educational resources.*

Transgender people face immense stigma when seeking medical care. This stigma can manifest in countless ways depending on the individual and their regional culture, ranging from microaggressions, such as intentionally misgendering a person by using the wrong pronouns or names, to outright violence and treatment refusal.

Everyone has a gender identity, very similarly to how we all have a racial identity. We all construct gender performances, very similarly to how we all move about this world in racialized bodies. For many transgender people, especially those who are also BIPOC, gender intersects with the rest of their **personhood\*** to exacerbate the common barriers discussed above.



**\*personhood**

*Personhood is the combination of our individuality and our humanity—keep reading to learn about these differences.*

Individuality ought not afford us any rights. **Humanity** is (supposed to be) the basis of rights. This may seem like a drawn out distinction, but it's incredibly important. A human rights framework requires systemic and equitable resource redistribution, while an individualism framework requires humans to “earn” the resources they need to survive in a capitalistic system designed to hoard and consolidate wealth. A **human right** is something afforded to every single person just because they are human—there is nothing they could ever do to lose that right. At least, this is the theoretical framework such rights claim to abide by. The list of things that all member states of the United Nations<sup>90</sup> (including the United States) consider to be human rights are outlined in the 1948 Declaration of Human Rights.<sup>91</sup> It is well worth your time to read this document directly, and as you go, mark the things you notice as true and not true in your community. Most importantly, in Article 2 it states, “everyone is entitled to all the rights and freedoms ... without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”<sup>92</sup> According to Article 25, access to medical care is a human right.<sup>93</sup>

However, as we have discussed in great detail throughout the Healthcare domain, that is not and has never been a reality. Transgender youth, as all human beings, have a right to medical care because medical care is a human right. So, why do we see such strong and persistent disparities tracking so closely along racial, gender, and class lines? Because we live in an individualistic, capitalistic, neoliberal society, and these systems are knowingly robbing people of our human rights.

Transgender youth face significant health disparities and lower rates of healthcare utilization.<sup>94</sup> Out of the 204 transgender youth who participated in this study,<sup>95</sup> almost half reported that they had intentionally avoided disclosing their transgender identities, even when they felt it was important to their care. Additionally, youth who were less **out\*** about their identities were less likely to have voluntarily disclosed their identity.<sup>96</sup> As is true of the entire Advocacy Builders Project, this finding further illustrates how this is work that needs to be done in our families, while it is also profoundly larger than our families.



**\*coming out process**

*The “coming out process” refers, in general, to the process people go through to tell themselves, their friends, families, coworkers, teachers, neighbors, and their communities that something about their gender and/or sexuality is different from what they were assigned at birth. This term, “less out” means these people are somewhere in the middle of this process. As an example, they may be out to themselves and to their close friends, but not to their parents or teachers. Coming out is an incredibly important part of many LGBTQ+ peoples’ lives, and it can look different for each of us. This is paragraph two of the answer.*

Creating healthcare facilities with intentionally inclusive cultures and procedures would increase the percentage of transgender youth who choose to voluntarily disclose their gender identity to their healthcare provider(s),<sup>97</sup> giving that medical team the full picture of their patient needed to maximize the effectiveness, appropriateness, and safety of care (e.g., appropriate radiological procedures or sexual health screenings).

*A Final Thought*

These pieces of our **identities** (gender, race, age, religion, physical abilities, etc.) intersect with our **built environments** (socioeconomic class, nationality, education, housing, etc.) and our **personalities** (hometown, favorite forms of art, sense of humor, cadence, etc.) to create a fluid and dynamic positionality for each of us—the place on the spectrum of humanity where we fit. The lifelong culmination of our positionalities, which very often shift, grow, or even transform as we live longer, make up our **individuality**—all the things that make each of us the unique, priceless, and irreplaceable people that we are. Through this web of individuality, we plant ourselves into **communities** that synthesize our identities, built environments, and personalities. We connect with others through our communication styles, our ever-changing bonds with loved ones, our passions, and our hopes and dreams for the world. Individuality is what makes up our lives; it’s the fabric of our daily interactions and the voices in our heads that walk us through each day—to say it’s important is an incredible understatement.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. Are the medical professionals I interact with kind, thoughtful, and proactive in my care? Do they listen to me and take my concerns seriously? Do I feel safe when I'm seeking medical attention?
2. Does seeking medical care threaten my ability to maintain my lifestyle and achieve my financial goals?
3. Do I feel better after receiving medical care?
4. Are my local healthcare resources available within my transportation range and within the hours I am free to see a doctor?
5. Am I able to easily get inside my doctor's office or clinic, and am I able to comfortably participate in that space as much as the people around me?
6. Are the decisions about my care made in partnership with my doctor in a way that I am both able and excited to continue treatment?
7. Are my medical teams supporting me in being proactive about my health and the health of my family?
8. Is preventative care something I've had access to? If so, what has that looked like? Has it made a noticeable difference in my life today?

## *Step 2: Family Discussion*

Using the Illustrated version of the UN Declaration of Human Rights<sup>109</sup> as your reference, walk through the thirty articles together and engage your family in a discussion about:

1. What a "human right" is
2. What specific rights every person should be entitled to
3. What inequities could lead to a person losing those rights, and
4. What impact losing such a right might have on their life.

# ENGAGEMENT GUIDE

## Step 3: Group Discussion

To highlight some of the ways that access to healthcare intersects with systems of dehumanization and inequity, split the following topics among your group and ask yourselves, what does this issue and/or population have to do with inequitable access to healthcare—specifically along racial, gender, and class lines?

1. Medicaid expansion
  - a. For quantitative research, review Analysis of the Fiscal Impact of Medicaid Expansion in Missouri from the Washington University in St. Louis Center for Health and Economics Policy.<sup>98</sup>
  - b. For advocacy information, visit the Makes Sense MO page on the Missouri Foundation for Health.<sup>99</sup>
2. Indian Health Services (IHS)
  - a. The IHS website contains information about tribal membership status and indigenous healthcare.<sup>100</sup> You should also consider exploring their budget, leadership, and eligibility tabs
  - b. For more information on enrollment and membership, visit the First Nations Development Institute enrollment page.<sup>101</sup>
3. Sex education, birth control, and abortion—in Missouri, nationally, and internationally
  - a. The Planned Parenthood website<sup>102</sup> learn has a plethora of research and educational materials to get you started
4. Consent, radical sex positivity, and rape culture from feminist and Womanist perspectives
  - a. Dr. Dae Sheridan's TEDx talk "Real Talk about 'The Talk'"<sup>103</sup>
  - b. *Fresh Air* episode, "How Notions of Sex, Power, And Consent Are Changing on College Campuses"<sup>104</sup>
5. Suicide as the second leading cause of death for adolescents in the United States
  - a. "Suicide Rates Among Adolescents and Young Adults in the United States, 2000-2017," *Journal of the American Medical Association*<sup>105</sup>
  - b. "Suicide among teens and young adults reaches highest level since 2000," PBS (a summary of the above report)<sup>106</sup>
6. The trendiness of "Eastern medicine," cultural appropriation, and environmental justice
  - a. "Indigenous People Want Brands To Stop Selling Sage And Smudge Kits" from Huff-Post<sup>107</sup> explores how burning sage is a particularly prime example of this.

**EXTRA:** Buy *Intersex Matters* by Dr. David Rubin (they/them<sup>108</sup>) from a BIPOC-owned bookstore and read it with your group.

## ENGAGEMENT GUIDE

### *Step 4: Explore More*

Think back to our re-written definition of “disparities in access to healthcare”: Differences in access to the sociopolitical factors that enable someone to seek quality and effective care.

These factors include, but are not limited to, insurance, savings and disposable income to cover upfront costs, the number of providers in their area that accept Medicaid and private insurance, employment with paid time off, and public transportation. All of these factors heighten racial, class, and gender inequities that have deep historical roots in the healthcare industry and often create chronic and comorbid conditions that make accessing quality, effective care even harder. There will always be factors and perspectives still missing from any definition written in such haste and without a larger group of colleagues to provide feedback, but we nevertheless challenge you to try rewriting it in your own words to be as focused on racial equity as possible— and in the way you’d feel most confident presenting to your child(ren).

- The United Nations has an international campaign called the Sustainable Development Goals which, in short, outlines 17 categories of global human development that the UN considers essential to the fulfillment of all human rights. This is a fascinating and complex platform that warrants some deeper exploration, but for this activity we’d specifically like to draw your attention to the following three goals:
  - Goal 3: Ensure healthy lives and promote well-being for all at all ages<sup>110</sup>
  - Goal 8: Promote inclusive and sustainable economic growth, employment and decent work for all<sup>111</sup>
  - Goal 10: Reduce inequality within and among countries<sup>112</sup>

Recall the case study we examined about barriers to access that people with disabilities commonly face. These three goals are the most directly relevant to this incredibly large and intersectional population, yet notice that the word “disability” can only be found in relation to one of the goals (Goal 10)—and even then, it is only mentioned twice, without ample discussion. We cited the UN heavily in this section, and it is undoubtedly a critical organization that creates space (albeit limited) for dialogue and compromise in an international political area that previously lacked any such nuance. Use these prompts as an opportunity to practice your skills of outlining specific changes you need to see within an organization that is flawed yet important.

- “Not a Masterpiece: The Supreme Court’s Decision in Masterpiece Cakeshop v. Colorado Civil Rights Commission” from the American Bar Association<sup>113</sup> describes the logistics and differing public perspectives on the Masterpiece Cakeshop v. Colorado Civil Rights Commission Supreme Court case. Read the article through the lens of human rights frameworks versus individualism frameworks. How do you see these tensions playing out? Use this example to practice synthesizing theory and “real-world” implications.

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# UNIT 2

# *EDUCATION*



# EDUCATION

## **2.1 Early Childhood Education**

There are many indirect connections to a person's health. Systems don't operate in silos or have simple linear relationships. We have to fine-tune our muscles to see those connections. For instance, how do we connect education and its impact on current and future health? We have to notice the links from a micro and macro perspective, the potential butterfly effect, and, most importantly, the overarching reach of white supremacy. How does education impact an individual's health? A child can have limited resources that can impact their development or quality of life. It can be the built environment and how that might have physical implications later in life. This section will delve further into how the early years of a child's life are crucial and how flourishing or flailing during this time affects a person for the rest of their life.

When practitioners talk about early childhood education, they are often referencing the formal and informal education and development of kids from birth to age five. Many people think of education as what is obtained in classrooms, whether in a traditional or home school; however, we tend to forget about informal education, or the social-emotional education that forms the bedrock of all future classroom navigations. Social-emotional learning is taught when kids are placed with caregivers who can teach them how to regulate their emotions, make them feel safe, and eventually cobble together behavior deemed "appropriate" for the K-12 classroom. And while this seems like an awful lot to pack into just five years, the human brain is capable of some pretty amazing things during these first five years in particular.

At birth, babies' brains are roughly a quarter of the size of the brain that they'll be by adulthood, and by the end of a child's fifth year, that brain will grow to almost 90% the size of an adult brain.<sup>1</sup> So much learning happens through the experiences kids are ushered through and the relationships that are formed during this period of rapid growth and development. And because the growth from birth to five-years old is foundational to the quality of the growth they experience, the early childhood years are a unique window of time when healthy habits and situations can be given to a child to set them up for a healthy future.

Researchers and practitioners offer us three ways to think about the future impact of positive or negative situations and their effects on outcomes for children. These are **latency, cumulative, and pathway processes**. **Latent** effects are when there is an early exposure of biological or environmental factors that do not show up for years or decades, even if there are intervening components. An example of this may be **low birth weight** and placenta size increasing the risk of cardiovascular disease regardless of healthy habits in adulthood. A **cumulative** effect would be the total sum of positive and negative effects over a life course that impacts an individual's health due to duration or intensity of exposure. If a parent always has an occupation that does not provide stable income or the ability to save money, the child is more likely to have adverse health outcomes versus if that child's parent occupation only creates temporary hardship. The final effect, **pathway**, are early events that set a child on a specific path in life. For instance, a family's attitude toward education can impact a child's readiness for learning, then their behavioral, cognitive, and emotional readiness, which may impact their social adjustment and academic success.

To make a connection read Healthcare 1.2.

Other aspects of typical childhood development are secure attachment, and consistent support and affection from an early age. Secure attachment can help a child navigate stressful circumstances, create healthy adult relationships, and provide foundational security to be open to new experiences and environments. Studies have shown that with consistent support and caregiver affection from as young as eight months, children grow up to be more resilient and less anxious than those who did not form secure attachments.<sup>2</sup>

But, not all children are given caregivers they can securely attach to or are born into situations in which their developmental processes aren't interrupted or pushed off-track all together, which means that we need to provide the support and investment to the early childhood years. We know from the research why it's important (the Disparate Outcomes section discusses this in greater detail), what we can do to foster thriving in this window, what can go wrong, and the cost to our children if we don't intervene. We know that because of this time in life, prevention is the absolute best intervention—because we know what kids need to flourish.

## *A Closer Look: Adverse Childhood Experiences*

One assessment that can indicate potential disadvantages in adult life is the Adverse Childhood Experiences (ACE) Assessment. This score tells the story of the relative level of risk of developing long-term challenges as a result of experiences in early childhood. Higher scores lead to a greater risk of persistent negative outcomes than lower scores do.<sup>3</sup> Adverse childhood experiences fall into three main categories; abuse (physical, emotional, and sexual), neglect (physical and emotional), and household dysfunction. However, the addition of environmental and community realms has given a more comprehensive outlook to all potential adversities.

And much like the rest of the early childhood landscape, there are racial disparities present in ACE scores. Black, Hispanic, and Native American children are much more likely to have high ACE scores than white children are.<sup>4</sup> Part of the reason for these disparities can be found by looking at elements found in the community realm, which account for many of the systemic inequities embedded in our society, including reduced access to employment, meaningful educational opportunities, and poor housing quality and opportunities, to name a few. While the expansion of the definition helps the layperson understand more about what feeds into an adverse experience and the long-term impact it can have on a person, the ACEs themselves are incomplete. The assessment as it stands does not score children on experiences had in the second or third realms and therefore makes trauma and adversity out to be highly individualistic experiences. As we have seen as a theme throughout the Advocacy Builders Project, individuals should not bear the consequences of systems' irresponsibility.

As they are currently, ACEs provide a useful shorthand in examining how individuals can name and process adversities in early life. However, thinking about how ACEs as a whole can be prevented for children has to be done with system support. Only by establishing and promoting universal access to high-quality childcare and preschool, home visitation where needed, and consistent family engagement and support will we see ACEs turn around for kids.

## *Disparate Outcomes*

**CLASS** By now, it's clear that the early childhood years are an incredible opportunity to maximize decades of research about what we know sets kids up for success—we know now, with almost formulaic precision, what is needed to ensure that children are given a firm foundation, and it comes down to ensuring that they have access to a handful of quality things:

- Age-appropriate health care to ensure their physical and social-emotional development is on track<sup>5</sup>
  - This boils down to making sure all kids are in environments in which early detection and intervention can be provided if development in either sphere is off track.<sup>6</sup>
- High-quality early childhood learning environments that will equip them with teachers able to contribute to developmental monitoring as well as prepare them with skills they need for the classroom.<sup>7</sup>

There are many details within these two main elements that can be specified when looking at an individual child's environment and the people they interact with—like proper nutrition and feeling safe in all their environments; however, if the above conditions are met, then it is very likely these other individualized factors are going to be met as well.

On the surface this looks simple—making sure that universal access to care is available for all children to thrive—but our society has chosen to monetize all of what we know to be essential to developing children. It costs roughly 30% of the median family income to even enroll a child below kindergarten age in center-based care<sup>8</sup> (for a more nuanced look at average child-care costs by region, see the below graphic). And with only 10% of child-care programs being considered “high quality”<sup>9</sup> to meet the needs of the developing child, families from all socio-economic ranges feel the pinch. A system that requires individual families to have astronomical financial resources in order to obtain high-quality care is a system that does not prioritize children—and it means we are forcing parents into impossible compromises while still leaving the vast majority of kids without the foundation that they need.

**GENDER** During these early years, children are taking their cues from adults on how they should behave in a way that conforms to the dominant gender norms and roles that we've established and perpetuated. Babies as young as 10 months are able to form stereotypic associations between faces of women and men and gender-typed objects<sup>10</sup>—knowing that hammers are associated with men and scarves with women. Babies don't recognize gender because gender is a fact (it's not)—babies recognize gender because they watch all the adults and other children around them recognizing and reacting to gender.

But what we also know about children and their developing brains is that much of the first 10 years of life is spent navigating the world through fairly concrete thinking with not a lot of room to delve into nuance and abstract thinking. When learning from adult patterns of behavior combined with the limitations of the developing brain, we set our young kids up to keep reinforcing patterns of sexism and misogyny. Children will reinforce and recreate these arbitrary “boundaries” for themselves and others, because that's what we have modeled for them.<sup>11</sup> All told, the adult presence in this realm of early childhood development is critical, because they can either “challenge or reinforce the bias that ... underline[s] gendered play.”<sup>12</sup>

**RACE** When thinking about early childhood education, the American narrative lacks depth. It's important to expand our perspectives, as many nations and cultures outside the United States are doing, to see education as all the learning that happens to kids in these years. Much of the way that kids are learning about the world around them is by their experiences and observations. For BIPOC kids, that means that part of their “education” includes taking in the physical and emotional realities of racism in the United States. Even more dispiriting, is that birth to five years is an incredibly sensitive time for brain development, and when the far-reaching tendrils of racism encounter a developing BIPOC child, the harm is persistent, and will leave an indelible mark on the brain.

The stress of racism (via targeted discrimination, structural inequities, or anywhere in between) is woven into the fabric of the United States, and therefore the lives of the BIPOC people who live here. Being that there are so many avenues that racism can manifest itself, the stress would be classified as a “toxic” type of stress—differentiated from the positive or tolerable versions in that “toxic stress is the result of strong, frequent, or prolonged activation of stress response systems in the buffering protection of a supportive relationship.”<sup>13</sup> Over time, toxic stress will disrupt development of the systems that allow children to learn and regulate their behavior and their physical and mental health.

For the young child who is learning about the world around them, the experience with racism doesn't even have to be directly aimed at them—it can be a second hand experience. Discrimination experienced by Black and ethnic minority mothers over time saw a positive association with social-emotional problems in their children six years later; mothers who experienced discrimination had hair and saliva samples show elevated IL-6 (which causes inflammation in the body and subsequently ages you faster) in their children aged four to nine; and children exposed to adversities prenatally and in their first few years of life have brains and bodies that are more vulnerable to “second or third hits” hits that have the “inability to recover after the source of stress is eliminated” and “are more likely to be long-lasting and more resistant to treatment.”<sup>14</sup>

This is the systemic harm that we expose the developing brains of BIPOC children to. And then we have the gall to offer “solutions” that are reactive and one-off at best.



# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. What resources (financial, interpersonal, educational, etc.) were available to you in your early childhood years?
2. What resources did you call on (or use currently) for your child's early years?
  - a. Where were you stretched?
  - b. Where were you supported?
3. Reflect on your early childhood years as well as your child's. What patterns of resources emerge?
  - a. How were the experiences similar and different?
  - b. What has been constant, and what has changed?
4. For your parenting of your kids from birth to five years old, how mindful are you of the messages your children are learning around gender in:
  - a. The media you consume (television, movies, books, etc)
  - b. The toys your child plays with
  - c. How explicitly you have gender-dependent conversations
  - d. How you narrate your own gender performance
5. Explore your reaction(s) to the disparate outcomes for young BIPOC children. Identify and name those reactions. Remember to bring these to your group and have a discussion over who is centered in these named reactions (for example, guilt, pity, driven, incensed, etc.).

## *Step 2: Family Discussion*

1. Talk through with your kids the support you gave them in the early childhood.
  - a. Discuss the trade-off or compromises you (the caregivers) made.
  - b. Ask kids to weigh in on how they felt in each environment (safe, scared, confused, etc.) they remember of their pre-school days.
2. What family traditions or practices do you have to move through stressful situations?
3. Think about what secure attachment and consistent support and affection mean to you. How do you show up around these for your kids? Take the conversation to your kids: How do they perceive and receive attachment, support, and affection? Reflect on how this conversation might change or cement the ways you craft new experiences and environments for your kids and others.
4. Talk with your kids about their gender experiences. Questions to ask:
  - a. Is there a time you felt you had to choose something or couldn't choose something because of your gender?
  - b. Have you ever felt worried you had to follow certain rules, or act a certain way, because of your gender?
  - c. How did those experiences feel? What are the problems with only giving some choices to certain people?

# ENGAGEMENT GUIDE

## *Step 3: Group Discussion*

1. Explore your reaction(s) to the disparate outcomes for young BIPOC children. Identify and name those reactions.
  - a. Have a group discussion over who is centered in these named reactions (for example, guilt, pity, driven, incensed, etc).
2. Consider your own childhood within the ACEs context and what you knew before or after reading this section.
  - a. Could you track your own experience in some of the ACE questions? Were there situations critical to how you see the world that were left out?
  - b. Were there any experiences you had that had adverse impacts on you? What about positive ones?
  - c. What did you know about the factors that weren't included in ACEs?
  - d. Did you learn anything new? If so, what surprised you?
  - e. For more reading on the benefits and drawbacks of using ACEs, read "Good intentions but the right approach? The case of ACEs" on the Public Health blog.<sup>15</sup>
3. The early childhood years are not something our society chooses to invest in, and the effects are felt by all caregivers of children between birth and five.
  - a. What are some of the ways that effect is felt by caregivers that we haven't discussed yet?
  - b. Give the podcast *No One is Coming to Save Us*<sup>16</sup> a listen. Discuss with your group what jumps at to you from that podcast

# ENGAGEMENT GUIDE

## Step 4: Explore More

1. The IFF's First Step to Equity examines regional inequity in ECE. The Playbook: Reimagined and Redesigned Early Childhood Education<sup>17</sup> was created out of a community organizing effort by We Power to envision solutions and a path forward. The IFF research report defines the scope of the problem and regional disparities, while The Playbook paints a path forward for empowered, inclusive, and equitable ECE.
  - a. Where do you see your experience reflected?
  - b. What resources for empowered and inclusive ECE exist in your area? What else is needed?
  - c. The Playbook is focused on the St. Louis region. If you're in St. Louis, where and/or how might you get involved?
2. Watch *Why Do Parents Spend So Much On Child Care, Yet Early Childhood Educators Earn So Little?*<sup>18</sup> from the Center for the Study of Child Care Employment on the cycle of under-paying ECE workers.
  - a. Think about why funding doesn't work well, and why it's expensive for parents to obtain childcare. Does this reflect or explain your experiences regarding childcare?
  - b. What could we do differently to make childcare and ECE more accessible for all?
3. Watch *Starting at Zero: Reimagining Education in America*,<sup>19</sup> *Raising America: Early Childhood and the Future of Our Nation*,<sup>20</sup> and *No Small Matter*<sup>21</sup> on health policy expansion in ECE.
  - a. How do you see your experiences reflected in these videos? If you don't, what factors in your life have contributed to that? What would look different if they weren't there?
  - b. What are the things people need to access ECE? What efforts are possibly locally to make health and ECE more equitable?
  - c. While regional work is important, national policy cannot be neglected. What does it mean if, nationally, our country does not make this kind of investment? What are the costs of region-only approaches?

# EDUCATION

## 2.2 K–12 Education

The **\*K–12** years are crucial to an individual’s lifelong health, because what happens in these 13 years sets kids up for virtually the rest of their lives. Education is closely connected to potential future income, future access to reliable healthcare, and where you might live and what you might eat in the future. But it's all a precariously stacked construction. Any “wrong” moves along the way, and students have to bear the responsibility of catching up all alone. They have to contend with a system that is full of a litany of checkpoints to indicate where you “should be” in relation to reading level or math scores, but doesn't have much in the way of equitable support to make sure that all students are able to achieve. Students and their families are instead tasked with the individual responsibility of not only knowing how to navigate the complexities of asking and getting help if they need it, but also carrying that burden despite knowing that the students who most need the navigation help are the ones least likely to be equipped for the intricacies of the system.

### **\*K–12**

*The limitations present in our medical systems currently equate sex and gender identity as one and the same, and in some instances throughout this project, we’ll also be replicating some of those imperfect, confusing practices. This is primarily due to the data available that we are able to find and apply to any given domain content. Where we can, we will also try to be more precise and separate sex and gender identity to our best ability.*

There's much research<sup>22</sup> out there about educational milestones, or indicators of success along the way in the K–12 years, and what students who graduate high school do (or have access to) in order to make it there.<sup>23</sup> The path to high school graduation begins all the way back in the **early childhood years**, with checkpoints all across the K–12 years.

To make a connection read Education 2.1.

For kids who are at any of these stages, the benefits compound over their educational span. For example, once kids are out of those early years, kindergarten has them hit the ground running—learning how to identify letters and the sounds they make, putting them on track to enter first grade ready to put all of the pieces together to learn to read. First through third grades are spent making sure that students have a firm grounding in reading and are able to apply the rules learned to all of the unfamiliar words ahead of them. By the end of third grade, the “learning to read” mentality in the classroom shifts to a “reading to learn” mode. For kids who aren’t up to that level, the effects are felt throughout all other subjects since “up to half of the printed fourth-grade curriculum is incomprehensible to students who read below that grade level.”<sup>24</sup>

From there, students and teachers<sup>25</sup> are presented with the trek to keep hitting milestone after milestone. Middle school is spent establishing good attendance patterns, because it’s necessary to be in school to learn all of the material that will eventually be on the standardized tests that determine “mastery” of a particular subject. In middle school, the hope and goal is that eighth grade English and algebra benchmarks in particular are met before going to high school,<sup>26</sup> as these also have a “strong predictive power for high school completion.” Once there, aiming for students to pass the ninth grade with at least a C in 6 credits becomes the next hurdle to clear. Then, all the previous considerations that have compounded to get a student to the end of their high school career—ability to read proficiently and on grade level, consistently attending school at least 90% of the time, and maintaining a passing grade for all of the necessary credits needed to graduate—move them to attaining a diploma—which will serve as a passport to a longer life<sup>27</sup> and more money earned over that life.<sup>28</sup>

The pathway above posits major landmarks that students who graduate high school must pass through in order to get that passport at the end. But the path doesn’t include anything about what could go wrong along the way—on an individual or systemic scale. Individually, students could stumble or flail in early elementary school if they have a physical, mental, or learning disability OR if they are a person who learns in a way that doesn’t always show up on standardized tests OR if they have transportation or housing issues that prevent them from attending school at least 90% of the time OR attend a school with a school resource officer (SRO), a police officer dedicated to meting out discipline in schools with predominantly Black kids and diverting them from the school system, directly into prisons.<sup>29</sup>

There are so many checkpoints for a child to meet along the way to high school graduation, and all of those checkpoints pose the threat of being chances to miss the “on ramp” toward success and safety in adulthood; however, something vitally missing from the context around making those markers are the systems that underlie them. **The checkpoints are fixated on making it sound like the likelihood of a child graduating high school comes down to their individual choices and circumstances.** The map supposes what it

takes to get to graduation; any other destination that isn't high school graduation is an individual's misstep and responsibility. Missing from this map are the environments students are expected to traverse in order to reach the goal at the end. How are schools set up to support or not support students?

Generally, we've set up our schools and education system to be the catch-all environment for our kids in the K–12 bracket. It's important to note that our societal expectations of everything school should be for all kids is unrealistic—schools deal with a wide variety of children with different social, cultural, educational, and developmental needs. That being said, schools have the tremendous potential to be a launch pad that supports all kids equitably if they were given the resources,<sup>30</sup> but that is not the case.

A particular place where kids can lose footing on the “ideal path,” is the school environment itself for BIPOC kids. Typically, schools are not environments where BIPOC children and youth are supported consistently and meaningfully. Much of this can be traced back to the unnamed biases that manifest themselves in a more difficult school experience for BIPOC kids. Whether it's disproportionately suspending Black and brown kids from class (even knowing that attendance is vital to the path of continued success), teachers utilizing preconceived negative stereotypes to create rules designed to silence those same kids into “good behavior”<sup>31</sup>, or discriminatory dress code policies that target Black students,<sup>32</sup>—t's clear that many aspects of education have become standard. There are “best practices” to erecting all the barriers possible to BIPOC kids on the road to graduation.

That's not to say it's 100% guaranteed to work. Despite all of the barriers, despite the learning environments rife with microaggressions (and microassaults, microinsults, and microinvalidations),<sup>33</sup> despite learning the history of a country you're a part of but not represented in (or negatively represented), BIPOC kids do reach the end of the path and get that shiny diploma at the end;<sup>34</sup> however, even though kids are making it through and overcoming the obstacles, **it *shouldn't have to be so hard***. We can and should build a more inclusive and supportive school environment to make the journey down the path more successful for all—producing healthier people.

This project is being created in the midst of the COVID-19 pandemic—which has stressed every system in place, due to the unprecedented nature of a pandemic situation and a lack of preparedness and timely response from those same systems. As people and systems figure out the way forward, the education sphere, in particular, is stressed. They must figure out how to balance appropriate safety precautions with ensuring universal access to a base level of education when all students do not have the needed tools, support, or ability to make the transition to virtual learning without some cost. Since getting behind at any stage in the educational journey creates lasting ripples that are extremely difficult to overcome, the



extent of that disadvantage to students who were already treated inequitably in the education system for a host of reasons remains unquantifiable; however, this will likely impact students who were already struggling the most<sup>35</sup> (indeed, the early research bears that COVID widened education inequities that existed prior to the pandemic<sup>36</sup>).

## *Disparate Outcomes*

**RACE** When it comes to education outcomes for BIPOC children, their unequal access to key educational resources, including skilled teachers and quality curriculum, are the core roots of the problem, rather than their race.<sup>37</sup> However, since race and racism has long dictated who is able to tap into those resources, race is often a quicker shorthand to name those disparities. BIPOC kids have many hurdles to face in the classroom. Conspicuously missing from conversations around educational inequity are the experiences of Native American kids. These kids also struggle to navigate unsupportive educational journeys,<sup>38</sup> but are rarely captured in the data that describes those struggles. As a result, they experience the added burden of combatting erasure. BIPOC kids must face classrooms that are not as well resourced as white children's classrooms. "Extra resources" that do get allotted to BIPOC classrooms come designed to restrict children to a certain mold, more than they are to provide individualized support. For example, rather than providing additional educational resources from which BIPOC kids could benefit, school resource officers (SROs) are brought in instead. With them, SROs bring over-policing into children's classrooms, which BIOPIC people already experience in public spaces. It's a terrifying trend on the rise.<sup>39</sup>

**CLASS** The K–12 years can be incredibly stressful for students who are poor. The effects of poverty ripple throughout the school day, compounding from year to year. To start, children in poverty are more likely to be both food and housing insecure,<sup>40</sup> which can make it hard to focus and retain what's being taught. Additionally, for children who are chronically housing insecure, that can translate to an incredibly disruptive schooling experience. Moving homes often means moving to a new school as well. Though schools are supposed to make accommodations to allow students to finish the school year at the school they started,<sup>41</sup> the reality doesn't always mean those supports are extended. Finally, underlying all of the individual impacts of poverty is that U.S. public schools are funded by property taxes, meaning if a child lives in a poorer area, they are far more likely to be zoned to an under-resourced public school. If that child is Black or brown, they're even more likely to be placed in an under-resourced public school than their poor white counterparts.<sup>42</sup>

**GENDER** It might be no surprise that the racial biases mentioned above aren't the only biases teachers hold in the classroom. Teachers consistently rate girls' mathematical proficiency lower than that of boys with similar achievement and learning behaviors.<sup>43</sup> And that's just at the teacher level. When combined with other identities, girls from low-income families, who don't speak English as their first language, have special needs, or are of color are all the more likely to struggle in school.<sup>44</sup> This sets the stage for women to choose careers that are undervalued by society, and being underpaid as a result, thus making living a healthy life harder. Across the board, women who are post-high school graduates are more likely to choose further education tracks that society regards as "womans' work," (college,<sup>44</sup> trade-school or certification program<sup>45</sup>), which therefore pay significantly less than career paths men often choose.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. The history of education in the United States also utilizes education as a tool of oppression for BIPOC kids. Everything from manipulating the system to deny the opportunities and tools needed for success to Black children, to using residential schools to assist in the targeted erasure of Native communities, to acculturating recent immigrants to assigned societal roles—the education system has a long established record of harming BIPOC children.
  - a. Very often we measure this harm through the disparate and increased prevalence of negative factors, but what is the cost of the absence or mitigation of positive factors? What is the cost of kids not being able to be kids? How do you measure stolen joy?
2. How easy or difficult was the path from kindergarten through the twelfth grade for you? Can you identify supports that made parts particularly easy or easier? Can you identify barriers that made finding support (or even just getting through) during those years harder?
3. Think back to the type of student you were in elementary to high school.
  - a. How did the identities that you carry play into that role? What were some of the ways that teachers, classmates, and your environment reinforce that role?
  - b. Did you have to/want to make an effort to be a different type of student? If so, why? What was the perceived benefit for doing that?
4. How often do you read or write every day? How important is it that you are able to read and write at the level that you do? What opportunities would be closed to you if you didn't have the literacy you do?
  - a. Explore “Understanding Literacy & Numeracy” from the CDC<sup>46</sup> and “What is readability and why should content editors care about it?” from the Center for Plain Language<sup>47</sup>, which discusses readability and web accessibility
  - b. Using the definitions from the resources, estimate your own degree of literacy
  - c. Consider the last time you applied for a job:
    - i. How did you find that opportunity?
    - ii. What steps did you have to take to apply for it?
    - iii. What would the impact have been if you had a lower (or higher) literacy level?
  - d. Now consider that the average reading level in the United States is between seventh and eighth grade. What would change in your life if your reading level were right where it was when you were between 12 and 14 years old?
5. Where have you been complicit in creating “benchmarks” for your own children—for example, how much you think they should read, what “type” of student you think they should be, what attitude you think they should have in their role as a student, etc. ? How did you arrive at those? What influenced that? Do you think reaching those benchmarks is realistic for your kiddo? After reading the above and reflecting on your own processing, are there any ways you want to re-approach those benchmarks with your kids?

# ENGAGEMENT GUIDE

## *Step 2: Family Discussion*

1. Talk about everyone's journey into reading. When did the shift from learning to read to reading to learn take place?
2. Talk about the barriers and supports your kids have (or have had) in their classroom and how that affects how exciting school is to them.
  - a. What is their relationship with reading? How long have they had one, and when did it start?
  - b. What patterns have they noticed about how their teachers treat them in the classroom? Have they noticed the teacher treating all of the students the same or does the teacher treat some students differently?
3. Talk to your child about their dreams for their future. For whatever job/career path/future they talk about, ask them if they think they'll graduate high school/go to college.
  - a. Talk about the culture your family has towards school. Is it considered important? Why? Have children share why they think school is/isn't important. Parents, you then share why you think school is/isn't important. What were the external influences that helped you arrive at your values? Talk about the similarities and/or differences that arise.
4. Parents, share with your kiddos a time that you experienced difficulties in school with your child—not in a paternalistic way. What obstacles did you encounter that you received grace around ("got a pass")? What obstacles did you encounter that you didn't receive the same grace around?
5. Unfortunately, learning incomplete histories in school is still a common and expected practice. Students of color are often not represented in the history of the United States, or if they are, they're only represented in a negative light that showcases the trauma of their generational histories. As a family, think about the last time you learned United States history outside of school. What questions did it bring up for new avenues of learning in the future?
6. As a family, make a list of resources that go into "quality education." What are the physical, emotional, and financial elements (to start!) that you can come up with?

## ENGAGEMENT GUIDE

### *Step 3: Group Discussion*

1. What were your feelings toward school in the K–12 grades? Did any shifts in your attitude happen along the way? What do you think contributed to the attitudes you held (changing or not)?
2. When thinking about benchmarks you consciously or unconsciously hold for your own children or other kids, what comes up? What is your perception of what would happen if your child did not meet these benchmarks? What about other children? Explore how these feelings are the same or different.
3. Thinking about the fact that not all schools are similarly resourced, what do you consider fundamental support students (and teachers) should receive for a meaningful education? What resources did you receive in school that helped propel you forward? What would have changed for you had you not received them?
4. Thinking about the supports you identified in your discussions, which ones would you be willing to sacrifice and why? Which ones do children and young people routinely go without?

### *Step 4: Explore More*

1. Watch the film *Pushout*.<sup>48</sup>
2. Watch the “Separate and Unequal” episode of PBS’s *Frontline* series.<sup>49</sup>
3. Unfortunately, learning incomplete histories in school is still a common and expected practice. Students of color are often not represented in the history of the United States, or if they are, they’re only represented in a negative light that showcases the trauma of their generational histories. As a family, think about the last time you learned United States history outside of school. What questions did it bring up for new avenues of learning in the future?
4. For some ideas, check out the podcast *Teaching Hard History*.<sup>50</sup>
5. As a family, make a list of resources that go into “quality education.” What are the physical, emotional, and financial elements (to start!) that you can come up with?
6. Read the Still Separate. Still Unequal Report.<sup>51</sup>

# EDUCATION

## 2.3 Higher Education

**Higher education can create opportunities for better health** through higher annual incomes, stronger access to emergency and preventative medical care, and the opportunity to harness the sociopolitical power that higher education carries in this capitalistic neoliberal society. And, the degree to which higher education improves our lives and our health is not equitable.

To make a connection read Healthcare 1.1.

Virtually all of the developmental and educational benchmarks discussed in the last two sections exist to push more young people into systems of higher education after graduating from high school. According to the 2015 census,<sup>52</sup> 33% of the U.S. population holds a bachelor's degree. Alongside other social determinants, those 1 in 3 people are more likely to live up to nine years longer than those without a bachelor's degree.<sup>53</sup> They have smaller likelihoods of living with diabetes, cardiovascular disease, or asthma and are more likely to avoid the burden of exorbitant medical bills by having affordable health insurance for every member of their household.<sup>54</sup> Estimates suggest that one year of education raises post-graduation earnings by about 10%, or roughly \$80,000, over a lifetime.<sup>55</sup> Some studies suggest that higher education can reduce people's engagement in behaviors such as smoking or using illicit substances,<sup>56</sup> partially because such behaviors may threaten the higher income that college education potentially provides.



This access to higher income means people with college degrees are more likely to foster healthy homes and childhoods for their families<sup>57</sup> by giving them access to 1) better nutrition, 2) **less policed\*** and less polluted (“safer”) neighborhoods and schools, and 3) more, higher-quality healthcare from infancy.<sup>58</sup> Perhaps most importantly, though, “higher education may also provide skills to analyze information and tackle complex problems—precisely what’s needed to navigate the modern health system and attend to chronic diseases.”<sup>59</sup> These are the correlations that predict how higher education attainment is an investment in a longer and healthier life.

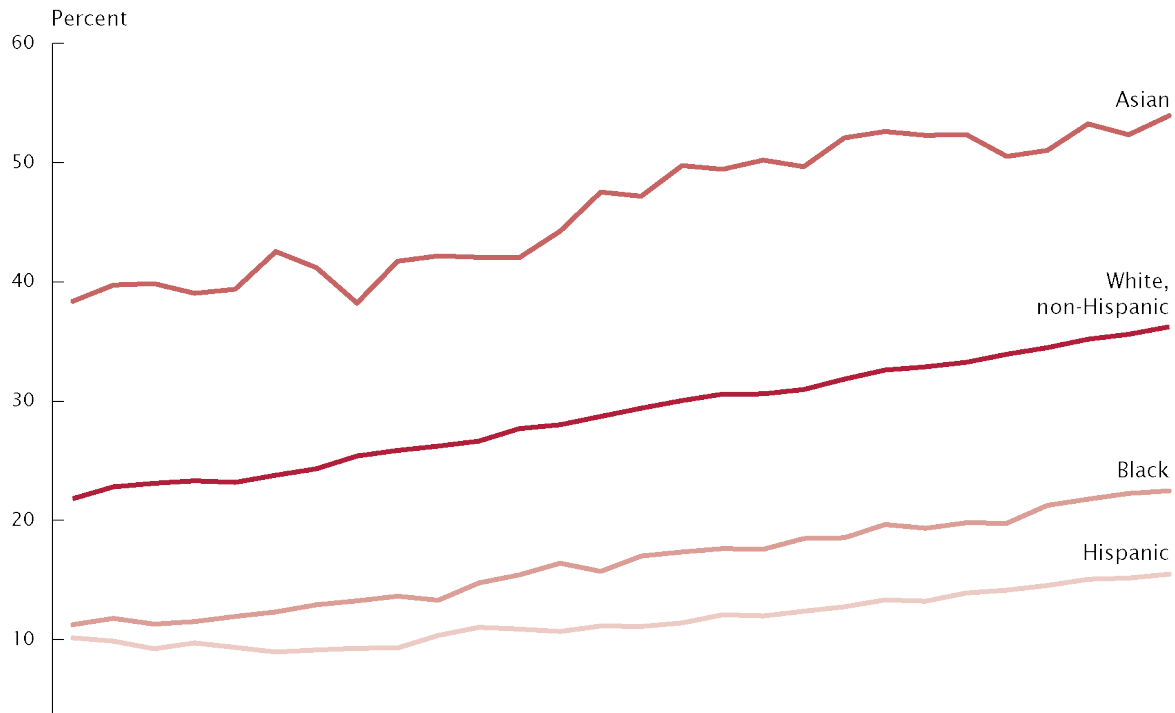
**\*less policed**

*The study mentioned above recognized statistical improvements across their population of college-educated adults, including Black people, in accessing less policed housing. However, this study does not pay mind to housing discrimination, which can impact Black and brown people regardless of education.*

There are no longer statistically significant differences between higher education attainment for women (33%) and men (32%),\* (with no government data on transgender and non-binary students), but there are significant gender disparities in the monetary and career values of a college degree. For example, Black women have historically had the smallest gender disparities for degree attainment<sup>60</sup> and were the first racialized group of women to exceed men in graduation rates. However, Black women are still paid only 62 cents for every dollar paid to white men—that is \$23,540 less per year. Latinx women are typically paid 54 cents for every dollar—\$28,036 less per year; Native American women, 57 cents to a dollar—\$25,884 less per year; white women, 79 cents to a dollar—\$13,186 less per year; Asian women, 90 cents to a dollar—\$6,007 less per year.<sup>61</sup>

Another group of people impacted by disparate access to economic and career stability appears when we look at degree attainment by race. Let’s look at St. Louis, Missouri, as one example: the lifetime monetary value of a higher education degree is \$50,000+ higher for white people than for Black people in St. Louis.<sup>62</sup> These degrees were earned in the same city, from the same schools, at the same time, in the same subjects. This is a tremendous impact of racism in higher education. This is a health disparity that steals nearly two decades of life from Black St. Louisans.

### Percentage of the Population 25 Years and Older With a Bachelor's Degree or Higher by Race and Hispanic Origin: 1988 to 2015



Source: U.S. Census Bureau, 1988-2015 Current Population Survey.

Though the Advocacy Builders Project is largely limited to the U.S. context, white supremacy in higher education is not bound by artificial national borders. International students “pay up to three times more than in-state students at public universities in the United States, ‘effectively subsidizing tuition costs for domestic students and functioning as a bailout for universities.’”<sup>63</sup> The majority of international students coming to the United States for their undergraduate education are from some of the wealthiest families in China, India, and South Korea, supporting about 373,300 total U.S. jobs<sup>64</sup> and contributing more than \$30 billion to the U.S. economy during the 2014–15 school year.<sup>65</sup> Yet, in 2016, we saw the second-largest uptick in hate crimes against Southeast Asian Americans in the 25 years for which data are available, second only to the spike after September 11, 2001. From 2020 into 2021, coinciding with the COVID-19 pandemic, these trends have only worsened. Nearly 3,800 hate crimes were reported in 2020 against Asian Americans and Pacific Islanders (AAPI), almost always in shared, public spaces—including college campuses.<sup>66</sup>

Having a higher education is strongly associated with better health outcomes throughout one's life, similar to the ways that strong foundations in **ECE and K-12** are essential to giving people the opportunity to pursue higher education; however, all of these predictors are talking about people who have graduated with a higher education degree.

To make a connection read Healthcare 2.1 and 2.2.

33% of the U.S. population falls under this category, but an additional 59% of the US population has some college or more—meaning they have completed at least one semester of higher education but have not finished a degree.<sup>67</sup> Based on a rough estimate from the CDC, we can infer that roughly 92% of the U.S. population has, at some point in their life, entered a higher education system, enrolling in and successfully completing at least one higher education course, yet over half of them were not supported to complete their degree.

Before we talk about what students need while in college in order to graduate with their health needs met, we need to do some framing on what it means to be “healthy.” College degree completion rests on many factors, including ones that tie to overall student well-being. Not only are colleges often dismissive of the importance of student well-being, the age at which students are most often enrolled in college is a critical age for physical and mental health development. ***There can be no conversations about health that do not include mental health.*** In similar ways to a person who gets seriously injured or who is diagnosed with a chronic illness while in college, a person who experiences the onset of a serious mental illness (SMI) while in college may not be able to complete their degree on time or in the ways they planned. These students will likely be burdened with added financial pressures, mental distress, social isolation and conflict, fear and uncertainty about their futures, and specific to mental illness, **stigma**. There are two key points to highlight before moving forward: 1) Stigma about mental health is profoundly real.<sup>68</sup> Misinformation is rampant and psychoeducation is slow-moving; our care systems are fragmented and prejudiced. 2) Everyone can benefit from mental health care, because mental wellness is a form of healthcare—the brain is a part of the body and it needs support.<sup>69</sup> The injustices of the world take major tolls regardless of how healthy or supported our bodies are.

The average age of onset for most mental illnesses is 12,<sup>70</sup> and more than 75% of mental health issues develop before a person turns 25.<sup>71</sup> 84% of college students are between the ages of 18 and 25.<sup>72</sup> In other words, people with mental health disorders are by far most likely to need access to mental health care for the first time while they are in college. So, what are colleges doing (and not doing) to address the immediate and long-term implications that a mental health crisis has on a student's ability to thrive vital to student health? Who has access to safe, affordable, and effective mental health care while in college, and who does not?

Untreated mental illness directly impacts help-seeking behaviors, diagnosis accuracy, access to healthcare, and the quality of our treatment and “recovery.” **The first time we held mental health counselors accountable to peer-reviewed science was just 40 years ago.** Our mental health system is fundamentally flawed, under-developed, and racist.

- Nearly 1 in 4 adults living with a serious mental illness (SMI) live below the poverty line.<sup>73</sup>
- The suicide rate for individuals with SMI is 25x higher than among the general population.<sup>74</sup>
- Suicide is the second leading cause of death for people in the United States between the ages of 10 and 34—across the lifespan, suicide is in the top 10 causes of death.<sup>75</sup>
- On average, people with SMI die between 13 and 30 years earlier than the general population.<sup>76</sup>

As of 2017, over 40 million people in the United States have a mental illness,<sup>77</sup> and while it is deeply flawed, this is the system that exists for us to support them through. So, thinking intersectionally, what does that mean for college-age students?

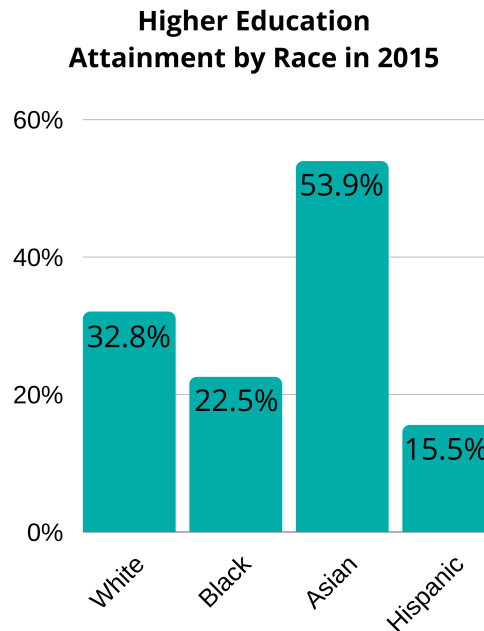
## *A Closer Look: Latinx Students*

Among Latinx adolescents, almost 65% did not receive treatment for their distressing mental health symptoms.<sup>78</sup> In **Healthcare 1.1**, we explored some of the barriers that Latinx immigrants in Texas face when trying to access healthcare services. The most statistically significant factor found in that study was the lack of access to affordable services and insurance. However, most four-year universities, especially public schools, offer some form of discounted or mandated (meaning included in the cost of tuition) student healthcare plan. Unlike most “adult” insurance plans, student health insurance increasingly includes a variety of mental health counseling services.

Building off our existing knowledge on some of the factors influencing access to healthcare for immigrant families, let’s focus on the experiences of undocumented students. According to a 2019 study, undocumented students expressed such high levels of normalized mental health distress “as a natural product of their unstable immigration status” that “many viewed treatment as futile because it could not address the underlying immigration related issues”<sup>79</sup> that they identified as the primary root of their distress. “Solutions to address utilization disparities must go beyond eliminating formal barriers to health access and address such psychosocial barriers, as well as the larger political and social context that produces them.”<sup>80</sup>

## Disparate Outcomes

**RACE** The 2015 census did not disaggregate its data to examine the relationships between socioeconomic class and higher education attainment. Even still, we can see that there are significant racial disparities in college graduation rates, especially for Black and Hispanic people<sup>81</sup>:



Missing from this data are Native American students, who make up 1% of the undergraduate population. This underrepresentation in higher education and other attainment programs leaves Native people frequently left out of government statistics. Research indicates that 41% of full-time Native American students working toward their bachelor's degree will usually complete their program in six years.<sup>82</sup> That costs more tuition money, takes more time away from family and community, and puts more time between these college students and the health and wellness benefits that come with a college degree. In 2019, just 25% of Native American people ages 25 and above had an associate's degree or more.<sup>83</sup> Remember that in the general United States population, that figure is 42%.

Access to student healthcare is not equitable when examining it through the lens of race. This is especially true for Native American students. Native American students are also underrepresented in existing healthcare protocols, facing mental health challenges on college campuses that go beyond those of non-Indigenous students. Nearly 1 in 5 Native Americans struggle with a mental illness of some kind, and rates of suicide among Native Americans are higher than the national average, particularly for youth.<sup>84</sup> Despite these risks, very few universities have 'culturally relevant' programs in place to support the mental health needs of their Native American students.<sup>85</sup> This is due in part to a lack of access to an

Indian Health Service clinic<sup>86</sup> and irrelevant and inappropriate services at university health centers.<sup>87</sup> Critically, the university environment itself is often a contributing factor to Indigenous students' mental health challenges due to persistent lack of representation encountered by Native American students in higher education spaces.<sup>88</sup> Taken together, these factors make culturally relevant mental health outreach essential to supporting Indigenous students' wellbeing.

As occupiers of unceded land, the U.S. government has negotiated a contractual responsibility to pay education expenses for Native Americans.<sup>89</sup> Yet, there has been a centuries-long campaign to pay for as few people as possible and to further strip Native identities.

One way this shirking of responsibility, continued violence, and erasure shows up is by ensuring Native American students are underrepresented and excluded while going through higher ed systems. For example, requiring that a Native person have an arbitrary amount of Native blood flowing through their veins to be recognized as such, or enforcing Blood Quantum standards on Indigenous tribal populations.<sup>90</sup> Another insidious method is through forced sterilization and family separation:

“Over the six-year period that had followed the passage of the Family Planning Services and Population Research Act of 1970, physicians sterilized perhaps 25% of Native American women of childbearing age, and there is evidence suggesting that the numbers were actually even higher. ... The law subsidized sterilizations for patients who received their health care through the Indian Health Service and for Medicaid patients, and black and Latina women were also targets of coercive sterilization in these years.... Rather than killing Indians through physical violence, as had been a hallmark of federal policies into the 1870s, politicians and reformers set out to kill off all markers of Indianness: language, clothing, and cultural and spiritual practices. In this context, the federal government criminalized Native healers and disparaged midwives and their birthing knowledge. ... Their ultimate objective, although never realized, was to absolve the federal government of any responsibility for Indian affairs.”<sup>91</sup>

Existing research focuses almost exclusively on the struggles and pain of Native peoples while intentionally choosing not to highlight their joy, attainment, healing, and advocacy. This gatekeeping of Native American identities and their erasure from social policy and resource allocation is a continuing form of genocide.<sup>92</sup>

**GENDER** Engaging in mental health care, especially in higher ed, is a gendered experience, as it is in all other forms of care. Boys and men largely experience mental wellness and illness in specific and statistically more life-threatening ways. More than four times as many men die by suicide compared to women; in 2010, 79% of suicide deaths were men—and the large majority of them were white.<sup>93</sup> Why are white boys and men developing suicidal ideation at such dramatically different rates? White supremacy charges everyone a different admission price for participation in society and returns different access passes. White men



get the most access, but their admission costs include forfeiting their full personhood and emotional capacity to care for self and others. White men become caricatures in our white supremacist society, and the impact on their mental health is gargantuan, because this caricature is not allowed to need help. This is true for Black men as well; however, due to living in a racist society day in and day out, Black men have also had to cultivate many additional resources to survive white supremacy—such as faith communities and connections to intergenerational families.

One major contributing factor to white men developing suicidal ideation at higher rates is that men are far less likely to receive mental health treatment at any point throughout their lives, but especially before they are 25<sup>94</sup>, after which the window for prevention exponentially diminishes. A 2020 study<sup>95</sup> set out to explore why (82% white) men aged 18 to 25 were not seeking treatment through their college resources. Here are three of their major findings:

- Traditional gender roles and expectations of boys and men mix with internalized stigma about mental health to create a self-imposed sense of “failure” in college-aged men when they feel like they cannot “solve” their problems alone.
  - Masculine gender roles and expectations become toxic when they prevent a person from seeking the care they need and/or when they falsely justify the mistreatment of others. This is toxic masculinity<sup>96</sup> in a very small nutshell.
- The more a person holds themselves to the norms of toxic masculinity, the more likely they are to have internalized stigma about mental health and what it means to have mental illness.
- Mental health providers are ill-equipped to address the co-occurring toxic masculinity and internalized mental health stigma<sup>97</sup> specific to the needs of this population

There is no one-size-fits-all solution when it comes to mental health care. Talk therapy on its own has several dozen variations, and it’s only one of the hundreds of proven treatments that exist across the world. Most people lean on several different kinds of treatment at once and throughout their lives, creating a care team that evolves as they grow. Part of this network of care requires that mental health providers, policy makers, and educators create, fund, research, and make accessible a significantly wider array of treatments that will be meaningful to people at every stage of their mental wellness.

**CLASS** Class is about money, but it’s also about access to resources: familiarity with the subtle ways to conduct yourself in an office, knowing how to dress your body type to appear what society deems “professional,” knowing how to ask “impressive” questions in class to develop relationships with professors. All of these unspoken rules will dramatically change your college experience and your ability to gain all the benefits of a degree. Everyone has stress, but having money and/or resources gives you the ability to adaptively respond to stress and to mitigate it.

There is privilege in being mentally healthy and especially in the ability to develop healthy habits as a young adult. The past decade's compounding literature has shown that one of the most powerful preventive measures young people can take in order to live longer, happier, and healthier lives is to have less stress— "Stress is known to alter blood flow and release hormones damaging to tissue, suppressing the immune system and raising risks of cardiovascular disease and mortality."<sup>98</sup> It is stressful and unhealthy to work multiple part-time jobs with a full college course load, but that is the reality of at least 70% of college students today.<sup>99</sup> Again highlighting the nuances between money and resources, the type of jobs we have matter. Some jobs are good for your resume, but those are gatekept by your access to resources—for example, office jobs, research positions, and places with "networking opportunities." Other jobs are going to pay more, but they don't add to your hireability—like bartending, sex work, and other jobs with high demands and little to no acknowledgement of their value. Some people have jobs because they need money to survive; others get jobs for spending money or to boost their resumes.

Systems of higher education are putting students in situations that require unhealthy and unsustainable behavior in order to graduate. Students who finish degrees experience long-term health and financial benefits that could arguably outweigh these damaging habits developed in early adulthood; however, for the 59% who do not graduate, we see no quantifiable protective health factors, and we know they are more likely to have developed unhealthy expectations of their own productivity as students. For example, consider this pervasive mindset: Even though I'm sick, I cannot take time off work to recover because I can't afford it, and I will be seen as an unreliable coworker and employee."

A 2020 study by public health professionals in California examined the social determinants of insufficient sleep in college undergraduates.<sup>100</sup> Poor sleep health, defined as getting less than eight hours of sleep on a regular basis or waking up more than once most nights, "is a major public health issue, as it is associated with increased risk of chronic diseases, including hypertension, diabetes, [and cardiovascular diseases] ... Poor sleep health [is] significantly associated with food insecurity, serious psychological distress, and poorer self-rated mental and physical health." This lack of sleep is starkly correlated with students not having enough money and resources to meet their basic needs. Among these students getting less than 8 hours of proper sleep, 95% said they could not afford a balanced meal, 96% had skipped or reduced the size of their meals in the past month to save money, 93% had gone hungry for at least one day in the past month, and 98% expressed serious psychological distress.

This study concludes by calling for expanded public education efforts on the risks of insufficient sleep. This is undoubtedly important, but the other half of this conversation is that colleges and universities must adjust their expectations of students. Telling one of the 70% of college students who work multiple part-time jobs on top of their classes that they should try to sleep more because it's unhealthy to live that way is a form of gaslighting.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. If you ever attended a higher education institution, reflect on your health at that stage of your life. If you have never attended a higher education institution, reflect on your health when you were between 18 and 25.
  - a. How do you remember feeling most days?
  - b. What attitudes about your long- and short-term health did you have? Was that something you thought about?
  - c. Did you have health insurance at the time? What was that like?
  - d. Did your insurance status and/or ability to access medical care influence any of your life decisions?
2. College-age (18 to 25) is also the age when many of us become politically activated, which can be a stressful, angering, motivating, and mobilizing moment all at the same time. How did you feel when you voted for the first time? Has there ever been a time when you didn't or couldn't vote? What information and/or experience do you have that makes it easier or harder to vote? How did your college experience, or lack thereof, influence your history with voting?
3. The college application process is extremely important to the financial aid and academic support that a student has access to throughout their 4+ years. This process is often convoluted, overwhelming, expensive, time-consuming, and full of discriminatory policies. Reflect on the supports you had and needed when you were 18 to 25 years old. How did those supports help you in college, or how didn't they? These supports could include family or friends, significant others, a high school counselor, a college advisor, peer mentors, a specific teacher or professor, etc. What privileges gave you access to some of those supports, and what disprivileges may have held you back from others?

## ENGAGEMENT GUIDE

### *Step 2: Family Discussion*

As a family, consider watching *The Mask You Live In*, a Netflix documentary that dives deeper into toxic masculinity and its impacts as a social determinant of health.

1. How could you start explaining gender inequality to your kiddos? The pay gaps described in this section could be a good starting point, but there's a lot more to this conversation than just money. How can you go farther? What learning and unlearning might you need to do before bringing your kids in? Who in your social spaces could support you in these ongoing conversations?
2. In what ways do you get help with your education right now? Do your parents or a school bus take you to school? Do you get extra help in the classroom or after school from a tutor? Do you have people who can help you with your homework?
3. What would happen if you weren't able to have some or all of that help? How easy or hard would it be to attend school, learn, and do all of your work?
4. What do you know about mental health and mental illness? What are your thoughts about them and why? What questions do you have that your parents could help you learn more about?
5. Parents to kids: "Mental illnesses often feel just as scary and overwhelming as having a stomach ache or other sickness, but a lot of people don't know how to tell their families or their doctors what they're feeling because mental health isn't something we talk about enough. That's why it's important for us to take this time while you're young to learn the words and phrases we need to describe our thoughts, feelings, and behaviors. I want you to feel safe talking about what you're feeling and thinking, and if you don't know how to talk about those things I want to help you find specialized helpers who can support you and our family."
  - a. What other ways can you continue your family conversations in this avenue? Consider these book recommendations as a starting place: *I am YOGA* (no AOC or IOC) and *Just Breathe* (AOC).

## ENGAGEMENT GUIDE

### *Step 3: Group Discussion*

1. If you attended college/university, what resources did you have (think family, financial, and other school supports discussed in the section) to help you move through college/university? What would have changed for you had you not received them?
2. Thinking about your transition to higher education, if you pursued that path, what supports did you need? How did your K–12 educational experience prepare you for higher education? What more could have been done, if anything?
3. While support for mental health and people living with mental illnesses is growing, the stigma surrounding these is still very real. How do you discuss mental health with your children or other family members/friends? What do you believe constitutes positive mental health and what is needed to maintain that?
4. Do you have student loan debt? Why or why not? Think what supports were in place to mitigate the need to take out loans or, alternately, why you had to take out loans. How does this debt payment impact your life now? What might your life look like without it?

### *Step 4: Explore More*

Consider watching the *Patriot Act* episode on student loan debt.<sup>101</sup> Student loan debt is under-researched, but its impact is massive and incredibly important to talk about. Use this episode as a launching-off point to understanding the scope of this issue and how it will continue to shape the future of political elections and agendas in the US.

- Go to the FSA website<sup>102</sup> to explore the state of our country's collective student loans.

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## UNIT 3

# *ECONOMIC STABILITY*



# ECONOMIC STABILITY

## 3.1 Poverty & Wealth

**\*Poverty** or **\*wealth** determines a person's health in our capitalist society. A person in poverty is likely suffering from “lack of” in many areas of their life. Money and one’s ability to have and to make more of it determine the healthy habits one is able to cultivate, practice, and maintain over the course of one’s life. For example, of the folks in poverty, about 35% are also food insecure.<sup>3</sup> They don’t have access to reliable, consistent food, and the food they do have access to is likely to be cheaper, more processed foods that aren’t as nutrient rich. More than 1 in 5 children diagnosed with a chronic disability has one or more social, emotional, behavioral or developmental problems—this comorbidity is two times more likely to happen to children living in poverty.<sup>4</sup> And what’s more, kids who grew up in poverty are more likely to be adults who live in poverty,<sup>5</sup> and unfortunately, it’s a compounding condition—the longer you spend being poor in childhood, the more likely you are to be in poverty as an adult. **Or, most directly connected to health and well-being, people in poverty don’t have access to consistent, meaningful, and prevention-focused healthcare.**

To make a connection read more in Healthcare 1.3.

### **\*poverty**

*An individual not having enough money to meet ALL of their basic needs (such as food, clothing, shelter, medical care), and due to the necessity of attending to those basic needs, also being unable to participate in additional social activities.<sup>1</sup>*

### **\*wealth**

*The debts you carry minus the assets you have (vehicles, homes, investments, etc.).<sup>2</sup>*

Depending on the environment, the lack of access to resources and the general damaging effects poverty can have on mental or physical health impact people differently. Various impacts necessitate creative solutions that can be tailored to individual people, and a buffet of ideas on how to eradicate poverty are out there (for some example solutions, head to the UN's website,<sup>6</sup> “How to Solve Poverty in 10 Steps” from the Borgen Project,<sup>7</sup> or the University of Michigan's Poverty Solutions<sup>8</sup>). However, the direct link missing from all the proposed solutions—and more broadly the whole presentation of poverty as a systemic problem facing our country—is any mention of wealth.

To be clear, introducing wealth into the conversation about poverty doesn't magically make poverty solutions any more clear cut, but it's indicative of the way power is often held in tandem with wealth. Wealth is often allowed to be kept completely outside any arena that is discussing poverty. Take for instance the social acceptability of reminiscing over “broke” college or younger days with friends or peers versus the social unacceptability of discussing salary specifics (in actual numbers) with friends and peers in the post-graduation or older years. One is considered commonplace, while the other is gauche and not done. It shouldn't be this way, because poverty and wealth are two sides of the same coin. As such, we'll be joining the two in conversation going forward, not because doing so will allow for solutions to suddenly emerge, but because despite being one of the richest countries in the world, the United States also has the most inequitable distribution of that wealth.

We conceptualize wealth as a “corporate” thing, a collective level where massive, systemic intervention is the only way to make adjustments. Poverty, on the other hand, is considered to be an “individual” problem that comes about as a result of individuals' choices. And because the branding for both has become so successfully entrenched, wealth inequity (with its system complexities) and poverty (with its individual woes) never meet. Wealth and poverty are never implicated in each other's proposed solutions.

But they should be. Because the factors that combine to put and keep people in poverty are the systems that we've worked toward illuminating in this project: access to/continuing quality healthcare, a supportive environment in the early years, access to and enduring support in pursuing education, being able to live in a healthy environment—the list goes on. And these are the very systems designed and maintained by wealthy corporations and people who make decisions to keep patterns of discrimination and oppression in place. For example, the **healthcare and insurance systems** that we have in place in the United States are ones that relegate people in poverty to access their care via Medicaid, a program with numerous restrictions that often force people to travel to free or low-cost clinics where they can receive treatment from inexperienced student doctors.<sup>9</sup> And that's only if preventative care is sought and obtained—otherwise, the option that remains is an emergency room visit, with the cost of that trip a mystery until it's yet another burden to add to the pile. Any single factor or a combination of these options might constitute the medical care of a person in poverty,

and it's entirely on them to weigh the cost and benefits of the possibilities before them—and to do so with the weight of additional systems also pulling to be considered as the most important priority. Since all of the systems hinge on individualism and capitalism, everyday life or emergency situations become a really terrible version of “Which Would Win”: spend a morning at a free clinic to get antibiotics for an infection or spend a morning at work to pay for the antibiotics? Spoiler—you can't have both.

To make a connection read Healthcare 1.3.

Looking over to the wealth side of things, it's clear that our capitalist ether values corporations and businesses over people, because it is assumed that businesses ultimately serve the people. Unfortunately, the power we collectively hand over to businesses to “help” individuals on a massive scale, largely never makes it to “the people,” but rather a smaller selection of individuals who will keep making choices to land them back in the same enriched place. What also happens is a value reassignment that casts folks as either “successful” or “unsuccessful” participants in our capitalist society. Among the “successful” and their “rewards” are people who can own a home and are rewarded with a Mortgage Tax Credit,<sup>10</sup> aspire to (and attain) a rental property with the reward of Publication 527,<sup>11</sup> or make all of their money through investments and be saved from income tax with the Capital Gains Tax Rate.<sup>12</sup> On the flip side, should you “choose” to be “unsuccessful,” you can try to jump through the hoops of receiving a Section 8 housing voucher.<sup>13</sup> Or, summed up into TikTok speak, there are things that are considered “classy if you're rich, but trashy if you're poor.”<sup>14</sup>

So why then are people in poverty made to feel as though they should be ashamed for expecting to be able to have enough money to survive (survive—not even be comfortable or thrive), when that same amount of money and so much more is freely and proudly handed over to wealthy folks with a “Best Bootstrap-Puller” award?

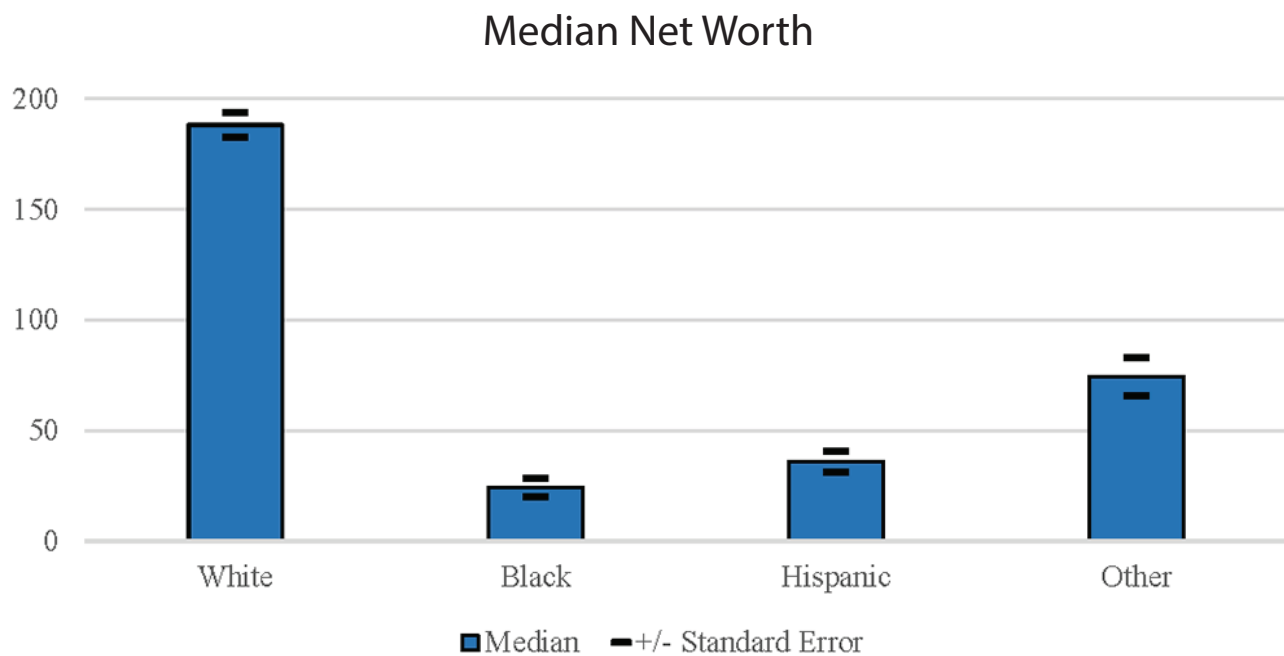


## Disparate Outcomes

**RACE** “Wealth accumulation generally follows a predictable life-cycle arc, wherein families generally accumulate wealth during their working years, in preparation for retirement.”<sup>15</sup> The life cycle of any given individual includes their cumulative education, the type of jobs and job advancement they were able to procure, and the health they were able to maintain. Wealth accumulation for a person essentially involves how they interact with other systems that determine their overall well-being.

Unfortunately, wealth accumulation also had an added, historical dimension that generally worked to the advantage of white people and to the detriment of BIPOC. The American government has a long history of facilitating the wealth development for white people and being exclusionary to Black people.<sup>16</sup> Other groups of color get lumped into that targeting from time to time, and it unfortunately becomes easier to see the reason for the vast differences from racial group to racial group. This is even more true when those same “government policies transferred wealth from nonwhites to whites.”<sup>17</sup>

Figure 1. White families have more wealth than Black, Hispanic, and other or multiple race families in the 2019 SCF.



Source: Federal Reserve Board, 2019 Survey of Consumer Finances.

A few of the many examples of this practice of facilitating wealth development for white people, while keeping BIPOC excluded include:

- The Homestead Acts of 1862 and 1866: “To help develop the American West and spur economic growth, Congress passed the Homestead Act of 1862, which provided 160 acres of federal land [all of it stolen from Native People] to anyone who agreed to farm the land.”<sup>18</sup> This act was later expanded into the Southern Homestead Act of 1866 which sought to specifically include Black people and give lands in a reparations style. In reality, about only 1,000 Black families were ever able to get the land, which was unfarmed, difficult to cultivate, and swampy.<sup>19</sup>
- The Dawes Act of 1887:<sup>20</sup> Responsible for Native people losing more than 65% of their designated reservation lands, the Dawes Act inflicted further harm against Native people by breaking up reservations into allotments for Native families. However, this was the federal government allotting land already controlled by tribes, essentially stealing the land and “benevolently giving” it back—twice. And Native people fared similarly to Black people during the Homestead Acts: they were “given” land unsuitable for farming and large portions of the land was leased to non-Native people.
- The Social Security Act of 1935: Latinx workers, like many Black workers, were disproportionately represented in the occupations not covered by the Social Security Act.<sup>21</sup>
- Foreign Miners Tax of 1850: A monthly \$20 fee that all foreigners were required to pay in order to be able to mine for gold—a fee that was only enforced with Latinx and Chinese workers.<sup>22</sup>

All of these legislative pieces made it easier for white people to acquire and hold onto assets that they could then pass down to later descendants, while simultaneously making it harder for BIPOC to do the same. One of the largest sources of wealth in American households is home equity<sup>23</sup> and inheritances, which are our the most direct route for families to transmit wealth between generations and account for approximately half of wealth accumulation.<sup>24</sup> These pathways to home-ownership and inheritance, that began hundreds of years ago, has dominoed to either put folks way ahead of or way behind the wealth-building curve. And the dominos will continue to fall.

**GENDER** Wealth is accumulated over lifetimes and depends on a variety of factors that have been outlined in other parts of this project, such as the **\*income** gap.

**\*income**

*An individual not having enough money to meet ALL of their basic needs (such as food, clothing, shelter, medical care), and due to the necessity of attending to those basic needs, also being unable to participate in additional social activities.<sup>1</sup>*

Women also face unique barriers that are both tied to how our society views women's capability with money<sup>25</sup> and the attitudes they are socialized to have towards money. Just a small selection of the barriers women face when accumulation wealth are:<sup>26</sup>

- The income gap (see Figure 1 above)
  - This is compounded for lesbians and transgender women, who may also face additional discrimination in getting and keeping jobs based on their identities
- The caregiving responsibilities women are more likely to have, which keeps them from putting that time in at work
- Women being less knowledgeable of financial systems and more risk averse
- Women being less likely to have business equity and less likely to have access to venture capital investments
- Women being socialized to be more risk averse when it comes to investing money, which compounds into a devastating effect over a woman's lifetime, especially since women are more likely to live longer than men.<sup>27</sup>

The list unfortunately goes on. However, there is a new narrative slowly emerging around women and wealth accumulation. As more and more research comes to light, there are some amazing women doing work to lift up fellow women in their journeys to financial empowerment: Tiffany Aliche,<sup>28</sup> Tori Dunlap,<sup>29</sup> and the investing team at Ellevest<sup>30</sup> are just some of the women who have dedicated themselves to financially empowering women with education and the confidence to confront the historical and systemic status quo.

**(SOCIAL) CLASS** Class never really leaves us, no matter what financial status we're able to obtain. In other sections, we've used about class as a shorthand for economic considerations and income on an individual level. Here directly discussing wealth and poverty, however, it feels especially important to examine the social considerations of class that could further or hinder a person's accumulation of wealth. Therefore, we'll be focusing on the social construction of class and the fact that "social class" includes not only your income, but also your "wealth, education [(formal and informal)], and occupation".<sup>31</sup>

Class and wealth are connected, but can exist outside of each other, because even though a person's financial situation might dictate how they describe their class ranking,<sup>32</sup> there are also behaviors that we're socialized to attribute to "lower class" and "higher class" people. The two are connected in the obvious way: class is used as a shorthand to convey an individual's income. When they operate apart, class is used to describe the behaviors a person is likely to engage in, due to their access to money and wealth. The unstated understanding is that class directly correlates with a person's ability to "behave appropriately" and also their general competence.<sup>33</sup>

The way that we are socialized to view poverty and all of the dog whistles that we associate with poverty, creates a definite distinction between folks who grew up wealthy and “high class” and are therefore familiar with all of the expected, unwritten norms and have access and relationships with other “high class” people, thereby cementing their status even further. This access keeps the cycle going, since these folks time and time again have the power to keep making decisions that leave their “high class” status intact and out of reach for the majority.<sup>34</sup>

These concepts are probably best illustrated with real life examples, so consider Cardi B and Donald Trump and the perceived “acceptability” of the actions of each. Cardi B has been criticized for her money management<sup>35</sup> and been the unfortunate target of people class policing her.<sup>36</sup> Conversely, Donald Trump’s money and investment mismanagement has largely been viewed as part of a larger plan, and a number of people have allowed him to cash in on that perception to their own disadvantage.<sup>37</sup> This comparison is the intersection of everything discussed so far in the disparate outcomes sections: there is a race, gender, and class lens to be considered for both. For more on the contrast of how we’re socialized to view Cardi B versus Donald Trump, see Group Discussion in the Engagement Guide.

Class never really leaves us, despite the wealth that we may attain or lose, especially if upper class people safeguard and gatekeep the connections with those in power as a means to maintain their upper class status.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. How were you socialized and raised to know about wealth accumulation? Were you taught explicitly, or did you have to seek knowledge out on your own?
2. Do you consider yourself to hold wealth or to be wealthy?
  - a. If you don't, identify some system barriers (mentioned here or beyond) that have prevented you from accumulating wealth. If you do, identify some system advantages (mentioned here or beyond) that contributed to your wealth.
3. Consider episode 3 of the Financial Feminist podcast<sup>38</sup>—what's your first memory about money, and how does it track with the attitudes you hold now?

## *Step 2: Family Discussion*

1. How would your family describe your social class? Parents, share with your kids if this social class is similar or different from how you grew up. What remained the same or changed in order for you to be in the position you are in now?
2. What are some examples of wealth your family has and will pass down to the children? Grandparents? Cousins?

## ENGAGEMENT GUIDE

### *Step 3: Group Discussion*

1. We referred to people in poverty as such, instead of referring to them as “poor people.” What is lost and gained from using “people first” instead of “identity first” language? What automatic associations do you make with the terminology “people in poverty” vs. “poor people?”
2. Reflect on the history that created the foundation for the current wealth inequality. What historical parallels can you see between this section and **Healthcare 1.1**?
  - a. What other historical practices can you call to mind that inhibited people from building wealth?
3. Did any of the disparate outcomes stick out to you? If so, which one(s) and why?
4. Discuss your conception of poverty by itself and wealth by itself.
5. Consider Cardi B and Donald Trump from the (Social) Class section above by watching Cardi B’s Instagram video<sup>39</sup> and reading “Cardi B Opens Up About Her Personal Expenses” from Refinery29<sup>40</sup> and watching “1980s: How Donald Trump Created Donald Trump.”<sup>41</sup>
  - a. As a group, discuss and compare the credibility granted to both Cardi B and (pre-presidency) Donald Trump by public reactions. Break down different elements that either played to the benefit or detriment of each person. In your discussion, consider and explicitly include race, gender, and class.

### *Step 4: Explore More*

1. Watch “How America Created Its Shameful Wealth Gap.”<sup>42</sup>
2. Watch “Why We Need a Wealth Tax.”<sup>43</sup>
3. Listen to the Financial Feminist podcast<sup>44</sup>
4. Watch the *Schitt’s Creek* episode “New Car” (Season 3, Episode 3).<sup>45</sup>
  - a. Consider how things are deemed “poor” or “rich” when the Rose family tries to shed their “upper class” appearance in favor of a “lower class” one to suit their needs. What social currency do they have access to that a “low class” family wouldn’t have?



# ECONOMIC STABILITY

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## 3.2 *Employment*

We operate in a capitalist society that assumes every “hardworking” person should be able to find pleasure and fulfillment in their labor. Capitalism demands daily maintenance, almost always at the expense of personal fulfillment outside of paid work. The empty promise of this economic system is that “equal contributions” to one’s community are supposed to fulfill our ever-growing responsibility to the “social contract”:<sup>46</sup> working 8+ hours a day for 50+ years is supposed to be enough to meet and exceed our basic needs and allow us to grow old feeling fulfilled. But what “counts” when we’re talking about employment? Who measures an “equal” contribution? There are a few important definitions for us to start with:

Being **employed** essentially means that someone with hiring power has offered someone with less power a set amount of money to perform tasks for a certain number of hours every week, usually taking up the vast majority of our lives; however, it can be extremely difficult and expensive to get and keep a job,<sup>47</sup> especially for those without expansive social connections, family connections, intergenerational wealth, and resources. These social connections—and the lack thereof—can be especially challenging when we consider the exorbitant costs of childcare, which pose massive barriers to employment for many parents and caregivers. Consider, for example, the cost of car payments, gas, insurance, mechanical maintenance, and parking, made much more complicated if two people in your house are trying to work using one car, and on top of the exorbitant costs of childcare.

Being **unemployed** means that someone is currently out of the labor force and they are searching for a job. Capitalism in the United States dictates that every person must aspire to paid labor if they are to be considered full members of the social contract<sup>48</sup> and therefore gain access to social services such as unemployment benefits, unhoused or “homeless” services, and many drug rehabilitation centers. This means these services are not a right, they’re a privilege.

Being **underemployed** means someone is employed in a low-paying, physically and/or emotionally taxing job that offers no long-term financial stability. Under-employing jobs are very often part-time and/or in the service industry, though not always. Many of the companies that under-employ people also take in millions to billions of dollars in profit every year. For example, dollar stores exploit international slave labor and skirt environmental protections to offer radically low prices, raking in millions while grossly underpaying their employees (domestic and abroad) and driving gentrification across the United States.<sup>49</sup> This pattern of under-employment takes advantage of people searching for any source of regular income—people who can't afford to hunt for a “better” job. Dollar stores, industrial agriculture and farming, delivery services, and countless other enterprises with similar operations know this and actively perpetuate the cycle of underemployment.

### COVID Consequences—Employment Edition:

A new consequence to under-employment may be rising with COVID-19. We're seeing a wide-spread shortage of jobs willing to pay a living wage and/or offer meaningful benefits, resulting in massive staff shortages in the service industry; however, it's important to recognize that many government-led and non-profit agencies engaged in social services also under-employ people, both due to under-funding and a national professional culture that systemically under-values this work—work which is very often done by women (**Remember our discussion of intersectionality and the racialized gender pay gap from Education 2.3**).

Doing **unpaid labor** involves physical and/or emotional labor that is necessary for human development, yet for which there is no formalized mechanism to receive financial compensation. Almost all elements of child rearing, housekeeping, and **relationship development\*** fall under this category. For example, BIPOC advocates and scholars educating us via social media is oftentimes unpaid labor.

Unpaid labor differs from **volunteer work** in that unpaid labor is expected and necessary, while volunteer work is just that—voluntary. Volunteer work is also full of social clout—think college application essays about volunteering at a tent city or PTA members who had a successful communications career before having kids, etc. It has to align with capitalist goals before it is venerated.

**\*relationship development**

*Building relationships always requires work, like getting to know a new friend, maintaining an intimate partnership, raising kids, creating fruitful partnerships with the people you work with, and sharing your ..lived experiences and/or the educational resources you've had the privilege of accessing in an effort to grow and sustain meaningful community connections. All of this is unpaid labor, because we're spending time and energy building connections that we need in order to maintain our community belonging—and yet there are significant intersections between the unpaid labor we each do and the privileges we carry. Developing peer support through an informal mommy-and-me playgroup you found on Facebook was probably unpaid labor on the organizer's part, and those connections are often important to those families' capacity to adjust to being parents—this is one version of unpaid labor in the form of relationship development. This is also fundamentally different from BIPOC advocates and scholars educating us via social media, which is also oftentimes unpaid labor in the form of relationship development.*

Very few types of work—like being a doctor, lawyer, astronaut or military member—are praised for making a meaningful impact. The jobs that are praised and highly compensated are also highly demanding, both in time and risk to personhood, and they are tightly guarded by class and access to formal education. The vast majority of people in the United States will only benefit from the work of these professions a handful of times throughout their life when compared to people in the food service industry, cleaning staff, construction workers, maintenance and repair workers, teachers, social workers, early childcare providers, and dozens of other underpaid, overworked, and overlooked professionals who contribute the most and reap the least. People in this second bracket of jobs are often given praise, but are almost never compensated accordingly. Think of phrases like nurses are superheroes, teachers make the world go round, America runs on Dunkin', and so on. This comparison is not meant to spark a battle over who works harder or is smarter or more deserving. It's meant to pose the questions: Are we affording livable and rewarding expectations for the people we rely on most? What myths of heroism, nationalism, colonialism, and white supremacy are ruling our systems of employment?

Capitalism creates a social environment and culture in which people have to earn their rights, which is fundamentally flawed and goes against the very framework of human rights.

Unless you are part of a tiny subset of people who have access to jobs with economic and cultural clout right out of teenageship (**generational wealth**), the cultural elements of capitalism teach us to whittle down our goals and talents until we arrive at a job title attached

to a specific set of routine tasks that contribute to society (again, the social contract<sup>50</sup>). Capitalism makes it a privilege to have access to resources that allow you to meet your own basic needs—for instance, **healthcare**.

To make a connection read *Economic Stability 3.1* and *Healthcare 1.1*.

Employment is a social determinant of health because health insurance is tied to employment in the United States.<sup>51</sup> The vast majority of comprehensive health insurance plans are only available through an employer, yet many employers offer no plans, plans that are only for full-time employees, or plans that are drastically limited, unaffordable, and inaccessible.<sup>52</sup> It's also important to note that many small business and non-profit organizations struggle to find solid health insurance plans to offer. This issue is grown and nurtured by run-of-the-mill corporate greed. The health insurance system in the United States is horribly disorganized and one of the most complex systems for a small organization to have to navigate alone; the people who work in insurance don't even understand everything about it themselves.

The common excuse is that there isn't enough money in the United States to pay for everyone's healthcare. That is simply not true. The federal budget is complicated and, mirroring the systems it creates, disorganized. Yet as of September 2020, the congressional budget has about \$3.3 trillion at legislators' discretion.<sup>53</sup> We are spending more money than any other country, and we still have worse health outcomes than many of those countries in almost all of the CDC's key health categories.<sup>54</sup>

It's plain and simple: Regardless of the specific job you land, there is still no guarantee that your employer-based health insurance will be there for you when you need it most.<sup>55</sup>

## Disparate Outcomes

We talk a lot about resilience in people—BIPOC, poor, queer, disabled people—but why aren't we talking about resilient systems instead? Why do people have to be resilient, while systems get to be fragile and reactive to the constant shifting of human society? Did we (white colonials, capitalists, American boot-strappers) build these systems to serve everyone's needs, or even our own? No.

*Systems* need to be built sustainably and with resilience so that *people* can thrive, react, and adapt to ongoing and necessary changes in our societies—not the other way around.

When systems are reactive and fragile, we create an employment system that causes people to cling desperately to the empty promises of capitalism, yoked to a financial system that cannot withstand economic shifts.<sup>56</sup> The United States often perpetuates a narrative of it constantly being a uniquely bad time to need a job. But please, do tell, when were the good times? When was it easy for every person to find a job with health insurance, retirement benefits, and a livable (not even comfortable) wage? What was the month, date, and year when enslavement, exploitation, workplace assault and harassment, and burnout first began? The answer is that these cruelties have existed for as long as organized employment. Capitalism is driving us to get jobs as fast as possible, AND capitalism is driving us to potentially die doing our job. A pandemic that has taken the lives of over 6.58 million people (and counting) and forced millions more out of their homes and/or into unprotected and highly demanding positions without insurance has **not** created a uniquely bad time for a job search—this is merely the latest chapter of an ancient and stale legacy.

To echo the eloquent summary of Niki Okuk,<sup>57</sup> “Are you tired of going to work and making money for other people? And who are those people anyways? Those people that make money from your work. Well, they're capitalists. They have capital, and they use your labor to make more capital. So if you're tired of going to work and making money for other people, then you're probably like me—just tired of capitalism.”<sup>58</sup> Arguably the primary tool of capitalism is to separate workers from the means of production—to make a “boss” out of the middle-man (language left gendered intentionally) standing between workers and their paychecks. It's a relatively simple tactic, so why is it so excruciatingly difficult to change? Because, as always, **capitalism and white supremacy are working together.**

To make a connection read more in Healthcare 1.1.

**RACE:** When attempting to find **gainful employment\*** in a capitalist society, it truly “takes money to make money.” And with that being the case, it should be no great surprise that people who have historically and systemically been **excluded from different ways to build generational wealth face additional barriers when seeking, gaining, and maintaining employment.** At the most fundamental level, having access to wealth makes it easier to be fully employed. Wealth allows you to invest in the education that will let you meet the requirements to be employed with benefits that further invest in your future. Wealth makes it so that a person is able to live “in a neighborhood with access to good jobs [or] to move to new places when better opportunities arise.”<sup>59</sup>

To make a connection read *Economic Stability* 3.1.

**\*gainful employment**

*In this context, gainful employment means you are taking in more income than you need to survive; those who are gainfully employed have spending money, sometimes called ‘disposable income.’*

Beyond facing the barriers at the heart of so many systemic inequities, even once BIPOC are employed, the hurdles keep coming, and a price is always required. That price is exacted from all BIPOC when “professional” behavior is expected, and all of the standards are rooted in white supremacy<sup>60</sup> and then further exacerbated by anti-Black bias if your skin color is darker.<sup>61</sup> It is more than enough of a price to pay that BIPOC are held to white supremacist standards of dress, speech, movement, timeliness, and jargon in all workplaces,—and the price we’re talking about here is also physical as observed as John Henryism.<sup>62</sup> Expend the extra effort to fit the mold white supremacy lays out is a goal forever out of the grasp of BIPOC, and it can literally wear a body out. Capitalism says, “work for 50+ years and contribute to your community in a way that makes a few of us even more money, but when you’re done you’ll get to spend another 20, 30, 40 years on a beach somewhere feeling great—so it’ll all be fine!” This concept of growing old in the fulfillment of the impact of your labor does not apply to Black people whose bodies have been irreparably damaged by the intersection of being overworked and underpaid. Overpowering the might of underemployment through sheer force cannot be the only way to grow your family’s wealth, especially when BIPOC bodies are broken and neglected in the process. To continue engaging with the concept and impact of John Henryism, start with episode 4 of the podcast *1619*.<sup>63</sup>



**CLASS** We know health insurance is essential to having the quality of life and security that we want for our families, and it is inextricably tied, in the vast majority of cases, to your level and type of employment. Your employment, in addition to dictating your insurance status, will dictate your financial stability. When your employment or financial stability goes, your healthcare is first to follow. Employment discrimination intersects with all identities—take a look through the following examples to see how many ways this could impact one’s financial status and insurance access simultaneously:

Even if someone does have enough privilege to weather the costs of finding a new job with adequate health insurance to meet all their immediate obligations, there are still more obstacles to navigate for them to keep that new job. A few of the hurdles are: maintaining constant access to transportation and internet, arduously conforming to the racist and sexist notions of “professional” attire<sup>64</sup> (including the added difficulties caused by **weight-bias in the workplace\***), and finding access to food, housing, and childcare for you and your family—all outside of work hours. There is an especially harmful intersection here for transgender and queer people, who are 120% more likely to experience homelessness than cis-het people.<sup>65</sup> They are often targeted for not conforming to corporatized standards of “appropriate” attire (which is just code for dress codes based on the gender binary).

**\*weight-bias in the workplace**

*Much of the language in the article linked above is offensive and inaccurate. The mental model is that fat people are unhealthy, and we almost never question that assumption. We need to question it, because **it’s untrue and incredibly harmful**. To start questioning that model, start with the Fat Reading List from Your Fat Friend.<sup>66</sup>*

To make a connection read Neighborhood and Built Environment 4.1.

And even then, in this new job with the best pay and best benefits they could find, they would almost certainly still be penalized and even fired if they ever became seriously ill or disabled.

We’ve said before that there can be no conversations about healthcare that do not include mental health. One major barrier to keeping a job when you’re living with mental illness is that, under the current ableist workplace norms, there is no room and no safety for a person to experience any level of dysregulation, heightened emotion, aggression, delusion, or anxiety. 13.1 million adults in the United States have a serious mental illness (SMI);<sup>67</sup> however, 89.1% of people with an SMI are unemployed.<sup>68</sup> In 2020, 82.1% of people with a physical

disability were unemployed.<sup>69</sup> To keep a job that provides adequate employer-based health insurance, you have to stay physically and mentally healthy, or you could risk losing your job and therefore your health insurance.

This is especially true in at-will employment states without exemptions,<sup>70</sup> in which employers have the power to terminate an employee for virtually any reason, without warning. It is still technically illegal for employers to discriminate against employees for race, religion, and gender, but without explicit legal protections, the heavy burden of proof will lie with the person who was wrongfully terminated—and they will still have lost their employer-based health insurance regardless of that legal outcome.

**GENDER** Parenthood inside the boundaries of heteropatriarchy dictates that men get paid more on average than women counterparts in the same positions, thereby affording men more reliable access to health insurance and a bigger paycheck for their entire families—this is nothing new; however, yet another impact of the (racialized) gender pay gap is that a mom’s jobs will be the first to be put on the chopping block when life changes.

Say, for example, you’re expecting a child, an aging parent needs more care, a child is struggling in school, there’s a pandemic, etc. **When something changes and your family needs more tending, what factors would you consider when deciding which parent takes on these additional, unpaid duties?**

To make a connection read Economic Stability 3.1.

Most often, women and/or **\*moms** will simply take on this second shift in addition to their day job,<sup>71</sup> where they’ll probably continue to be underpaid by the heteropatriarchy. If a family does have enough privilege for one parent to exit the workforce, it’s very likely to be the parent who makes less money—statistically, moms. Remember that unpaid labor involves physical and/or emotional labor that is **necessary** for human development, yet for which there is no formalized mechanism to receive financial compensation. It is a privilege for a parent to securely exit the workforce, AND the unpaid labor they will continue to provide is necessary to the health, wellbeing, and sustainability of our entire society.

**\*moms**

*This section is talking about anyone who identifies as a mom, and “mom” is intentionally being used within the heteronormative gender binary.*

These periods of unpaid labor, most often falling on moms, create gaps in their resumes that further decrease salary potential, worsen the myth of imposter syndrome, and feed insidious stereotypes that moms are unreliable or “risky” hires if they ever attempt to rejoin the organized workforce. They also create a harmful lack of security and financial independence for women with families; without their working partners, stay-at-home moms or moms who cannot earn their full budget are often forced to become reliant on men to meet their basic needs.

What choices could be involved in a person’s path to motherhood? What societal messages are cis-women socialized into thinking about motherhood? Is it idealization, romanticism, distortion? What sacrifices does motherhood require AND what resources can cis-women access through motherhood that give the position power?

White women want power and most often access it through white men, primarily through motherhood.

How can we define the labor of motherhood?

- It’s not just **employment**: While there is an expectation to perform semi-routine tasks for a semi-set timeframe (at least 18 to 25 years per neurotypical child), it’s not always routine—you’re expected to adapt and decipher the needs of your child(ren) virtually all on your own, and you can’t quit motherhood once you start. There is no set wage or capital being earned; there is no one to pay a wage because the labor is going to a child. It’s usually quite the opposite; someone in the household almost certainly needs outside employment in order to meet the expectations of motherhood. Does this mean the double-shifts required of many mothers makes the labor of mothering **underemployment**? There’s also no supervisor or coworkers to cover a shift if a mother goes on vacation from parenting—or is there? Could partners, grandparents, aunts, uncles, or friends serve to meet this criteria of the employment definition? Do we want to define our families in such capitalistic ways?
- It’s not just **unemployment**: Motherhood is outside of the organized labor force, and not all mothers are searching for a traditional “job.” Full-time mothers who do not have a partner working in the organized labor force are still not considered full members of the social contract—they most often do not have access to many social services such as unemployment benefits, unhoused or “homeless” services, food assistance programs, etc. Again, these services are still not a right for all mothers: They’re a privilege.

- The definition of **unpaid labor** may be the best fit, but it's not complete: Motherhood very directly involves physical and emotional labor that is necessary for human development, yet for which there is no formalized mechanism to receive financial compensation; however, we have to consider that the circumstances through which some people are able to **choose** to become mothers do provide power and resources that complicate our conceptualization of all motherhood as strictly unpaid labor. Does that make some versions of mothering **volunteer work**, with the social clout and veneration to back it up? A teenager still in high school becoming a mother is a fundamentally different set of circumstances than a highly educated white woman with generational wealth seeking out IVF.

All of these definitions are attempting to reduce an incredibly intricate, diverse, and ever-evolving experience into the confines of capitalism. Every definition listed above is inadequate and reductive. What are we missing? What is the labor of mothering? Is any labor ever truly voluntary under capitalism?

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

Let's think about health insurance fees and deductibles. That first sentence probably made you want to stop reading, and that is exactly part of the problem! This stuff is boring and confusing for most people, and that is no accident. Nevertheless, important to our discussion of why more people cannot find "fulfilling" employment is that insurance fees and deductibles will reset when a person switches to a new plan. This could potentially mean that thousands of dollars spent on healthcare in February with the assumption that insurance would cover the rest of the year's expenses would be lost in October for the sake of switching to a "better" plan. This is a daunting risk, especially in light of the fact that "many companies won't start your insurance coverage until you've worked 30 days, which means you can find yourself with a month of lapsed coverage."<sup>72</sup> For people with chronic illnesses, people expecting a new baby, people going through hormone replacement therapies, people whose jobs pose a significant threat to their well-being, or people who may need to see a doctor on a much more urgent or regular basis, this is not a viable option. Spend some time in a small group of your peers and try to compare notes on what makes up a quality, sufficient healthcare plan for you and your family.

1. Reflect on your experiences with health insurance. How much time have you spent without access to it, wishing you had it? Have you ever had health insurance, but the coverage was not enough to be useful?
2. If you are insured, do you know how to use your health insurance benefits? Do you understand your coverage? Who taught you these things? Have you ever had a claim denied for no reason or a reason you didn't understand?
3. If you're not insured, do you know who in government and hospital systems might be able to help you get it? Where would you start?
4. Roughly how much are you having to spend on healthcare per month? If you're insured, this might look like a percentage of your pay going toward premiums. If you're uninsured, this might look like paying for prescriptions out of pocket or using the ER or urgent care as your only access to doctors.
5. How much could you safely afford to spend on healthcare? Is that number higher, lower, or about the same as the current reality of what you're spending on healthcare?
6. If you're insured, are there services that you need and are not covered by your insurance? Are there services you are eligible for but don't use or don't need? Why might that be? If you're uninsured, are there symptoms you've been forced to ignore?
7. Reflect on any other aspects that might impact whether your health insurance coverage is sufficient. For example, the size of your family, age, or access to resources that impact health long-term (fresh foods, sunscreen, over-the-counter medications, sleep, therapy, etc). Do you think any of these factors would be enough to maintain your family's health without health insurance?

# ENGAGEMENT GUIDE

## *Step 2: Family Discussion*

1. What types of labor are you and your family engaged in?
2. Have a household conversation about the many types of labor you're each engaged in. Who has paid employment? Who does volunteer work? Who's responsible for all the different domains of household maintenance and family planning? Who does volunteer work? How and why did they choose those particular organizations to volunteer with? Who's in school, doing homework and studying at home? What else?
3. Help your child(ren) brainstorm a list of all the things your family pays for in order for caregiver(s) to go to work. Think transportation, childcare, convenient meal options, etc. What else can you think of?
4. What would your kids think qualifies as a healthy work environment? How many jobs actually fall into that? To help facilitate this conversation, equate a work environment to a school classroom that they like working and learning in.

## *Step 3: Group Discussion*

1. If you have health insurance, where does it come from? Who is the primary policy holder? If you don't have health insurance, have you ever made employment decisions based on the healthcare you would (or would not) receive?
2. What might happen to your insurance status if you lost your job unexpectedly? Your child(ren)'s insurance? What options would you have to pay for emergency healthcare? What healthcare would you then have to live without if you couldn't find new coverage?
3. What are some of the barriers that prevent individuals from finding coverage? Would they have any feasible options for accessing meaningful healthcare without coverage? How might their lives be different if they had health insurance? How about the lives of their child(ren)?



## ENGAGEMENT GUIDE

### *Step 4: Explore More*

1. Motherhood is not a trap, AND sometimes people get trapped in motherhood. Sometimes motherhood is also wielded to gatekeep, gaslight, and girlboss.<sup>73</sup> Read through “The Death of the Girlboss” from Vox<sup>74</sup> to clarify how this language is being used, then reflect on some of the ways you’ve seen these patterns show up in your parenting circles. Do you know any “girl bosses” what qualifies them as such? What power or resources are they gatekeeping? Is avoiding the concept of motherhood as employment one way in which we strive to protect the experience from capitalization? Does this also have the impact of devaluing the labor of motherhood?
2. The very concept of a girl boss attempts to position itself as ahistorical—an unacceptable premise. The social script that cis-women cannot fully experience the power and capacity of their bodies unless they’ve birthed a healthy child has been profoundly influential and harmful throughout history. As one Eurocentric example, consider the musical *Six*,<sup>75</sup> a retold biography of the six wives of Henry VIII, with special attention paid to the songs “Ex-Wives”<sup>76</sup> and “Heart of Stone.”<sup>77</sup> Discuss the insinuation that a woman giving her life to birth a son was “worth the sacrifice.” Who benefits from this framing? In what ways might everyone also be harmed by it? Consider the implications this social script has on the romanization of motherhood, the prolific “mom shaming” culture that surrounds it, and the limitations it creates for parents to find and create meaningful support systems outside of the nuclear family unit to care for children within their communities.

# ECONOMIC STABILITY

## 3.3 Incarceration

Critical Resistance,<sup>78</sup> a grassroots movement, defines the prison industrial complex (PIC) as “overlapping interests of government and industry that use surveillance, policing and imprisonment as solutions to economic, social and political problems.” We live in a capitalist system and the PIC profits off individuals being imprisoned;<sup>79</sup> however, its impact isn’t only economic. Incarceration enormously reinforces and compounds on so many determinants of health, including education, health, employment, and financial stability. Incarceration enables the **capitalist system** and reinforces the idea of the caste system,<sup>80</sup> which is “a division of society based on differences of wealth, inherited rank or privilege, profession, occupation, or race.” Essentially, mass incarceration is modern day slavery by design.<sup>81</sup> The PIC is an old model that continues to be updated to accommodate broader social, economic, and political problems. Another way of looking at this would be when you upgrade your cell phone to the latest model and sync it with your old phone; your brand new phone has all of the information from your old one and is also a newer and more complex vessel.

To make a connection read Economic Stability 3.1.

In an interview, Richard Nixon’s domestic affairs aide, John Ehrlichman, stated:

“The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the anti-war left and Black people... We knew we couldn’t make it illegal to be either against the war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news... Did we know we were lying about the drugs? Of course we did.”<sup>82</sup>

It is common practice for prisoners to be forced to work for free. This is supported by the Thirteenth Amendment. Section 1 of the Amendment says: “Neither slavery nor involuntary servitude, ***except as punishment for crime*** whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.” Black individuals are incarcerated in state prisons at 5.1 times the rate of imprisonment of whites. Considering the forced labor and the disproportionate racial makeup in prisons, it is even more apparent that prison labor is slavery with a new name and face.

The Nixon campaign paved the way for Ronald Reagan to put the War on Drugs in full effect. As a consequence, the number of people incarcerated for drug offenses went from 40,990 in 1980 to 452,964 in 2017, a 700% increase less than 40 years later. Harsher sentencing laws, with mandatory minimums and limited parole release, led to longer prison sentences. Also, technical violations of probation or parole led to a considerable amount of repeat incarceration, perhaps due to very minor violations, like breaking curfew or not paying supervision fees. If the parole or probation officer filed a “detainer” because of a violation, the individual would be ineligible for bail.

Two other examples of how the prison industrial complex is set up for a higher incarceration rate are “low-level fugitives” and offense categories. Low-level fugitives are individuals that may have unintentionally missed a court date and now have a bench warrant out for their arrest. The second example, offense categories, is far too oversimplified and includes a wide range of offenses. We know we’re stepping away from facts and numbers right now, because we need you to remember that these are real people, and we’re not willing to let this be as simple as a “facts and figures” conversation. For instance, a person acting as a lookout during a break-in in which someone was accidentally killed can be guilty of murder. Now you may say they shouldn’t have broken into someone’s house or business in the first place; however, many of these offenses are due to circumstance, because they didn’t have the resources (e.g., money for food, etc.) in the first place.

In five states (Iowa, Minnesota, New Jersey, Vermont, and Wisconsin) the imprisonment rate for Black individuals compared to whites is **10:1**.\*

**\*10:1**

*This statistic accounts for the racial demographics for the general population.*

The lifetime likelihood of imprisonment for individuals born in 2001 is 1 in 3 for Black men and 1 in 17 for white men. We know the United States is the leader in many areas, and one of them is the incarceration rate. The Institute for Criminal Policy Research released a brief on the prison population from 223 countries, which showed 655 incarcerated people per 100,000 people in the United States.<sup>83</sup>

However, the Prison Policy Initiative states the incarceration rate as 698 per 100,000 people in the United States.<sup>84</sup> Discrepancies in reporting highlight inconsistent data collection due to a lack of care for the incarcerated, even though the system functions by numbering the inmates instead of naming them. Whether it's 655 or 698 per 100,000 people, the number is alarmingly high. Our current system is designed to accumulate bodies for a slave labor machine and not to enact any espoused value of justice.

The argument is not that any country imprisons people well, but that there are countries that can imagine prison differently. Imprisonment is happening everywhere, but over 2 million people are imprisoned in the United States—a stark difference from any other global north country.

Research indicates that state policies impact the mass incarceration rate. Local jails and state prisons have an almost 2 to 4 times higher incarceration rate than federal prisons. From the pie chart below, there are both prison and jails; the basic difference is that jails are short-term stays and prisons are long-term.<sup>85</sup>

Since 2017, there have been more individuals admitted to jail, 4.9 million, than prison admissions, 600,000. Looking at the total jail admissions, including multiple admissions for some individuals, it totals an estimated 10.6 million people imprisoned. Since jails are meant for shorter term sentences and include people that have not yet been convicted, they have fewer facilities and usually a limited budget. Many individuals that have not been convicted cannot afford to pay their bail amount, which means they must remain in jail while awaiting trial. The median bail amount for felonies is \$10,000 which is roughly 8 months' income for a jailed person who cannot pay their bail.

Bail bonds have become another corrupt business of the PIC. If an individual cannot afford to pay their bail, they can turn to a private bail bond company. These companies take an average of 10 to 15% of the bail amount and any other type of collateral (e.g., car, jewelry, house, etc.).<sup>86</sup> If the defendant does not show up for court, the bond company then pays the rest of the bail, and takes the collateral. There is a tremendous amount of psychological harm and other negative effects for individuals who are in jail because they cannot afford

bail or even a bail bond. Individuals who are unable to pay bail or a bail bond and are imprisoned pretrial are four times more likely to be sentenced to prison than those who were released on bail. One reason is that they will hastily plead guilty to a lower charge even though they're not guilty of their alleged crime.

### *A Closer Look: Preschool-to-prison pipeline*

Many kids are incarcerated and punished as early as preschool. Schools are severely disciplining kids, specifically Black kids, which has proven to increase the likelihood of being hurled into the PIC; this is called the preschool-to-prison pipeline. Black kids in Missouri are 4.5 times more likely to be suspended than white kids.<sup>87</sup> In 2015, young Black boys with disabilities were 20 times more likely to be suspended compared to white girls without disabilities. Roughly 30 to 50% of kids in custody are special education students despite 9% of the general population being special education students.<sup>88</sup> In addition to suspensions, Black kids are more likely to suffer from violent police tactics that School Resource Officers (SROs) use. These suspensions and abusive interactions are used without any hesitation for the smallest of offenses, such as cursing, using a cell phone, or minor insubordination, which is similar to the “broken-windows” theory or zero tolerance policing.<sup>89</sup> There's never a justifiable reason for police brutality, and it's more proof that policing is used for no reason except to uphold white supremacy.

In Kansas City, Missouri, a seven-year-old Black boy named Kalyb Primm Wiley was handcuffed by an SRO because he cried in response to being bullied for his hearing impairment. He was led to the principal's office, handcuffed to the chair and left there until the principal showed up. Kalyb was only 50 pounds and was so traumatized by the experience that his mother had to homeschool him.

Schools with SROs have five times more arrests than schools without them.<sup>90</sup> Not only are these suspended kids more likely to be referred to juvenile court, they're also more likely to drop out of school. 1 in 10 youth who have been arrested, convicted or not, are held in an adult jail or prison. As stated earlier, the PIC doesn't desire a low incarceration rate, it benefits them to have as many incarcerated individuals as possible. This includes children that are incarcerated for kids' stuff (e.g., truancy, running away, etc.), with no care for its negative impact on their social and cognitive development while in the prison system.

## *The economic impact of the PIC*

How does this all relate to economic stability as a social determinant of health? First, let's unpack how it's connected to parts of the United States' economic system. The amount spent on each inmate varies state by state.<sup>91</sup> The higher the incarceration rate, the lower the employment rate. A 2016 study showed this cost: The U.S. economy has \$57 to \$65 billion in lost output annually. According to the Foundation for Economic Education, when prosecuting those with drug offenses, the federal government loses \$80 billion annually. Through the legalization of marijuana, the state could decrease its spending by \$6 billion, and the federal government could decrease theirs by \$4 billion. The less we spend on incarceration, the more the government can spend on welfare programs, education, healthcare, etc. As it stands now, from 1987 to 2007, when states increased their correction spending by 40%, they decided to also decrease higher education spending by 30%. For example, in Kentucky, \$14,603 is spent annually on an inmate, and in New York, \$60,076 is spent on an inmate per year.

Let's not forget that all of these billions of dollars spent over the decades are, of course, taxpayer money. The Vera Institute of Justice found that in 2010, of the 40 states that provided data, the taxpayer cost of prisons is 13.9% higher than the costs reflected in the states' corrections budgets.<sup>92</sup> These extra costs include: retiree health care for corrections employees (\$1.9 billion), employee benefits and taxes (\$613 million), capital costs (\$485 million), health and hospital care for the prison population (\$335 million), states' contributions to retiree health care on behalf of the corrections department (\$837 million), states' contributions to pensions on behalf of the corrections department (\$598 million), and underfunded pension contributions (\$304 million). These extra costs, not reflected in the budget, amounts to roughly \$5.4 billion dollars, with the total price to taxpayers of \$39 billion.

Despite being unbelievably expensive to the taxpayer, the PIC also turns a profit from forcing its prisoners into free labor, and if the incarcerated refuse, they're punished and put into solitary confinement.<sup>93</sup> This labor isn't confined to prison grounds—it's also abused by corporations. Some work in call centers, sew clothes for retailers, and make military weapons; prison labor is an over a billion dollar industry that mainly profits the corporations that exploit prisoners with minimal funds actually used for prison maintenance. Even if prisoners are paid, they're paid an obscenely minimal amount that's close to zero, and they're not considered employees, so they're not offered any type of employment protection or care. And this treatment is legal, validated by the 13th Amendment: "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction." The United States government still blatantly adheres to (and profits from) this amendment, as



**UNICOR**\*<sup>94</sup> makes a half a billion in sales every year, and their mission is to “protect society and reduce crime by preparing inmates with job training and practical work skills for reentry success.” The first part of their mission statement is problematic, because this conveys that inmates are dangerous individuals. On top of that, incarcerated individuals are required to pay half of their earnings, \$0.25 to \$1.15 per hour, to cover any financial obligations, which includes “court-ordered fines, victim restitution, child support, incarceration fees, and other monetary judgments.”<sup>95</sup> They claim this program “benefits everyone,” but how does this benefit the incarcerated if they’re forced into slave labor? Interestingly enough, and to no one’s surprise, the majority of UNICOR’s buyers are other government agencies, including the Department of Defense.<sup>96</sup> Taxpayers fund the PIC and the government makes an obscene amount of money from it.

**\*UNICOR**

*The Federal Prison Industries Inc. rebranded as UNICOR and is owned by the United States government. It is a prison “labor program” for inmates within the Federal Bureau of Prisons and a component of the Department of Justice.*

**Each year spent in prison reduces an individual’s life expectancy by two years.**<sup>97</sup> Not only is incarceration a burden on the federal and state budget, it also has a big impact on health, access to basic needs, and unemployment. In 2015, a study showed that incarcerated people are more likely to have chronic issues, like tuberculosis, or infectious diseases; 20% of prisoners reported having an infectious disease versus 4.8% of the general population.<sup>98</sup> Even with known underreported mental health data, “49% of state prisoners, 40% of federal prisoners, and 60% of jail inmates [reported] symptoms of a mental health disorder, compared to roughly 25% of the adult general population ages 18 to 64.”

Where does the PIC leave the formerly incarcerated? There’s the question of the chicken or the egg: Does lack of resources cause susceptibility to incarceration, or does incarceration lead to limited opportunities post-release and lower health outcomes? The lack of resources not only affects the incarcerated and their families, but the community as a whole as well. The presence of more formerly incarcerated residents in a community has an impact on the non-incarcerated neighbors. The community has less access to opportunity due to limited available workers, less community bonding with the constant flux of individuals going to jail or prison, and often heightened police vigilance. All of this weakens the social network and impacts the local economy, which destabilizes the community and leads back to a likelihood of criminal activity. Families that have a lower socioeconomic status already need financial support, and if one of the caregivers is now incarcerated, their only option is to turn to public

programs, like the Supplemental Nutrition Assistance Program (SNAP). Additionally, children of incarcerated parents are more likely to move or end up unhoused, which has an enormous impact on their future. Also, since incarcerated and formerly individuals are not a protected class, the stigma will legally follow them (and their family) forever.

It wasn't until 2008 that national data on incarceration and unemployment became available, indicating it isn't a priority because the United States and private companies are not inclined to change anything, such as prisoners' right to vote, incarceration for minor offenses, lack of rehabilitation, etc. In 2008, the unemployment rate for formerly incarcerated individuals was 27%,<sup>99</sup> about five times higher than the unemployment rate for the general population. If someone is Black or Hispanic/Latinx, especially if they're a woman, their chances of unemployment exponentially increase due to gendered and racial structural barriers.

Unemployment is highest within the first two years of release, and considering they have no money upon release, they need to get jobs quickly. The Brookings Institute states that once formerly incarcerated folx are employed, they receive an income well below the poverty line. The federal poverty level for a single family household in Missouri is \$12,760. This then impacts their access to housing, healthcare (including mental health support), and increased susceptibility to addiction. Research suggests that had the incarceration rate not increased during a 24-year period, the poverty rate would have fallen by 20% instead of remaining steady or even increasing.

It's been noted that employing individuals that have encountered the criminal justice system can be beneficial to the employer instead of detrimental. For example, call center employees with criminal records had longer tenure and were less likely to quit their jobs. This may be due to being "thankful" for being employed, since they don't have a lot of opportunities in the job market. Some prisons have started different programs, like coding<sup>100</sup> or horticulture and landscaping, to allow prisoners to learn an employable skill and give them better opportunities to find a job outside the construction and manufacturing industries. It is important to note these skills do not guarantee employment, as it is still up to the employer on whether or not to put their biases aside. One study gave employers a set of fictitious resumes that had similar job applicants' skills, but prison record, race, and sex were randomly assigned.<sup>101</sup> Employers were less inclined to hire formerly incarcerated individuals stating their presumed prior experience and had biases that included tardiness and substance use.

There's a need for a shift in the culture, in which the carceral system actually offers support that helps a person grow and adjust, so they are prepared to rejoin society when they're released. Our system claims justice, but doesn't practice it. There are several policy recommendations on how to increase the employment rate for formerly incarcerated individuals, but that would require lawmakers to pass these laws and for companies and individuals to comply with them.

A few of these include:

- Issue a temporary basic income upon release
- Make **bond insurance\*** and tax benefits for employers widely available
- Enact occupational licensing reform
- Implement automatic record expungement procedures
- Ban blanketed employer discrimination
- Enact occupational licensing reform

**\*bond insurance**

*“Bond insurance is a type of insurance policy that a bond issuer purchases that guarantees the repayment of the principal and all associated interest payments to the bondholders in the event of default. Bond issuers will buy this type of insurance to enhance their credit rating in order to reduce the amount of interest that it needs to pay and make the bonds more attractive to potential investors.”<sup>102</sup>*

Some organizations and state legislatures are trying to change policies around post incarceration.

- The Urban Institute evaluated six organizations that were funded for a “Fatherhood Reentry” project. They found that multiple partnerships, such as organizations working with technical schools, community colleges, a variety of employers, and other nonprofits provided a wide network that helped the fathers build skills and increase job opportunities post-release. They also found programs focused on reentry must be willing to advocate for their constituents, to counter the bias and preconceived ideas employers may have of incarcerated and formerly incarcerated individuals.<sup>103</sup>
- There are five states that have reduced their prison population without negatively impacting “public safety”: Connecticut, Michigan, Mississippi, Rhode Island, and South Carolina. They all had varying changes in policies and practices that got the prison population down by 14 to 25%, depending on the state. The key strategies for all five states were: measures to get justice reforms underway and maintain momentum, decreased prison admissions via fewer new prison commitments, decreased prison admissions via reduced incarceration for failure on community supervision, increased prison releases via increasing the feasibility and/or efficiency of release, [and] increased prison releases via requiring less time served before eligibility for release.<sup>104</sup>

However, this is putting a Band-Aid on a broken system that's built off policing and saying incarceration is essential; the actual answer is abolition. Ironically, incarcerated and formerly incarcerated individuals do not have the right to vote, so the policies that are written into law are voted for by non-incarcerated individuals. The YouTube clip "Defending Prison-Based Gerrymandering"<sup>105</sup> shows how gerrymandering is used for a politician's gain and negatively impacts the people in the PIC. This lack of right to vote prohibits them from participating in democracy, voting for policies and programs that would actually benefit those directly and indirectly affected by the PIC.

### *How did we get to our current PIC?*

"Prison has become a black hole in which the detritus of contemporary capitalism is deposited. Mass imprisonment generates profits as it devours social wealth, and thus it tends to reproduce the very conditions that lead people to prison." —Angela Davis

Four hundred years later, we've proven that we are still a nation that must depend on a slave labor force to support our basic societal functions and without any regard for their and their families' well-beings. And we do so by trading the humanity of over 2 million currently incarcerated people in our country and the millions more that have served their time and been released, but must forever bear the scarlet letter of "formerly incarcerated."

There's this binary notion of "good" or "bad" in our justice system, and the more marginalized identities you hold, the more likely you are deemed "bad" before you even get the right to defend yourself. This is why we should abolish the prison industrial complex.

Ideally we could simply advocate for taking down the prison industrial complex, but most lawmakers aren't going to listen to moral arguments or how it negatively impacts the population as a whole. There is the assumption that formerly incarcerated individuals are inherently bad and lazy, therefore they don't deserve an opportunity to have a job, family, or access to basic healthcare. This is why it's important to understand the economics of it as well, because it's helpful to know the facts when it comes up in conversation. Another point to consider is the difference between reform and abolition. Just like police reform has proven to not reduce police brutality, the same goes for the PIC.

## *Disparate Outcomes*

**RACE** It is almost impossible to talk about the PIC without talking about systemic racism and the history of Black people in this country. A big example is the opioid epidemic that is currently happening, and it wasn't until it started affecting white individuals that it was called an epidemic instead of just the "War on Drugs." In the same light, the punishment for crack cocaine is significantly higher than the punishment for powdered cocaine; the former is associated with Black drug users and the latter is associated with white drug users. The only chemical difference between the two is that crack has water and baking soda, making crack cocaine a cheaper version of powdered cocaine. An individual in possession of powdered cocaine would need 100 times the punishable amount of crack cocaine to receive a similar sentence.<sup>106</sup> This stems from the Anti-Drug Abuse Act of 1986, predicated on the idea that individuals in possession of crack cocaine were more likely to be in possession of a firearm, however, in 2000 it was found that less than 3% of crack cocaine offenders had firearms. In 2010, Barack Obama changed the punishment for crack cocaine and powdered cocaine from 100:1 to 18:1; however, this law was not retroactive and did not reduce or increase any sentencing for individuals under the 100:1 ratio.

Discriminatory treatment by both the police and courts markedly heightens the likelihood of incarceration among people of color and poor people in all racial groups. Incarceration then leads to worse health through exposure to an array of unhealthy conditions both during incarceration (including overcrowding, violence, and poor sanitation) and after release (including social exclusion and marginalization, as reflected in barriers to employment and therefore earnings). Social exclusion and marginalization in turn lead to greater poverty, powerlessness, and homelessness, further exacerbating the risks of poor health. This diagram is a simplified representation of a complex process. For example, racism, lack of economic opportunity, and prejudicial treatment by police in themselves can each lead to ill health—independent of whether incarceration occurs—such as when a person's ability to afford decent housing or healthy food is limited, or when use of excessive force by the police results in injury.<sup>107</sup>

**GENDER** LGBTQ folx imprisoned: highlighting transgender women

Currently, in most states, individuals are imprisoned “by the sex assigned at birth or according to genital characteristics.”<sup>108</sup> This increases chances of mistreatment, violence, and sexual assault for transgender and gender nonconforming (TGNC) individuals. There are not many policies in place to protect TGNC folx, but this is very slowly changing on a case-by-case basis. The case of *Passion Star (aka Zollicoffer) v. Livingston*, addressed Passion Star’s 14 years of physical and sexual abuse endured as a Black transgender woman who was placed in Texas’ **male\*** prisons.<sup>109</sup> She had filed grievances with the Texas Department of Criminal Justice after these numerous vicious assaults, but was told to “‘suck dick,’ ‘fight,’ or to stop ‘acting gay’ if she does not want to be assaulted.” Girls and women of color and girls and women that identify as LGBTQ are disproportionately imprisoned and have longer sentences. It can be hard for an incarcerated white male to find employment post-release, several degrees harder for Black men, and severely difficult for a Black transgender woman to find stable employment and housing post-release. Research and data collection for transgender women has recently increased, but there are still many gaps present. The lack of data collection then impacts the policies and provided services. Numerous studies that look at the criminalization of drug use, homelessness, etc. exclude the experiences of transgender women even though they are disproportionately policed.<sup>110</sup> The studies that do include transgender women are mainly around anti-prostitution laws, ignoring all other factors that contribute to poverty and criminalization. Many public service organizations gender their programs (for example, domestic violence shelters and drug treatment facilities), and laws regulate access to public space based on gender. Combined, this highlights the shaping of transgender poverty. One study states, “the carceral production of transgender poverty demonstrates that criminalization is not only a consequence but also a cause of both poverty and inequality.”<sup>111</sup>

**\*male**

*The reason we are only using male and female terminology throughout this section is that it’s what the system uses and the only data they collect. This shows the inherent violence and abuse that the PIC inflicts by operating in a strict and arbitrary gender binary.*



### *A Closer Look: Men and fatherhood*

The high incarceration rate for Black men created false narratives that Black men are absent and careless fathers. They have similar values compared to white fathers and polled higher when asked how important it was for fathers should actively provide direct care to a young child.<sup>112</sup> Black fathers are more strongly tied to notions of direct parenting. In spite of all the barriers Black men face—policing, economic inequality, poorer health outcomes—they still are engaged in their child’s lives, more than white fathers are with their children, knocking the myth of the “absent Black father.” These stereotypes are willfully ignorant and steeped in bias from a white supremacist culture.

### *A Closer Look: Women in jail*

With women, the high number held in jail pre-trial can be due to their lower income compared to incarcerated men therefore making them less likely to be able to afford bail. Formerly incarcerated women are also more likely to be homeless compared to formerly incarcerated men, due to lower incomes, childcare costs and availability, and limited post-release programs for girls and women. Due to the financial burden, women are more likely to be incarcerated due to parole and probation violations than their alleged crimes, and Black women are even more burdened with these barriers.<sup>113</sup>

As stated earlier, Black and Hispanic individuals, specifically women, face the highest rates of unemployment. Formerly incarcerated Black women have an unemployment rate over 2 times higher than formerly incarcerated white men’s unemployment rate. Also, while nearly all formerly incarcerated white men hold full-time jobs, most formerly incarcerated Black women only hold part-time jobs. Once again this highlights intersectionality and how Black women endure the highest amount of discrimination.

## *A Closer Look: Children and families*

Children need, at minimum, a stable support system, healthy environment, and proper care and nutrition for their positive well-being and decreased chances of experiencing negative developmental impacts. Children of incarcerated parents and other close relatives are not set up for positive well-being. They are more disposed to have psychosocial issues and economic difficulties and have increased chances of school expulsion or criminal activity. Research has shown that children who have regular visitation are less likely to suffer from adverse mental health outcomes during<sup>114</sup> or even following parental incarceration.<sup>115</sup> This can then increase chances of better emotional well-being and better behavior in school. Also, the consistent or frequent visitation between children and their incarcerated parent(s) can increase chances of the parent(s) regaining custody after their release.

Although women are usually the primary caregivers and not considered a flight risk, they are still held behind bars with limited contact with their children. The impact this has on their families and children is great, especially without the lack of support and weakened bond. Children with incarcerated mothers are put into situations that are very likely to cause clinically significant mental distress, such as depression and anxiety, because a major factor in every child's protective environment (their parent) has been taken away. This puts them at greater risk for dropping out of school, which then has an impact on their job opportunities and socioeconomic status when they become adults.<sup>116</sup> Single mothers whose husbands or partners are incarcerated are more likely to have mental health issues, addiction, and an overall increase in stress, which will most likely impact their ability to be able to be fully present and a solid support system for their children.

Some policy recommendations are increased accessibility, such as placing incarcerated parents in a facility closest to home and minimizing the trauma from search policies, reducing or removing costs of telephone calls, and allowing video visits. For instance, Shamika Wilson-Johnson's husband was incarcerated in California, so she moved with their two kids from Georgia to California so their family could be closer to him.<sup>117</sup> The cost of living is already significantly higher, and the travel costs to visit him in prison can be upwards of \$500. They have sometimes lived in homeless shelters, because she has to support her family, attend school, and put phone minutes in her husband's prison account. If video visits were allowed, their family would have the ability to afford rent and not have to choose between basic needs or seeing their incarcerated partner/parent. Over 5 million children have parents who are in or were in the PIC;<sup>118</sup> think of the generational trauma and continued imbalance of access and opportunities.

# ENGAGEMENT GUIDE

## *Step 1: Reflection*

1. What connotations does the word *reform* bring to your mind? Many of the sources we cite have reliable and good information, and simultaneously they are cogs in a capitalist machine. Where is it that reformation won't address all of the issues and consequences of incarceration? Where is it that abolishment has more benefits?
2. If you have not directly known someone incarcerated, how do you think this still impacts the community?

## *Step 2: Family Discussion*

1. What impact can the juvenile system have on children?
2. Consider juvenile facilities. How do you think this trauma will impact them in the immediate and distant future?
3. What is considered a “good” job for previously incarcerated individuals?
  - a. What wealth are they building?
4. Think about the jobs mentioned in this section that previously incarcerated folx have—do the employers have insurance? Are they under-employed there?
  - a. What does it mean to not have insurance?
5. Where can oversimplification sometimes be a bad thing? What are examples in which something that may seem like a small act that might not be popular end up having a large negative or positive impact? How do we get more comfortable with messy systems instead of getting attached to the simplest and potentially incorrect explanation?
  - a. One of the researchers who came up with the “broken-window” theory of policing later said, “It's to the point now where I wonder if we should back away from the metaphor of broken windows. We didn't know how powerful it was going to be. It simplified, it was easy to communicate, a lot of people got it as a result of the metaphor. It was attractive for a long time. But as you know, metaphors can wear out and become stale.”<sup>119</sup>

## ENGAGEMENT GUIDE

### *Step 3: Group Discussion*

1. Over 113 million adults have an immediate family member who's been in prison or jail in the United States. In what ways do you think this impacts the families, communities, and larger society?
2. Thinking back to the “broken-window” theory of policing, how else does whiteness end up doing more harm when they intended to do good even when they explicitly state a limitation or concern?
  - a. George Kelling and James Q. Wilson, the researchers who came up with this theory to reduce crime rates, based on a study done by Phillip Zimbardo, stated “How do we ensure ... that the police do not become the agents of neighborhood bigotry? We can offer no wholly satisfactory answer to this important question.”<sup>120</sup>
3. Which elections/elected officials should we be calling on to change the state policies that impact the mass incarceration rate? Also, think about abolition, and people that are being abused right now—who can change that?

### *Step 4: Explore More*

1. After reading Ta-Nehisi Coates’ “The Black Family in the Age of Mass Incarceration” from *The Atlantic*,<sup>121</sup> how did the individual stories impact your larger perspective on mass incarceration in the Black community?
  - a. Do you think you would have supported some of the ways the PIC is used to bolster the economy prior to reading this section? How has this section shifted your mindset on the incarcerated?
  - b. Review GlobalTel’s list of companies that use prison labor.<sup>122</sup> How much of this list surprises you?
  - c. Recall the systemic financial exclusion that women face from **Economic Stability 3.1**. How might a formerly incarcerated Black woman have these same systemic exclusions compounded upon their reentry?
2. Watch “Angola for Life”<sup>123</sup> and read “American Slavery, Reinvented” from *The Atlantic*.<sup>124</sup>
3. Watch “Mass Incarceration, Visualized” from *The Atlantic*.<sup>125</sup>
  - a. This short clip does a good job of highlighting a larger issue and impact of incarceration, specifically in the Black community in under three minutes; however, what is the main missing point in the video?
4. Read Angela Davis’ book *Are Prisons Obsolete?* and watch her talks on prison abolition
  - a. How does the PIC support capitalism, and how do we even get to abolition?

## ENGAGEMENT GUIDE

5. Ava DuVernay directed a miniseries, *When They See Us*, that was based on the Exonerated Five, formerly known as the Central Park Five. She closely worked with the Exonerated Five to try to accurately depict the events that happened.
  - a. Before watching the miniseries how did you perceive the Exonerated Five? Were they kids? Young men? From supportive homes?
  - b. Where did the system fail them?
  - c. One of the lead prosecutors wrote an op-ed<sup>126</sup> after the release of the documentary, defending her name. What aspects of white fragility are showing up?
6. Review the resources compiled by Critical Resistance.<sup>127</sup>
7. Read the ACLU's report on the School to Prison Pipeline<sup>128</sup> not only as a source for information, but for ways to be engaged in advocacy
8. Watch the film *13th* on Netflix.<sup>129</sup>
9. Read through the Prison Policy Initiative's Economics of Incarceration Resources.<sup>130</sup>
10. Listen to podcast *Ear Hustle* for stories about inmates while in prison and post incarceration.<sup>131</sup>
11. Listen to *Prison Project Podcast*<sup>132</sup> about the "impacts of incarceration on marginalized communities, the ethics of the death penalty, mental health and recovery court, legal trends in bioethics, solitary confinement, and much more."
12. Listen to additional podcasts about abolition
  - a. *Beyond Prisons*<sup>133</sup>
  - b. Imagine Black Presents: Abolition Learnings<sup>134</sup>
13. Listen to the Wrongful Conviction Podcast<sup>135</sup>
14. Read Angela Y. Davis' *Are Prisons Obsolete?*<sup>136</sup>

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## UNIT 4

# *NEIGHBORHOOD & BUILT ENVIRONMENT*



# NEIGHBORHOOD & BUILT ENVIRONMENT

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## ***4.1 Food Availability and Security***

### Disclaimer

In this section, there's discussion about people in larger bodies (hereafter referred to as "fat" as opposed to other associated terms) and the relationships, barriers, and stereotypes they encounter navigating the world, but most especially, the world in pursuit of health. As we have discussed at great length throughout this project, so many systems and experiences impact our health. When zooming in to focus on the medical community that is in charge of regulating and setting health standards, many people with various identities are left out of the consideration and creation of those standards.

There is one disclaimer that feels vitally important to preface this content with: what constitutes "health" is arbitrary. "Health" is determined by standards developed without the inclusion of many people, for reasons rooted in white supremacy, as well as other layers and nuances that are far too numerous to name. Equally important to the arbitrariness of health and its standards is that health inherently has a positive judgment associated with it at an individual level. Also mentioned many times, shifting the responsibility to an individual obscures the ultimate culpability that a system should bear for perpetuating harm on the people it's designed to serve.

For those reasons, keep in mind as we go through this section that none of it is intended to give advice on health practices. Simply put, we won't be using "health" as a measure of goodness or worthiness. Instead, we enter this conversation rooted in the ideal that all people, no matter the body they have lived in, do live in, or will live in, should be immediately valued and treated as a person with equal value to any other body.

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It's hard to have a conversation about food without some value assignment taking place. From the start, there are “healthy” foods and “unhealthy” foods; cheap or expensive foods; rich or lean foods; organic or non-organic foods. There are many pairings, and all of them usually come with some sort of positive and negative bend, with individuals making the choice to select something “bad” or “good.” Time after time in this project, we've illuminated the ways that systems are designed to shift their intentionally designed failings as individual responsibilities; therefore, it should come as no surprise that our food system (including food bought out and brought home) in the United States, worth over 2 trillion dollars,<sup>1</sup> is another place where obfuscation is occurring.

If we put down the idea of food and the pursuit of the positives associated with it as individual responsibilities, then we can pick up the system's responsibility to food, which brings us to food security. Food security as defined by the UN is “all people, at all times, hav[ing] physical, social, and economic access to sufficient, safe, and nutritious food that meets their food preferences and dietary needs for an active and healthy life.”<sup>2</sup> In the United States, roughly 10% of the entire population is considered to be some level of food insecure, with some specific subsets (such as households with children or households with a single woman heading it) being disproportionately represented.<sup>3</sup> Many factors that we've already reviewed go into food security (for example, education, access to wealth, gender and income, etc.). Increasing long-term accessibility to a variety of “nutritious” foods is an important element of food security. And the immediate rhetoric that does the most harm and distracts systems-level objectives away from sustainable, equitable improvements is the should-dos, dog-whistle, blame-and-shame cycle directed toward people who struggle with food insecurity. The people this rhetoric attacks are also, oftentimes, fat.

In the United States, of the roughly 20% of adult people who are considered food insecure, about 42% are also classified as O-word.<sup>4</sup> The link between food insecurity and fat people, also referred to as the *food-insecurity-O-word paradox*<sup>5,\*</sup>, is another wide-spread example of systems being designed in a way that fails individuals yet holds them solely accountable for “their failure,” or in the case of O-word, their “disease.”

***\*food-insecurity-O-word paradox***

*Simply put, the “baffling” phenomena that a person living with food insecurity is also fat. It is considered a paradox, because the expectation is that for one to be food insecure means that one would also be “underweight” and “malnourished.”*

A quick note about the O-word: we're not going to use it in this section. It is a word that is applied as the name for a disease, a designation to mean everything and nothing all at once, while, most importantly, pathologizing fat people. The O-word is calculated by the Body Mass Index (BMI), a useless tool that is both sexist and racist (for more on BMI, see the Gender Disparate Outcome section). We'll be referencing the O-word, because that is the reductive term that overwhelmingly represents the fat population in research and literature at this time. For the purpose of this content, we'll generally be using fat and the phrase "O-word" interchangeably. If you'd like to start reading more about why the O-word was intentionally excluded, you can start your reading with "What's in a Word? On Stigma and Terminology" from *Frontiers in Psychology*<sup>6</sup>.

Before going further, it's important to note that not all fat people are food insecure and not all food insecure people are fat. There are many factors that can contribute to either fatness or food insecurity, and people who are at the intersection of both are likely to have elements that exacerbate each other. Since the connection between food insecurity and fatness is so strong in the reported data and so distorted in our cultural reality, people living at this intersection have to manage and navigate a life of compounding stigmas and tangible and intangible systematic consequences. These are designed to limit their access to broader physical and social environments.

The arbitrarily set, Western ideal of a "healthy" body says that for a body to be "healthy" or desirable, it needs to be underweight by the Body Mass Index (BMI) measurements (as seen in "The Real Ideal: Misestimation of Body Mass Index"<sup>7</sup> and "The Body and the Beautiful: Health, Attractiveness and Body Composition in Men's and Women's Bodies"<sup>8</sup>). That ideal is rooted in the racist and eugenics work of Darwin and other race "scientists" who used fatness and other body characteristics to place most BIPOC at the bottom of a manufactured hierarchy, with white men at the very top and Black people at the very bottom. Despite around 80% of societies historically favoring fat bodies as the ideal, white supremacy and patriarchy in the United States justified/justifies slavery, racism, classism, and control of women by weaponizing fatphobia.<sup>9</sup>

The way the fatphobia weapon is wielded has incredibly detrimental costs for fat folks in need of medical care.

Fat people are automatically assumed to be unhealthy and undesirable. There are many unconscious judgments externally and internally placed on fat people that make it more difficult for them to get treated with respect or humanity in medical settings. O word people are treated as though their "disease" is their fault, and because they are "responsible" for "choosing disease," there is instantly an unsavory aspersion cast on them whenever they do seek help for a (non-fat related) medical issue. Weight stigma/bias is harmful to the overall

well-being of fat people. It is a condoned discrimination and reported at rates comparable towards that of racism.<sup>10</sup>

Here are some examples of the condoned discrimination against fat people:

- Fat people are 52% more likely than thin people (determined by BMI) to try out new primary care physicians over a two-year span and 80% more likely to go to the ER for treatment that could be administered in a primary's office,<sup>12</sup> all of which potentially speaks to the discomfort fat people feel when going to a medical setting and therefore preferring to get care in a way that anonymizes them.
- Current medical "best practice" condones problematizing individual fat bodies in medical settings, which can alter the rest of a person's life. Patients who undergo bariatric (weight-loss) surgery, for example, must take a vitamin supplement everyday for their lives, or become horribly sick since their bodies are no longer able to adequately absorb vitamins and minerals.<sup>12</sup>
- Weight stigma is a risk factor for inflammation, stress, high blood pressure, increased blood sugar and risk of Type 2 diabetes, depression, anxiety, disordered eating behaviors, and weight gain.<sup>13</sup>
- Weight cycling, the repeated loss and regain of weight, more commonly seen in fat people, is associated with higher death rates. Mortality rates of people who weight cycle are higher from cardiovascular disease, risk for heart attack, stroke, diabetes, high blood pressure, and suppressed immune function. "Despite weight cycling's detrimental effects on health, it is often not considered as a confounding factor in research that investigates the relationship between body size and health, [making it] hard to say for certain whether worse health outcomes in larger-bodied people are due to weight itself, or due to confounders such as weight cycling."<sup>14</sup>
- The prescription that the medical establishment mandates to fat people is to lose weight in just about any situation. However, food restriction (which is not synonymous with fasting) puts our bodies in starvation mode and is harmful. Through decades of weight loss research (most of it funded by weight loss and drug companies, influencing what is funded and published), we know that dieting doesn't work—intentional weight loss fails 90% of the time.<sup>15</sup>

Added all together (plus many more we haven't delved into), the facts above paint a dispiriting picture of what fat people must guard themselves against in medical settings. This is only in the context of healthcare. It does not touch any other systems mentioned in this project (for example, education or employment) but rest assured, weight stigma and bias are alive and thriving in those places as well.

Bringing food insecurity back in, where does that leave us? Fat people are not given useful, meaningful information on the intersections between our healthcare, access to food, and

daily discrimination in everyday settings. On the food side of things, fat people could be missing a myriad of different puzzle pieces that contribute both to their food insecurity, and also exacerbate their status as a fat person navigating the world. They could be located in a food desert, not have the resources to procure food that is “nutritionally” dense, experience weight discrimination as a fat person that affects the education and employment they receive—the list and complexities go on and include a fat person’s humanity. Missing from the above content is the social-emotional well-being of fat people. Experiencing weight shame/stigma for so much of life inhibits one’s ability to safely explore the world for the purpose of enjoyment (food, sexuality, movement, etc.).

It’s also important to note that when all of the theoretical “solutions” for food insecurity swirl about, we apply morality to food. The same fallacious reasoning is applied to people we are socialized to think of as “deserving” to become food secure. We are not taught to prioritize the needs, wants, and power of fat people when we’re discussing food security, despite the disproportionate impact these systems failings have on them. Designating who is deserving is a tool of capitalism and white supremacy that only creates deeper disparate outcomes. These systems want to be self-sustaining, and the blame-and-shame cycles further that agenda.

## *Disparate Outcomes*

**RACE** In her book, *Fearing the Black Body: the Racial Origins of Fat Phobia*, author Sabrina Strings outlines the creation of fatphobia in the West as a tool to villainize people, particularly Black women, through the slave trade, colonization, and “race science” propaganda.<sup>16</sup> To uphold white Anglo people as the standard for “purity” while simultaneously cementing pathways to subjugate enslaved people, race “science” began to cast Black people as voracious in regards to food and sex, or put another, more basic way: animalistic imperatives. The larger bodies of enslaved Africans became the “proof” of this claim. Despite the previous societal preference for large bodies, white supremacy quickly snapped to create justification upon justification to reinforce this body ideal. Sometimes this “appetite” was referenced as a foregone conclusion and used to prop up another “finding” of race “science,” as was the case with Samuel Cartwright’s theory of drapetomania. Other times, the supposed appetite was exhibited as the focus of the justification, as with Saartje Baartman.

Samuel Cartwright was the Civil-War era Confederate doctor who coined the “medical diagnosis” of drapetomania—the mental illness afflicting enslaved people who tried to break the bonds of their enslavement. In his published journal article detailing the particulars of this “illness,” he characterizes enslaved Africans as people with

Such little command over [their] own muscles, from the weakness of [their] will, as almost to starve, when a little exertion and forethought would procure [them] an abundance. Although [they have] exaggerated appetites and exaggerated senses, calling loudly for their gratification, [their] will is too weak to command [their] muscles to engage in such kinds of labor as would readily procure the fruits to gratify them.<sup>17</sup>

The use of the “exaggerated appetites and senses” as a known “fact” of Black enslaved people helped both establish the “discovery” of drapetomania, while reasserting the depiction of Black people as gluttonous savages.

Saartjie Baartman, on the other hand, was used to explicitly advance the propaganda of the difference inherent in Black bodies being not white and therefore being wrong.<sup>18</sup> Saartjie or Sarah was a Khoikhoi woman tricked and enslaved into traveling England and Ireland as a circus-eque freak/side-show. The main attraction was her body: “short, not quite five feet, ... and very curvaceous... [with] big hips and a big bum.”<sup>19</sup> For years she was exhibited for the “peculiarity” of her body, put on display in various stages of undress with people paying more for the “right” to touch her. “Naturalist scientist” George Culvier hailed her as the link between animals and humans and ensured her continued sexual exploitation for centuries by pickling her brain and genitals and showcasing them in Paris’ Musée de l’Homme, where the pieces of her body stayed on display until 1974. It took 28 more years for her body to be removed from France’s museum storage and returned to South Africa to finally be laid to rest.

Highlighting Black bodies’ differences to white bodies and judging them as inferior was an important dehumanizing tactic that helped us arrive at our society’s fatphobic present. With fatness and Blackness having such analogous origins, it should come as no surprise that the CDC reports non-Hispanic Black adults as having the highest prevalence of O-word of any racial group (38.4%), despite being less than 15% of the U.S. population.<sup>20</sup>

**CLASS** As we’ve discussed many times throughout the project, health is easier to access if you have the cash to do so. With prevailing Western thought including thinness as part of the definition of health, that still holds true. The two options presented for “achieving health” are striving for weight loss on your own or opting for medically-assisted interventions. Both help an individual pursue thinness and reject fatness; because while it is essentially impossible to lose weight permanently,<sup>21</sup> there is a more positive association with fat people actively trying to lose weight. Both non-medical or medical weight loss paths come with an explicit price tag.



The actual cost that an individual is able to pay also directly correlates with how much weight they can lose. Take, for instance, a study out of Duke's Global Health Institute. They compared popular weight loss programs and popular weight loss medications to determine the cost effectiveness of each intervention. With their selected "interventions," they reported losing a kilogram of weight cost anywhere from \$155 to \$338.<sup>22</sup> Additionally, they also reported that people who participated in the most expensive weight loss "intervention" that cost upwards of \$2,500 a year, also lost the most weight. Finally, included at the bottom of the report's findings is a disclosure regarding the principal investigator's conflict of interest—having a history of being a paid consultant for more than half of the weight loss "interventions" selected for comparison. This brings us to another primary motivation of our fatphobic society, apart from anti-Black racism: money.

The 2022 weight loss industry in America is worth more than 70 billion dollars<sup>23</sup> (put another way, roughly 15 billion dollars less than all of the money that was spent on all elementary, secondary, and vocational education in the whole country<sup>24</sup>). This industry includes weight loss programs, meal replacements/appetite suppressants (bars, shakes, pills, etc.), health clubs, weight loss technology and apps, and medical weight loss "interventions" (prescription pills, surgery, etc.)<sup>25</sup>, to name the most familiar culprits. And that \$70 billion+ is expected to sustain and grow in the coming years, especially as people try to shed pounds after the lockdown portion of COVID.

Unfortunately, the disregard for the lives of fat people that we've seen throughout this section only acts as fuel for the weight-loss machine. And even more perversely than in other places that we've seen, the very fact that weight loss doesn't work is what keeps the companies raking in the dough, the ultimate win for the company—loss for the people. Those seeking to lose weight will either be on the hamster wheel of fad-dieting, hoping that this particular combination of food/liquid will be the silver bullet, or regain the weight. Once the weight is back on, chances are that folks will now have even more weight to get rid of when they try the next diet in the line up.

That cycle is where the danger and the cost lay for the average fat individual. Not to the 70+ billion dollar industry, but to the people who weight-cycle through it, and increase their risk for heart attack and stroke.<sup>26</sup> Not to the investigator at Duke's Global Health Institute who was both paid for their research contributions and to consult for companies of the very "interventions" they were studying; but to the people who took part in that research taking the drug Lorcaserin, which was pulled from the market in 2020 for increasing a person's chance of cancer.<sup>27</sup> Fat people are expected to pay for their "sin" of being fat through their wallets and with their very lives.



**GENDER** At the very heart of all the justifications for why one shouldn't be fat is the Body Mass Index (BMI). Through a simple calculation, one's height and weight contribute to a number that will tell medical providers just how "healthy" a person is, based on where they fall in the range. For our purposes (and in just about every conceivable application outside of that), the range of what is considered "good," "bad," or "middling" isn't remotely important. What is of the greatest interest to this on-going discussion is where the history of BMI fits in alongside the development of all the other fatphobic ideals and practices we have today and how it perpetuates a cycle of harm against fat people.

For a quick history on BMI and why it matters so much to the medical establishment, we'll first pop back to the early 1800s and Adolphe Quetelet's quest to articulate an average body to cast as the "ideal" body.<sup>28</sup> Quetelet, like all of the other "scientists" we've traced back to this time in fatphobia's history, was a eugenicist and is credited with the creation of BMI included among other racist theories he contributed to the race "science" field.<sup>29</sup> For his Index, he looked at a sample of French and Scottish men's weights and labeled the resulting bell-curve overweight, ideal weight, and underweight.<sup>30</sup>

The beginning of the 20th century had insurance companies linking "excessive" weight with decreased life expectancy among their paying life-insurance customers,<sup>31</sup> and they sought to find a quick and easy way to better determine the "health" (read: weight relative to the now century-old "standard") of potential policy-holders. Enter Ancel Keys in the 1970s. He took Quetelet's Index and replicated the sampling done with five populations of majority white men from the United States, Finland, Italy, Japan, and South Africa to create the Body Mass Index (BMI).<sup>32</sup> Despite Keys and colleagues noting a limitation of their tool not being applicable to the South African Bantu population of men included in the study,<sup>33</sup> by 1985, the National Institute of Health was using BMI as the primary factor in determining a person's O-word status.<sup>34</sup>

BMI is so crucial in the larger discussion of fatphobia, because it is the main weapon utilized in the "War on O-word". The campaign began with the CDC declaring that O-word was a leading cause of death in America,<sup>36</sup> trailing just behind smoking, and the efforts of eliminating O-word were subsequently co-signed by different government offices (the Office of the Surgeon General,<sup>36</sup> First Lady Michelle Obama's Let's Move Campaign,<sup>37</sup> etc.), reinforcing the discrimination already happening in medical settings across the nation.

The discrimination that BMI encourages isn't applied evenly across populations: **cis\*** women and **transmasc\*** people tend to have higher BMIs than cis men and transgender women,<sup>38</sup> which should come as no surprise since both sampling efforts that contributed to our present-day BMI did not include either groups to generate their definition of "average" or "ideal." Compared to the bodies cis men inhabit, there is a shocking lack of curiosity in investigating

the ways that the bodies of cis women differ. The dearth of information goes on to endanger cis women, transmasc, and nonbinary people in non-weight related medical situations, and is compounded when weight does become part of the equation.

**\*cis**

*Cis in relationship to identity refers to a person whose sense of personal identity and gender corresponds and aligns with their sex assigned at birth.<sup>39</sup>*

**\*transmasc**

*A person who was assigned female at birth who identifies with a gender on the masculine end of the spectrum.<sup>40</sup>*

To start, there are layers to the discrimination experienced and the ramifications to long-term well-being across the gender spectrum, and capturing just how deep the disparity is for LGBTQ+ people still remains to be seen,<sup>41</sup> as evidenced by the fact that **sex and gender\*** are two separate facets of a person, but are often conflated and co-mingled when applied to LGBTQ+ populations.

**\*sex and gender**

*With limitations present in our medical systems currently equating sex and gender as one and the same, we'll also be replicating some of those imperfect, confusing practices. This is primarily due to the data available that we are able to find and apply to any given domain content.*

Beginning with the layer that we are socialized to be more familiar with some of the barriers that fat cis women face in the medical establishment include:

- Being far more likely to be misdiagnosed than (cis)men for heart attack, autoimmune diseases, and sex-specific diseases.<sup>42</sup>
- Compounding this risk for fat cis women is the fact that just being fat (or “weight-distracting”) also puts them at the risk for misdiagnosis.<sup>43</sup>

Zooming in specifically on fat LGBTQ+ people (primarily cis women and transmasculine people), barriers abound still:

- Studies have found that weight may be more stigmatized for sexual minorities compared to their straight counterparts.<sup>44</sup>
- “Both fat people and transgender people are categorized as not credible, as morally and medically deviant” and therefore not deserving of the same care and consideration that a thin (as defined by BMI), cis person would be.<sup>45</sup>
- Studies have pointed to increased BMI as a potential long-term consequence of gender affirming hormone therapy,<sup>46</sup> which, with our fat and transphobic society, has concerning implications for the accessibility and availability of gender-affirming care. If BMI is directly correlated to early death, then that could be used as a justification for denying transgender people the care they need.

Weaponizing BMI as a means to deny people in gender and sexual minorities’ medical care that recognizes them as full humans means that fat cis women, transmasculine, and nonbinary people will continue to pay a “fat tax”<sup>47</sup> with their well-being.

## ENGAGEMENT GUIDE

### *Step 1: Reflection*

1. Da'Shaun L. Harrison, author of *Belly of the Beast*, when talking about health says, "For one to be healthy, they not only must be non-disabled, but must also be in an environment that allows for them to be mentally secure, physically safe, and socially well. As such, this means that Black people, especially those of us who exist with multiple marginalized identities are always, already unhealthy."
  - a. How do you define "health" for you and your body? Do you have any identities that would disqualify you for "health" by Harrison's standards?
2. What is your personal experience with fatness? If you've ever been on a diet or pursued other methods of losing weight, what were the motivating reasons behind doing so? What ideal was it in pursuit of? How did you define your goal (in terms of a number on the scale, a specific body type, body feeling, etc.)?
3. If you live or have lived in a larger body, in what ways did you modify yourself to fit spaces not designed or intended for your body?

### *Step 2: Family Discussion*

1. What is your family's ethos around "health?"
  - a. Come up with a definition and elements that show up in how "health" is sought in your family.
2. Does your family often prescribe moral judgments to food (for example, "junk food" in the form of sugary food or high-carb food, "healthy food" in the form of fruits or vegetables, "safe/dangerous food" in the form of food that causes allergic reactions, etc.)? Why or why not? What would the harm or benefit be in changing your ways from what they currently are?

# ENGAGEMENT GUIDE

## *Step 3: Group Discussion*

1. What are people's individual definitions of "health?" Where is there overlap? Where are there differences?
2. What associations do you have with the word "fat?" With the "O-word" or "overweight?"
3. When do you think it is ok to use "fat" in conversation with people? When does it not feel ok?
4. Weight and money go hand in hand in our capitalist society, and that is incredibly apparent throughout the above content. What are some of the weight-cost relationships that are on your mind after reading?
5. Having large body features is not always considered an undesirable thing (e.g. being very tall while being thin (according to BMI), intentionally added muscle, surgically enhanced features, etc.). Where do you think the line is drawn in society's eye when "good big" becomes "bad big" or just plain fat?
6. The prescription that the medical establishment mandates to fat people is to lose weight in just about any situation. However, food restriction (not fasting and not restricting food branded as fasting) puts our bodies in starvation mode, which is harmful.<sup>48</sup> What are some of the differences you can highlight between restricting food intake and fasting from food?
7. This section doesn't look at the mental health or social implications and cost of being fat in a fatphobic society. What are some ways you imagine internalized fatphobia hinders a person mentally or socially?
8. In what ways is our society built to shame and exclude fat people?

## *Step 4: Explore More*

The content of this entire section was heavily influenced by activists in the fat liberation movement and authors contributing to that body of work. Below are the individuals and groups that can help encourage your thinking as you delve more deeply into the fat liberative world.

1. The Fat Doctor Podcast with Dr. Asher Larmie<sup>49</sup>
2. Unsolicited: Fatties Talk Back podcast with Marquisele Mercedes, Caleb Luna, Bryan Guffey, Jordan Underwood, and Da'Shaun L. Harrison<sup>50</sup>
3. The Belly of the Beast: The Politics of Anti-Fatness as Anti-Blackness by Da'Shaun L. Harrison.<sup>51</sup>
4. Da'Shaun Harrison's interview with Left Bank Books<sup>52</sup>
5. Fearing the Fat Body: The Racial Origins of Fatphobia by Sabrina Strings<sup>53</sup>

# NEIGHBORHOOD & BUILT ENVIRONMENT

## 4.2 Environmental Conditions

In the context of social determinants of health, “environmental conditions” refers to one’s entire sphere of influence.<sup>54</sup> Specifically for this domain, we will be talking about 1) the global, physical, and ecological environments, and the effects of human interaction on altering previously established patterns, and 2) the social and cultural environments that dictate communally-held/prescribed beliefs that people are socialized into replicating and internalizing. Discussing sustainability within each of these environments gives us different examples to better understand the diverse functioning of sustainable and unsustainable systems. By using multiple examples from different time frames, scopes of size/complexity, and intersections with different subsystems of capitalism and white supremacy, we’ll navigate the ways in which we can translate the very concept of sustainability and how it is presently used to evolve physical and social inequity.

Sustainability in its balcony concept is intrinsically motivating; it’s fruitful with social and intergenerational connectedness; it’s grounding, sentimental, and hopeful. It’s also hard to define, and slow-moving. Sustainability, as both a theoretical concept and the actionable scaffolding for meaningful community activism, is key to our co-creation of an equitable world.

Sustainability is a morally-neutral process that happens in the world—like gravity—the ideal version of this process would be aligning a future that can self-replicate while causing the least amount of harm to people and the natural environment. The reality of capitalism, however, creates ways for systems to harm or benefit various groups of people, and natural environments. We are essentially using two definitions throughout this content: 1) equitable sustainability (see below for full definition), and 2) capitalism’s sustainability, in that it maintains and self-replicates the system by expressly targeting people with oppressed identities and their environments.



There are common threads between these two versions of sustainability, but the actions we take to accomplish them are drastically different. It warrants significant investment to understand its immense value to our collective work. The word “sustainability” is often used to be almost synonymous with intersectionality; no individual can hold every perspective at one time, meaning sustainable “things” must be collaborative.

To capture the full spirit of all that sustainability can offer us, we’re going to move through-out this section with this template of a definition for equitable sustainability: the process of a) decentering people with the most power (historical, interpersonal, financial, legislative, cultural, hierarchical, etc.), in order to b) center the people/natural environments in need of support and to c) focus on creating an ecosystem of shared responsibility and equitable, well-distributed resources. To accomplish this, we must d) remove the white savior desire to find a perfect, one-size-for-all solution for any scenario. Equitable sustainability is creative, collaborative, and a synthesis of our collective wants, needs, and goals. It’s the next evolution of shared social values. This version of sustainability builds human-nature into the process and anticipates that perfection is not possible with people, so therefore doesn’t seek to achieve it. Instead, it places emphasis on creating checks and balances to make restoration for harm done, when people make an inevitable mistake.

Remember, however, that sustainability is a natural process driving our bodies and environments toward homeostasis—it is not good or bad. We must assign its meaning and direct its power in the direction aligned with our goals. Equitable sustainability is the ideal; our current reality is capitalism’s sustainability.

Capitalistic sustainability often calls us to think about our environmental conditions in regards to natural disasters. Natural disasters are defined as “a sudden and terrible events in nature (such as a hurricane, tornado, or flood) that usually result in serious damage and many deaths.”<sup>55</sup> Essentially, they are events that humans have no power to prevent once they start. Humans have been dealing with natural disasters for all of time, and our species as a whole has very consistently been able to cope through them. We can cope through virtually all disasters—usually not well, and usually while still experiencing immense pain, suffering, and loss of life.<sup>56</sup> Coping, however, can never be equitably sustainable.

White people and people in power often indulge in the self-serving fantasy of a “great equalizer” natural disasters, pandemics, power outages, water contamination. They say that, “We’re all in the same boat!”<sup>57</sup> No, we are not, because we (as an imperialist global superpower<sup>58</sup>) are focused almost entirely on coping through disasters, never addressing their core issues, never investing tremendous effort into preventing them—capitalistic sustainability at its finest. When we cope with a problem, we accept that it will happen again (for example, buying a whole box of Band-Aids because we will inevitably get more cuts and scrapes).

When we cope with a disaster, we accept that those with the most access to finite resources will live and those whose access to finite resources have been limited will die. There are no “great equalizers” in capitalism and white supremacy.

Coping also means that when scary things happen, being small, individualistic, and self-centered is what our instincts most often tell us will keep us safe. This usually happens on a large scale when the general public has extremely limited information (for example, milestones toward the worsening of climate change) and the people who have more information (for example, FEMA) are identifying worst case scenarios (for example, the sinking of the entire state of California). These scenarios are aimed at motivating policy change, but they are things our brains cannot actually imagine. Worst case scenarios feel fake, even when they aren’t. And, even if the worst is to happen, life will continue for those who remain. Our brains are built to carve new pathways that allow us new behaviors as environmental patterns are proven to us,<sup>59</sup> and we NEVER see the worst case scenario of a disaster coming to fruition, because if they did, it would mean we would have lost our own lives, and our brains can’t have evolved to understand how we could have behaved differently.

Public perception of global disasters moves in waves. We usually start with a shock—“OMG I can’t believe the power is still out in Puerto Rico after hurricane Maria” when, to those working in that environment, there were a lot of warning signs and events that led up to and predicted this change. We then move into a massive wave of panic and dysregulation, where emotional experiencing is high, individualism is high, effective problem solving is low, and performative, self-serving echochamber-advocacy that uses harmful and reductive imagery without context is through the roof. Then we get tired, something else terrible happens, AND the same grassroots activists working on these issues well before the disaster continue to work toward their goals, increasing access to effective problem solving for the masses. This is capitalistic sustainability, the antithesis of equitable sustainability.

This must be interrupted, because capitalistic sustainability will inevitably extract the cost for maintaining itself from BIPOC and other marginalized communities first. This has long been established as the pattern of our society, and it’s a price they can ill-afford to pay.

BIPOC have been at the forefront of disastrous consequences since the foundation of capitalism and white supremacy: “Government programs that help people recover their wealth after natural disasters end up reinforcing inequality.”<sup>60</sup> Take the next few minutes to read through “How natural disasters benefit rich people but make the poor poorer—an illustrated story,” an infographic from The Guardian for an excellent example from Hurricane Harvey in 2017 of the many ways in which FEMA and other government programs fail to facilitate equitable, sustainable, meaningful recovery after disasters. Estimated increases in the white-Black wealth gap attributable to natural disasters are a staggering demonstration of the impact government responses (and lack thereof) have on reinforcing, reinvesting, and replicating patterns of oppression.<sup>61</sup>

We chose to shore up levees in white neighborhoods prior to Hurricane Katrina, even though we knew any levees failing would lead to them all failing. Natural disasters hurt everyone and they are a threat to all life, AND the communities with weakest levees had the strongest rushes of water, the most vicious decimation of their environments, cultures, homes—the lowest chances of survival. Cycles of victimizations continued to be perpetuated in the aftermath of the disaster. Trauma tourism skyrocketed, and we constantly elevated nonconsensual images of Black people and non-Black POC suffering, while failing to correct racist systems.<sup>62</sup>

This cycle of veiled ignorance, trauma tourism, and white-centrism is also present in our approach to endemics, pandemics, and ongoing health crises, dictated by our social environment. Take alcohol and tobacco use as a prime example. In a reactionary effort to lower alcohol and tobacco dependence for white kids following significant political backlash from white adults with monetary power, a slew of government restrictions passed to limit alcohol and tobacco advertisements.<sup>63</sup> Since the root of the legislation was to protect white youth, BIPOC youth remained the target for marketing efforts of Big Tobacco. One 2010 study from the Harvard School of Public Health reported “storefront tobacco ads [became] ubiquitous in lower-income neighborhoods, particularly those with higher Hispanic and [Black] populations.”<sup>64</sup> Another 2009 study (the heyday of these policy changes) estimated that the amount of alcohol and/or tobacco product advertisements may be up to two to three times more common in BIPOC neighborhoods compared to white neighborhoods.<sup>65</sup> Policies simply limiting advertisements of addictive substances are inherently flawed in that they fail to address the behavior itself. Efforts to limit exposure for white kids worked by increasing the burden placed on BIPOC kids.

Equitable sustainability is freedom in all environmental conditions.

“I am not free while any woman is unfree, even when her shackles are very different from my own.” —Audre Lorde<sup>66</sup>

When we sacrifice BIPOC to center white people, we expose the mechanism of white supremacy. White people are not:

- Superior
- Makers of “better” choices
- Immune to the human condition

But white people are the first to be given stolen tools to better their own environmental conditions. Equitable sustainability is justice, and it is necessary for anyone to be free. It needs to be rooted in hopefulness to be most effective, even if we cannot yet overcome intergenerational legacies of targeted harm. Centering equitable sustainability is vital for effective social and political change. There can be no peace until there is justice—and we must make justice sustainable.

## Disparate Outcomes

**RACE** We have woven in specific examples of disparate outcomes for racism and environmental conditions throughout this section (targeted tobacco marketing in BIPOC neighborhoods, BIPOC people at the front lines of natural disaster catastrophes, etc.), but something we have not yet considered is how equitable sustainability can be operationalized and acted upon in the advocacy, research, leadership, and policy change spaces. The connection and rootedness to one's physical environment, culture, and community is often among the first tools we learn for emotional support, social reasoning, and identity development. It is also a cultural connection directly threatened by systems of oppression, as they recognize its immense power and potential for collective organizing.

When large groups of people are forced to separate from the land and community they consider home, smaller groups of families, neighbors, and friends often travel and resettle together to consolidate resources, increase social supports, maintain language and cultural practices, and increase neighborhood safety in their new, often hostile, environments. As these smaller groups settle on different lands and form nest eggs of safety and preserved heritage and cultural knowledge, they often form strong networks with neighboring hubs of resettled people from their homelands, over time forming a **diaspora**.\*

### **\*diaspora**

*The concept of a diaspora was originally organized as a way of maintaining cultural and religious heritage across space and time, as with present-day Palestinian people, African people removed to the United States and Europe, and Jewish people. Diasporas can serve as a powerful form of resistance to forced or attempted physical and cultural isolation by violent imperial forces. Some diasporas are organized around religion, culture, and/or ethnicity without signifying racial identities, however immense investments into this cultural concept have been made by racial groups, especially Black people. Members of the African diaspora, for example, primarily defined as including the descendants of all people enslaved by the Trans-Atlantic Trade,<sup>67</sup> have contributed immense political stimulation, community involvement, and resource acquisition to the concept and philosophy of diasporas, playing a major role in this framework's longevity and impact.*

Today, the term “diaspora” is used to describe any “dispersion of a people, language, or culture that was formerly concentrated in one place, to scatter, to displace, to live in separate communities.”<sup>68</sup> To be a member of a diaspora is not necessarily to be an immigrant to a country, but to experience the disintegration, separation, and/or isolation of one’s “home” (culture, religion, food, education, etc);<sup>69</sup> however, both identities can overlap. Community connections within diasporas are essential to the individual level of cultural health and well-being and to government and leadership structures. They provide cultural and organizational leadership to structure and direct efforts for language restoration, education, historical documentation, genetics testing and healthcare, political alliances, and more.<sup>70</sup>

How can we organize communities toward collective action for increased self-determination, resource redistribution, and conflict resolution? We must create a route of hopefulness, reconciliation, and creativity to take us into equitable sustainability and out of capitalistic sustainability; diasporas are a window into that future. Diasporas can provide an environment for community building and rebuilding by:

- Directing energy and resources toward fine arts: The National Gallery of Art’s exhibition, *Afro-Atlantic Histories*, aims at testifying to the “feelings of connection and detachment that many African Americans have toward Africa, [and] dismantling the notion that the U.S. was the world’s [only] proponent of slavery.... The diaspora has a rich cultural legacy, with diasporic art expressing Blackness in disparate places across the Atlantic.”<sup>71</sup>
- Preserving Native languages: Native Hawaiian is in critical danger. By 1970, after decades of US imperialist intervention (banning Hawaiian language from school instruction, the United States illegally overthrowing the Hawaiian government, etc.) only 2000 native speakers remained. Today, through the efforts of language activists, the speaking population has rebounded from dozens almost to the numbers of the ’70s. “Word by word, [Hawaiians] are trying to teach [themselves] what got dropped between the generations, and hold on.”<sup>72</sup>
- Political leadership and representation: “While diaspora activists ... are relatively safe compared to those in their home countries, the operation and effects of transnational repression can curb their freedoms, and even threaten their physical safety.”<sup>73</sup>
- Serving as primary advocates for financial reparations paid to diasporic members by imperialist state governments: The Healing Foundation was created to advocate for reparations for Australia’s Stolen Generation, the native Aboriginal population that was forcibly removed from their homes. One of their efforts made the Australian government create a reparations fund to communicate “not just that [they were] deeply sorry for what happened, but that [they] will take responsibility for it.”<sup>74</sup> The Healing Foundations efforts continue to encompass current Aboriginal disparate outcomes.<sup>75</sup>



**CLASS** Class and environmental conditions meet at a nearly 1:1 ratio—wealth buys safety, because it buys protection from pollutants and access to safe spaces. More than that, class intersects with environmental conditions through the inequitable consumption and hoarding of limited resources. To continue exploring the value of equitable sustainability to our discussion of the ecological and social environments, let's take the example of “personalization” as a means to restrict resources.

Having something “personalized” to fit the exact whim of a moment is a longstanding class signifier, because it indicates the ability to pay extra money for high-priced goods, to reflect a person's individuality in order to make it more representative of their current interests. Consider monogrammed clothing and bags, custom cabinetry or storage spaces, wall cut-outs or structural details built around a single item. These details are often fun and special ways to highlight things that are important to us, and they can be relatively easy to accomplish. At the individual level, this type of personalization is still a class signifier, but it is also within the bounds of capitalistic sustainability—and it doesn't have much of a lasting impact.

At the corporate level, however, this pattern of individualization, ownership, and over-consumption have significant impacts on city planning, gentrification, class signaling, and the overall built environment. Branded chain restaurants stand out as a prime example of this; take a quick scroll through Bored Panda's list of buildings that very clearly used to be Pizza Huts.<sup>76</sup> It's a bit comical, and it's also frustrating, because these businesses who've taken over a space with such powerful branding now face an additional hurdle in their development on the free market, because they inherently look cheap. Capitalism tells us that wealthy people deserve things custom tailored specifically for them, which we extend into the corporate spaces we use.

This process takes away from the potential investments we could be making into engineering techniques that are wide-serving and malleable—ways to build a quality building, one time, and customize the surface details to meet the diverse needs of various tenants; however, this would be a slow process, as sustainability is never in a rush, while capitalism always is.

Personalization also speaks to the disposability of some things versus others. When do we restore a building or tear it down? When do we reuse old materials in a new design, and when do we replace/upgrade them? A rising class marker in gentrified neighborhoods may be the trendy re-use of aesthetic building materials that may or may not match the details of the existing structure. Think stained glass, ornate front doors, floor-to-ceiling bookshelves, grandfather clocks, etc. These details don't have especially mindblowing functionality—they are a class marker, because they have been restored, elevated, and saved. Oftentimes, these reused materials require more money and time than a replacement would, but the aesthetic



impact and trendiness of sustainability through the guise of capitalism give that project added clout.

As part of the lasting effects of the COVID-19 pandemic, the world is facing major supply chain disruptions, significantly stunting the global production of phones, cars, and computer technology.<sup>77</sup> Trade in value for old/used parts has therefore skyrocketed in the last year, signaling the fallacy that reused parts are subpar to newly-produced parts. Used parts are not subpar, they are simply a slower investment.

**GENDER** Sustainability throughout this content has been best understood as making our actions more in-line with a future that can self-replicate while causing the least amount of harm to people, but most especially for people with oppressed identities. It also has revealed itself in the ways that systems create harm or benefit for groups of people. While both are concepts of sustainability, they are also in direct opposition to the other: one seeks a way to equitably benefit everyone, and the other to inequitably advantage a few. Unfortunately for us all, the latter concept of sustainability is our ruling reality of the moment.

Looking to the social and cultural elements of our environmental conditions, we can see the perniciousness of how unsustainably we have rooted the health outcomes of LGBTQ+ people to a healthcare system that is ableist, racist, misogynistic, homophobic, and transphobic—and the list goes on. The neglectful mishandling of the HIV/AIDS epidemic by government and public health officials, as well as the actions of the medical community enforced hateful and predatory policies against patients with HIV/AIDS, led to the death of over 100,000 people between 1981 and 1990, just nine years.<sup>78</sup> PrEP is a revolutionary and life-saving prescription drug that significantly reduces the risk of spreading and contracting HIV,<sup>79</sup> and it hit the market and insurance coverage in 2012<sup>80</sup>—over 30 years after the first infections. HIV/AIDS first garnered the attention of the CDC while being recorded in minority communities: BIPOC, drug-users, sex workers, and “men who have sex with men (MSM)”<sup>81</sup>. Because of their marginalized statuses, the PrEP medication was developed slowly, even decades later. For a bit of comparison on how reactive drug development can be, the COVID-19 vaccine was developed and distributed throughout most of the United States within one year.<sup>82</sup> While COVID does have a disproportionate effect on some marginalized populations, white people still account for over 50% of COVID’s overall death toll,<sup>83</sup> therefore making a timely vaccine and roll-out the best way to protect white people (and therefore white supremacy) in the face of a viral pandemic.

The cultural environmental conditions of being a queer person in the United States today must be considered inside its historical context of attempted isolation, abandonment, and casual disregard. The HIV/AIDS epidemic death toll carved a hole in an entire generation of LGBTQ+ people, which continues to limit access to generational wisdom and mentorship today.

“The climate emergency, [ongoing military] conflict, and the alarming rise of exclusionary politics all threaten future progress towards gender equality.”<sup>84</sup> Crisis after crisis is bound to give us whiplash, AND ground ourselves in the reality that all the crises we’re witnessing on a near-daily basis are connected by the systems they shape. We are not outnumbered by a faceless beast outside our control—we are the cocreators of this world, we prescribe its meaning, and we can reimagine a future that is safe, equitable, and sustainable. Sustainability is slow, but so is healing and reconciliation. So too, will be our growth.

## Step 1: Reflection

From 2018 to 2020, the world experienced a series of devastating losses of significant cultural and historical artifacts, both due to natural disasters and political conflicts. Consider what differences and/or similarities you can observe between the 2018 to 2020 public responses to

- a. the damage caused by an accidental fire at the Notre Dame cathedral in Paris, France, causing zero casualties and minimal injuries (see “Notre-Dame fire: Millions pledged to rebuild cathedral” from BBC News)<sup>85</sup>

vs.

- b. the damage caused by consistent military and militia bombings of civilian spaces throughout the country of Syria, (see “How the U.S. Hid an Airstrike That Killed Dozens of Civilians in Syria” from the New York Times<sup>86</sup>) an ongoing political conflict with at least 300,000 casualties<sup>87</sup> and that has displaced at least 13 million people<sup>88</sup>

1. Do you remember any of these events? What lasting memorial to these losses do you find when you attempt a Google search—who is being prioritized in mass media?
2. What differences in capitalism, nationalism, imperialism, and militarism can you recognize as empowering and/or deterring financial resources for restoration efforts? Consider the differences in TV airtime, donations from individuals and agencies alike, and social narratives on the historical and cultural “value” of different artifacts.
3. What diasporic communities have been impacted by each of these losses?
4. Can you name any buildings and/or historical artifacts housed in Syria? Can you name anything that has been damaged or destroyed in the civil war?<sup>89</sup> Could you recognize the building of Notre Dame just from a picture? Can you name any other historical buildings in France?
5. The fire that damaged Notre Dame is largely considered to have been an accident, a natural disaster. This is untrue of any bombing. How does the blame-and-shame cycle discussed in **Neighborhood & Built Environment 4.1** translate to this example?
6. Thinking back on the past couple of years, what other events have had contrasting public responses?

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### *Step 2: Family Discussion*

The history of the River Thames in England is an excellent example of how an interrupted pattern of capitalism and oppression can be transformed into a sustainable process of growth and diversity. Between 1830 and 1860, estimates of over 1 million people died of cholera in the greater London area, largely due to the flow of raw sewage through the Thames.<sup>90</sup> “In 1858, sewage clogging London’s Thames River caused a ‘Great Stink.’ A century later, parts of the famed waterway were declared biologically dead.”<sup>91</sup> After decades of ecological restoration and public advocacy, the Thames is among the cleanest rivers and water-sources in the world. “The river today is ‘home to myriad wildlife as diverse as London itself.’”<sup>92</sup>

Review the “The Long and Winding History of the Thames” from the Smithsonian Magazine for a deeper history and timeline of the river’s restoration, including several short videos and other multimedia examples listed throughout the article and linked at the bottom of the webpage.<sup>93</sup>

1. What intersections can you see between the sustainable processes detailed in this ecological cleanup and the various examples of health and social environmental conditions?
2. What lessons may be transferable from the Thames to other ecosystems around England and internationally?
3. What elements may be unique to the privilege and position of England that are not transferable and therefore not sustainable?
4. What role(s) does wildlife and biodiversity play in the health and wellbeing of a community, and our daily living? The Thames runs between rural and urban communities throughout the United Kingdom—does that interconnectedness of potentially different values, needs, and resources influence your answers?
5. Consider the emphasis on the new-and-improved River Thames as a tourist attraction for London—how is capitalism continuing to influence seemingly-sustainable endeavors?

Let this example of the Thames restoration efforts be a launching point for you and your family to start noticing and discussing the cleanliness and ecological maintenance of the many ecosystems you encounter in your daily lives. To start, try noticing the importance of each natural element in the ecosystem you’re observing:

**FIRE:** Controlled/prescribed burning of vegetation are essential to a forest’s health, ensuring soil fertility and tree health to protect and feed wildlife, and reducing the likelihood of accidental, uncontrolled wildfires. This is a technique you and your family can observe in St. Louis’s Forest Park every year.<sup>94</sup>

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**EARTH:** Clay, soil, rock, sediment, shell, and sand—in various combinations and ratios—make up a diverse landscape of earth beneath our feet. The type of earth present in an ecosystem impacts the types of restoration efforts appropriate for the situation. Visit the St. Louis Science Center GROW Pavilion and Gallery to see and read more about the types of earth present in every state in the United States.<sup>95</sup>

**WATER:** Water is our most shared element, and it's essential to all life on this planet. Water is so essential to our futures that many plants can grow big and strong without ANY soil if they just have enough water. Visit the Center for Home Gardening at the Missouri Botanical Gardens to learn more about water gardening, see examples, take a water gardening class, and maybe try it yourself at home.<sup>96</sup>

**AIR:** Clean air is hard to imagine and easy to forget, because we can't really see it! Try incorporating the Air Quality Forecast into your daily weather checks, where you can also learn more about how clean air impacts our health, mood, and community at large.<sup>97</sup>

### *Step 3: Group Discussion*

Capitalism will always look for ways to make money off public perception of tragedy, trends, suffering, and change. Environmental conditions and sustainability are no exceptions. There has been a lot of talk in recent years of so-called “climate criminals”<sup>98</sup> like, a lot of talk (see “Taylor Swift’s reps respond to backlash against her private-jet usage” from POPSUGAR,<sup>99</sup> “The dirty dozen: meet America’s top climate villains” from The Guardian,<sup>100</sup> “Kylie Jenner, Travis Scott labeled ‘climate criminals’ over private jet photo” from Chron,<sup>101</sup> and “How Wealth Inequality Powers Climate Change” from Bloomberg<sup>102</sup>—it goes on). All these tabloid articles are talking about the same revolving door of people (mostly celebrities and CEOs) who are “most responsible” for the majority of carbon emissions when compared to the everyday individual; however, notice that all of these articles are written by tabloids—there’s a reason for this! Spoiler Alert: it’s capitalism.

The barebones definition of climate change is that greenhouse gasses (mostly carbon) are being emitted into the atmosphere at higher rates than our atmosphere can filter them, thereby trapping them and heating up the planet, causing massive ripple effects throughout every ecosystem and natural process we rely on for daily living.<sup>103</sup> The VAST majority of carbon emissions come from industrial production lines—agriculture (and food waste), electricity, factory production, transportation, and energy production.<sup>104</sup> Climate change is a matter of scale—there is no human action, however heinously wasteful they may be, that can ever compare to the emission capacity of a machine. These machines are run by large groups of people, mostly middle-class workers, often working for large corporations. There is not

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one person who is solely responsible for those emissions, as we are all consumers of the goods it creates. There is no ethical consumption in capitalism.

If we compare the individual actions of “climate criminals” to the individual actions of everyday people, yes there is a drastic difference in carbon emission that often feels disheartening—AND no individual will ever compare to the system of capitalism. Then, why do we keep making these lists of awful celebrities and CEOs?

Is it a distraction from the guilt and confusion many of us feel about our own environmental impacts?

1. Is it a distraction from worker unionization, proposed updates for a greener production process, and/or other forms of anti-capitalist worker empowerment?
2. How do you feel after reading articles like this? Does it encourage you to act in any particular ways—to change your current actions or start doing things you didn’t before?
3. Could part of the motivation be to halt collective action, discourage continued education and advocacy for climate action, spread misinformation, and immobilize people?
4. Could part of it be to encourage accountability among powerful people, foster leadership and collective responsibility despite overwhelming feelings of disempowerment, to shame people whose actions don’t create a safe future for us and our families?
5. Is any of it working? Do these articles contribute anything valuable? Is this sustainable?

### *Step 4: Explore More*

Watch the 2019 HBO miniseries *Chernobyl*<sup>105</sup> for a deep-dive into the intersections of sustainability, nationalism, energy independence, ecological disasters, pollution, healthcare, and most importantly, environmental conditions.



# NEIGHBORHOOD & BUILT ENVIRONMENT

## 4.3 Access to Housing and Its Quality

There is more to housing as a social determinant of health than just the physical impact on an individual; there are also psychological and cultural impacts that create barriers and poor health outcomes. Housing is an element of everyday life that serves or hinders a person, community, or larger population. The physical surroundings come at greater immediate cost than other environmental factors, because the consequences are fast and harsh. When people are unable to pay the steep price of housing,<sup>106</sup> the quality of it suffers, and so does the health of the people living there.

To illustrate the various costs an individual incurs when being housed, we'll look at a few dimensions of housing, at different proximities. We'll start inside of a housing situation and see the damaging effects that poor quality walls can have on health. From there, we'll transition to what role the nearby environment and neighborhood play in hindering health. Finally, we'll see what remains true and what changes when thinking of housing quality for unhoused individuals.

The effects poor housing can have on individual health is most easily understood through the physical aftermath—the consequence of living in a place that actively harms you. There are a variety of physical housing issues that lead to poor health. These effects are both immediate and long-lasting, and their simple existence in the community is a threat to public health. For example, it is well known that black mold toxicity can cause respiratory issues after the initial contact.<sup>107</sup> If it is a short-lived exposure, then usually a treatment of antihistamines and nasal decongestants will mitigate lasting ill-effects. But, if a family were to live in a mold-riddled housing situation that remains unaddressed for whatever reason (lack of financial ability to address it, landlord refusal or unwillingness to treat the health hazard, etc.), the outcome for long-term mold exposure is more severe than a short-term contact. Preliminary research shows long term toxic mold exposure can lead to memory loss, increased chances of depression and anxiety, and long-term respiratory issues.<sup>108</sup>

Unfortunately, the impact of housing conditions that worsen health over the time exposed does not end with mold. For instance, lead poisoning can impact brain development and result in decreased cognitive abilities, adverse behavioral changes, and immunotoxicity and toxicity to the reproductive organs.<sup>109</sup> Not only does it affect a child's development, it can result in kidney damage in adults as well.<sup>110</sup> There is no safe level of lead exposure, and many old homes used lead-based paint. Although it was banned in the late 1970s, there are homes that still have lead-based paint on their walls, because there's not enough resources (i.e. money) to safely remove it.<sup>111</sup> It's not just old homes that have issues with lead poisoning—places like Flint, Michigan, have lead in their water due to old pipes and cities refusing to test the water before using it as its main source.<sup>112</sup> It's important to note that Flint's water didn't just contain lead, but other harmful bacteria as well. The public water source was known to contain sewage and toxins from landfills at one point in time.<sup>113</sup> Even after an outbreak of Legionnaires' disease and other reported health issues, officials refused to listen and take action, not considering the needs of the people. Other poor housing conditions include asbestos, pest infestation, poor indoor air quality,<sup>114</sup> and poor insulation.<sup>115</sup> With these housing issues come severe medical health effects, which can result in high health expenditures—when the budget is already tight. And when the budget is tight, families may be forced to live in unsafe home environments. If what's inside the home isn't safe, can we find a place of refuge in the outdoor spaces of our neighborhoods? What if those spaces are also unsafe?

Similar to the case of lead poisoning in Flint, Michigan, just because a person has housing accommodations does not mean that housing is fit to live in. Some factors that are important to consider are: the age of the house, the socioeconomic status of the neighborhood, and the primary racial demographic makeup of the neighborhood. Take for example, the presence and infestation of rodents and cockroaches having a negative impact on health (i.e. respiratory issues, salmonellosis, kidney or liver failure, etc.). It's important to note that pests and vermin are attracted to areas that legislative bodies designate for refuse (landfills, abandoned buildings, buildings with structural issues, etc.). Rodents and insects live everywhere, regardless of refuse, and they're important elements of the natural environment; however, they become unsafe for humans when the natural environment is polluted and humans are put in restrictive environments where they can't maintain housing structures. Poor quality housing is still placed in these areas and individuals are left to deal with the ramifications of an outside creature in their homes and impacting their health and sense of safety. Wealthy neighborhoods most often have marginally less visible infestations because of extreme poisoning and population control programs, paid for by their municipalities, which inevitably run off into the water and ground supplies of nearby areas. The presence of cockroaches and rodents isn't just a visible nuisance—they also spread diseases.<sup>116</sup> In 2021, more than 14 million houses reported cockroaches and/or rodents in their home.<sup>117</sup>

One example of a prevalent rodent infestation is within the Clinton-Peabody neighborhood in St. Louis, Missouri, coming through the pipes and any holes: “What we’re seeing is documentation of residents complaining of mice problems going back at least three years,” said Sarah Turner, co-managing attorney in the Housing Law program at Legal Services. “Management was informed about access points, like holes around pipes, back in 2016, and this year it was still not being corrected when the health department began its inspection in late 2017.” The reports started after an abandoned building was demolished nearby and an already poor housing infrastructure forced the rodents to relocate. Even when residents bring the issue forward to the owner, housing association, etc. they’re often told to just keep cleaner homes.<sup>118</sup>

This notion of cleanliness stems from a history of environmental racism, starting in the 1700s; from white purity to dirty people doing dirty work to zoning around waste management<sup>119</sup> and land use.<sup>120</sup> Places that are “dirty” are deemed to be representations of the people that inhabit them, regardless of their control over the environment and regardless of the resources that were intentionally stolen from the beginning for a safer and cleaner space. Also, most of these spaces are primarily for Black and brown people due to the nature of how the system has been, and continues to be, set up.

Alongside the perception of keeping unclean houses, there are other things connected to your housing situation that can impact your mental state:

- The stress of having to navigate substandard housing conditions
- The economic worry because you can’t afford better housing
- The stress from not being heard after voicing concerns numerous times
- The discomfort of being in a house that may be cold, damp, hot, or stuffy
- The prolonged stress of noise and overstimulation
- If you’re a caregiver, add on the stress that this may be having a negative impact on a child. Research shows that poor housing quality can negatively impact a child’s mental health.<sup>121</sup> This comes from the caregiver’s stress around housing that’s directly or indirectly felt by the child.

Then there is the problem of overcrowding.<sup>122</sup> Multiple families or multi-generational living in the same house is found in many cultures. Such living situations encourage a community mentality where there’s an ecosystem already set up to help when needed; however, overcrowding is when there are more people inhabiting a place than is feasible in that area. It’s usually because of cost and resources, the housing available within their income range, and/or desire to be located close to their community aren’t meant for a family of 6. This can lead to adverse mental health issues, stressors in child development, sleep disorders, and alcohol/substance abuse, not to mention increased risk of infectious disease.<sup>123</sup> In these

cases, more federal housing supports, like Section 8, help alleviate this issue and create an environment for multiple families and communities to thrive by giving them options to stay in a place that's more inhabitable and suitable to their needs, goals, and lifecycle.<sup>124</sup>

Urban planning is usually given more thought and investment in higher SES neighborhoods, and ones where the majority of residents aren't Black and brown individuals. The lack of planning has detrimental health effects that may not be immediately visible. For instance, having playgrounds is a fun, communal, and sustainable way to support a child's development, as that safe space to play can increase their self-confidence and help with problem solving for future challenges.<sup>125</sup> The key word is safe; having a playground is one part, and the other is for it to be a place where there is no gun violence, the playground equipment is safe, and it's devoid of racist microaggressions.<sup>126</sup> There needs to be a sense of community in which you know kids can play without worry. Additionally, there's an importance for green spaces and sidewalks, which allows individuals easily accessible spaces for exercise and for safe walking to limit injuries from motor vehicles.<sup>127</sup>

The lack of green spaces in certain neighborhoods isn't by chance, but by design.<sup>128</sup> Historically redlined neighborhoods are associated with worse health outcomes, due to food apartheid, access to transportation, and access to quality healthcare just to name a few. Redlining originated in the 1930s when the government created the Home Owners' Loan Corporation (HOLC) to help the housing market during the Great Depression.<sup>129</sup> They graded over 200 cities to determine which ones were "low" or "high" perceived risk for lenders—the most hazardous areas were outlined in red. Race was a big predictive factor in perceived risk, and some would say almost the only factor as to why those neighborhoods were redlined. The U.S. government wasn't shy about calling it out, either.<sup>130</sup> Although it's now illegal, the importance of knowing this history is that it shapes not only the current health outcomes (for example, chronic disease, lower life expectancy, etc.) of the individuals living in those areas, but also current day policies and racial segregation (for example, housing policies, zoning, etc.).<sup>131</sup> Most developers won't invest into a historically redlined neighborhood unless it's in alignment with gentrification, rather than rebuilding within the community.

Looking beyond the house, what are the options with no roof? The leading cause of homelessness is lack of affordable housing.<sup>132</sup> Almost 5 million households rely on federal rental assistance programs, but only 1 in 4 eligible low-income renters receive help. People who are unhoused and/or don't have stable housing might not have proper storage for their medicines, may be unreachable by healthcare providers, and may not be able to receive many federal aid or social service benefits that require proof of address. Those who are chronically homeless face higher morbidity factors when it comes to physical and mental health and increased mortality.<sup>133</sup> An acute health problem might be able to be treated in a few days if caught quickly, but without access to proper care, that health problem could turn into a severe health issue that requires hospitalization. In 2017, it was reported that 1 in 3 people

who are experiencing chronic homelessness have a mental health disability.<sup>134</sup> There is a lot of stigma surrounding mental illness, specifically with the unhoused. It is unfortunately common for people experiencing homelessness to encounter violence, such as assault, rape, and murder.<sup>135</sup> People conflate homelessness with mental health issues or substance disorders, thereby capitalizing on prejudiced social stigmas that attempt to make it an individual's responsibility as to why they're in stressful and dangerous situations.

With children, there's an added layer of homelessness impacting their development at such a malleable age. "Young children who experienced both pre- and post-natal homelessness were at increased risk of being hospitalized, having fair or poor health, and experiencing developmental delays compared to children who were never homeless."<sup>136</sup> Not only does it impact young kids, but residential instability (moving frequently, couch surfing, etc.) in youth is associated with teen pregnancy, depression, and early drug use.<sup>137</sup>

In 2022, Missouri passed a law that sleeping on state-owned lands, including under bridges, is now a felony.<sup>138</sup> Cities "with a higher per-capita homelessness rate than the state average will not receive further state funding" and can be sued by the attorney general until they lower their homelessness rate (the law will go into effect January of 2023). This way to lower the rate of people experiencing homelessness does not actually address the cause. Other cities have created park benches that don't allow someone to lay down<sup>139</sup> or bought one-way bus tickets for individuals to leave town (without informed consent).<sup>140</sup> Homelessness is often presented as a problem that can be swept away, instead of as a societal issue that needs to be addressed on multiple levels.

## *Disparate Outcomes*

**RACE** We've discussed redlining and its current-day health implications; now let's dive into the impacts of redlining as it was created for the sake of white people at the expense of BIPOC communities. There is pride in having a sense of community, especially when it's healthy and thriving, but the danger lies when those in power don't like what they see and destroy anything that's profitable and beneficial to marginalized communities. For instance, Black Wall Street was a Black-owned district in Tulsa, Oklahoma, that was affluent and prosperous, because Greenwood residents circulated money within their community through supporting local businesses. However, in 1921, a white mob decimated and burned 35 city blocks because of an alleged (and unverified) incident that supposedly questioned a white woman's purity. In the 1940s, Greenwood started to rebuild and was on the trajectory of economic success,<sup>142</sup> but redlining and the city using eminent domain<sup>142</sup> demolished any possibility of growth. In the 1970s, the government determined that area to be of little use due to consequences of redlining and demolished many businesses and homes to build a



highway.<sup>143</sup> Since the families were forced out of their homes, the Frederick Douglass Elementary School was closed and became a police substation.<sup>144</sup> Where there were once busy storefronts, all that remains are abandoned buildings amidst an interstate. Some community members saw this as “the second destruction of Greenwood.”

The same racist ideologies that fueled the fire in destroying Black Wall Street are the same that determined which districts will be redlined. The tone of these conversations is part of the insidious nature of redlining, because we’re all socialized to use coded language when we’re speaking of people and places. For instance, a Black child that lives in an area of high poverty and can’t get a playdate because the other child’s parent (not Black) doesn’t feel it’s “safe” for their kids to be around each other. Another example is kids having to face adversity after adversity, like losing their friends to gun violence, while managing school, growing up, and trying to appear “respectable” in a “dangerous environment” when getting a job or admission to a university.<sup>145</sup> Or an increased police presence, which disproportionately threatens young Black kids.

Another example of the legacy of redlining is gentrification, where there’s an influx of higher-income, usually white residents into a traditionally lower-income BIPOC neighborhood. Gentrifiers bring the idea of saviorism, or “I’m lifting the neighborhood up,” that is ultimately detrimental to the original occupants of the neighborhood. The increase of higher income residents increases the rent for current and historical residents, which in turn pushes them out of the neighborhood. Where there was once a sense of community and looking out for one another, now that community is disbanded. Gentrification redefines what that neighborhood looks like without the consent of people who already live there and who built it for themselves. Although there may be added economic opportunities or potentially better health services, the higher cost of living and stress from cultural displacement outweighs this good by making the space inaccessible and often unsafe. There are also instances where (usually white) people buy properties in lower-income BIPOC communities and do nothing with them. For instance, there’s an individual who buys properties in Old North St. Louis, Missouri,<sup>146</sup> through “blockbusting” and then proceeds to leave them abandoned for over a decade. The FBI even looked into some of these properties as persons and development companies used it for tax credits.<sup>147</sup> This has negative impacts on the neighborhood, as it prohibits community growth if five of the buildings on a block are broken down shells with overgrown vegetation, destroyed infrastructure (plumbing and electric), and unknown biohazards. Once again, the legacy of redlining perpetuates the cycle of white people profiting off the loss and pain of mostly Black and brown communities.



**CLASS** We've talked about the high cost of living forcing people and families into poor housing, but another major factor that plays into this cycle is credit history. Depending on the landlords, some individuals and rental companies will not offer a lease if the potential tenant has a credit score that is less than 600.<sup>148</sup> No matter if the person has a stable job and is fully capable of consistently paying rent. No matter if that person has never missed a monthly payment, despite living below the poverty line. Their past and their understanding of the complexities that go into a credit score will continue to be held against them.<sup>149</sup> Factoring into their past could be something they had limited/no control over: applying for a credit card later in life or being piled up hospital bills from an accident. Or, that "past" could have been nothing more than being raised in a low-income household, where saving wasn't an option and they didn't have the resources to learn about credit history and its importance for navigating the world.<sup>150</sup>

**GENDER:** Domestic violence (DV) and intimate partner violence (IPV) are serious public health concerns in this country, and they happen in people's homes. One of the biggest barriers individuals face when trying to leave abusive partners is the lack of safe, stable, and affordable housing. Domestic violence includes romantic partner, child, and elder abuse within the home, while IPV is specific to romantic partners.<sup>151</sup> About 1 in 4 women and 1 in 10 men have experienced IPV at some point in their lifetime.<sup>152</sup> While under-researched, preliminary findings indicate LGBTQ and nonbinary people experience higher levels of IPV relative to straight cisgender people.<sup>153</sup> Enduring psychological, verbal, physical, and/or sexual abuse in a space that is supposed to be safe, but is quite the opposite, has harmful short-term and long-term health effects. Chronic abuse creates cycles of intense fear, anxiety, panic, shame-and-blame, isolation, confusion, and repetition that creates a barrier between one's daily life and safety in their home, versus their capacity for long-term well-being. IPV victims are at a higher risk for homicide, alcohol and substance use, miscarriage, nutritional deficiency, post traumatic stress disorder, neurological disorders, sexually transmitted infections, and other health issues.<sup>154</sup> Some of the protective factors supporting people who are impacted by the cycle of IPV include a strong community, including safe and stable housing, emotional support, access to health services, and access to financial support.<sup>155</sup>

## *Step 1: Reflection*

1. What challenges have you ever encountered with a place where you lived? How did you meet that challenge?
2. When renting or buying a house, what neighborhood factors have you looked at that played into your decision of living there?
3. Safe and affordable housing can already be difficult to find, but with the added fear of an abuser finding and harming you, it makes it almost impossible. When people ask things like, “Why didn’t they just leave?”, it is an oversimplification and degradation of the individual’s effort to survive.<sup>156</sup> What are some other barriers that come to mind in accessing safe and affordable housing as a victim of IPV or DV?

## *Step 2: Family Discussion*

1. What were factors in deciding where your family should live? Did you face any barriers to making those plans come to life? Were there supports that made deciding on a place to live easier?
  - a. How do you keep the physical environment of your house safe and set up to promote the health of all the people in your family?
2. How do you set up your household for emotional well-being?
3. What causes stress in your household?

## *Step 3: Group Discussion*

1. Read this resource on environmental racism<sup>157</sup> and discuss:
  - a. The lasting legacy of racialized cleanliness in U.S. history
  - b. What’s deemed acceptable for certain communities to live with and not others (i.e. land refuse around predominantly Black neighborhoods)
  - c. Its groundwork for zoning laws
2. When thinking about housing, especially in regards to wills and trusts, how does financial elder abuse show up within and outside of a family?<sup>158</sup>
  - a. These are ways to protect our elders, but how can we protect and advise our elders with a race, class, and gender lens?<sup>159</sup>
3. Colder housing conditions have been associated with increased mortality, especially for older adults. What community action can be taken to support older adults within unhealthy housing conditions while maintaining their autonomy?

## Step 4: Explore More

1. Watch “How America’s hottest city is trying to cool down” on YouTube<sup>160</sup>
2. Watch *The Cost of Winning*, an HBO documentary, following a high school football team in Baltimore, Maryland.<sup>161</sup>
3. National Network to End Domestic Violence (NNEDV) talks about the impact of safe housing,<sup>162</sup> and they have created a toolkit with resources and information to help survivors.<sup>163</sup>
4. Learn about the Pruitt-Igoe Apartments, a subsidized housing project in St. Louis, Missouri, that sparked family separation based on racist, gendered biases.

This housing project was primarily created for Black women in St. Louis with funds from the 1949 Housing Act.<sup>164</sup> St. Louis wanted to work on housing developments in historically Black neighborhoods, what they called “slum clearance”;<sup>165</sup> this was created to attract middle class white families from the suburbs and was a failed effort to integrate neighborhoods and solve a housing crisis post–World War II. As we’ve already discussed, historically Black neighborhoods have thrived in the past, when they’ve been afforded freedom and autonomy. Synthetic, policy-mandated racial integration isn’t a solution—the solution is to provide relevant and abundant resources, just like we do in white affluent areas. In 1954, after the completion of Pruitt-Igoe, St. Louis officials applauded themselves for creating a housing project for displaced families from the same funds that demolished Black neighborhoods.<sup>166</sup> It was also a way for the city to contain the Black population in a state-sanctioned space, however, in the late 1950s, the city ran out of funding for upkeep and what was once flaunted as the city’s dream (someone else’s dream) became a deteriorating building, forcing occupants to leave with less neighborhood space and less viable housing than they started with.

In 1972, the city moved the residents that remained into one small portion of the housing project and demolished three of the other buildings. Not only was that problematic, but Black women were not allowed to have men in their homes due to “perceived reproductive irresponsibility,” which would cost more taxpayer money.

- a. Read “Remembering Black Women in St. Louis’s Pruitt-Igoe Housing Projects” from *Black Perspectives* for stories from women who lived in Pruitt-Igoe.<sup>167</sup>
- b. Read its connection to current day activists in “Gateway to inclusion” from the *Harvard Gazette*.<sup>168</sup>
- c. Watch *The Pruitt-Igoe Myth*<sup>169</sup>

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## Dear Fellow Advocate:

We're different people than we were at the start of this project, partly due to the natural passage of time, but also due to this project itself. We all sat to think of the gifts we wanted to leave you with from this project—here are our thoughts:

### Message From Author A:

Systems of oppression distort our collective memory. Access to quality resources is the first step to (re)learning systems and community advocacy. The Advocacy Building Project was designed to be your first step, but don't let it be your last. Use this project to continue learning how to synthesize the boundless intersections between the past, present, and future. This world is our responsibility. All of us, especially white people, must do what we can to make it an easier place to live. Build the communication skills you'll need to make big, heavy, complicated topics still feel human. This isn't just about theory or statistics—we're talking about other people here. Move away from striving to be a static "good" or "moral" person, a fixed status that helps no one, including yourself; quest for being a curious, hopeful, fluid individual who strives for intersectional, equitable sustainability. That may feel like a lot of pressure, but we are very capable of doing and surviving hard things when we go together— don't act alone.

We are helpful in the face of capitalism and white supremacy if we have an equitable and compassionate community around us. We are hopeful in the face of capitalism and white supremacy if we have creativity and accountability to ground our understanding of our place in the world.

### Message From Author B:

These topics are so vast, but it is important to get a basic understanding of the social determinants of health to recognize that everything is public health and everything is connected. We hope you've now discovered a foundational truth of this project: there's a way for everyone to understand and engage with complicated systems, no matter your age or knowledge of the issue, no matter your particular passions or skills. I also hope that you've started, or continued, building the muscles for being inquisitive and analytical when you read that random article or hear a conversation about X issue, like incarceration or transportation. Our intent was not to hold or impose any guilt or shame, but to hold us all (including us as authors) accountable for our actions—from conversations with our kids to where we decide to spend our money. Although I helped write this, I am (un)learning everyday.

My journey is not even close to being done. We all live in the same systems, and we're all impacted by white supremacy and capitalism. True accountability lies in when we decide to be honest with ourselves regarding how we're complicit in it and how we can disrupt it. Everyone's freedom and well-being is tied together—we don't live in silos and we can't go at this alone.



### Message from Author C:

It's been a long road through this project, for all of us, and I hope that you've felt a transformation from this work—I know I have. I hope as you wrap up your time with the project, you've gained some new skills, such as the ability to recognize that the strategies of oppression are virtually the same in every system or the skill to articulate the ways you make choices that directly support or oppose a neo-liberal, capitalist, or white supremacist agenda.

The world we live in is a complicated one, and every choice we make, from the type of food we purchase to our vacation destination, leaves a footprint and a consequence. The trick is not to let the weight of every decision pull on us to the point of inaction. It's to feel the tension, name it, and either do the action (i.e., acknowledging and owning the choice made to be complicit in a system-wide harm against others) or to find an alternative that feels more responsible and better for our fellow human of an oppressed identity. Practicing decision-making in which the choices we make are ones that we own (for better or for worse) will ripple out to people around us. Where there are multiple people making ripples, waves soon follow. Here's to making waves!

*Maleeha Ahmad, Rhema Anazonwu, & Jasmine Winter*

## YOUR TURN

Like the authors, you are a different person than you were at the start of this project. The principles below guided the authors while undertaking ABP. Now it's your turn to let these principles guide you on your journey toward advocacy.

- 1. Advocacy, allyship, equity, and self-reflexivity are lifelong journeys that require constant re-educating, un-learning, and updating of language and attitudes as we experience more.**

What do you seek to re-learn? What is something you recently un-learned? What language do you use that you would like to update? Attitudes?

- 2. This is work that needs to be done in our families, but it is also profoundly larger than our families. We are collectively and personally responsible for making the world a more just and equitable place than the legacies into which we were born.**

Consider possible ways for you to explore allyship and advocacy in the spaces you occupy.

- 3. There can be no peace until there is justice.**

What does this statement mean to you?



## ABOUT THE AUTHORS

### **Maleeha Ahmad, MPH**

Maleeha Ahmad earned a Master of Public Health, Global Health at Washington University in St. Louis as well as dual bachelor's degrees in Psychology and Fine/Studio Arts from Augusta University. Now a public health professional, Maleeha offered her public health expertise, specifically around social determinants of health, as co-author of the Advocacy Builders Project.

Maleeha is also an award-winning street photographer. Her images are taken with a particular interest in public health and the creativity of people of color. The greatest influence on her art stems from her Pakistani American background. Exploring and balancing Eastern and Western cultures impacts her daily interactions and drives her work.

### **Rhema Anazonwu, MSW**

Rhema Anazonwu is a native Texan and biracial Nigerian American. In addition to holding a BA in Psychology from the University of Texas, she earned a Master of Social Work at Washington University in St. Louis. Rhema had an active role in We Stories as the first program manager for the Family Learning Program and later as a co-author of the Advocacy Builders Project.

Rhema's professional focus revolves around education advocacy—in particular the many identities (and intersections of those identities) that experience inequities in the current educational landscape. Her broad experience with how patterns of inequity play out over and over in the world of education, despite population differences, lent itself well to the Advocacy Builders Project.

### **Jasmine Winter, MSW, LMSW**

Jasmine Winter is a Licensed Master Social Worker having earned her degree at Washington University in St. Louis. In addition, she graduated from University of South Florida with dual bachelor's degrees: International Relations with a focus on Women's and Gender Studies and Communication with a focus on Public Advocacy. She completed her practicum with We Stories supporting the Family Learning Program and later contributed to the Advocacy Builders Project as a co-author.

Jasmine is an LCSW candidate and is a therapist and case manager at BJC Behavioral Health with the Intensive Community Psychiatric Rehabilitation (ICPR) team. She is committed to continuing her engagement in anti-racist, anti-colonialist community building with an emphasis on mental healthcare, treatment of mental illness and generational trauma, and public advocacy for the greater defense of self-determination within healthcare, education, economics, and environmental sustainability.

