AMERICAN PUBLIC HEALTH ASSOCIATION

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ADVANCING RACIAL EQUITY
RACISM: THE ULTIMATE UNDERLYING CONDITION

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WEBINAR

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TUESDAY
JUNE 9, 2020

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The Webinar convened via video teleconference, at 2:00 p.m., Tia Taylor Williams, Moderator, presiding.

PRESENT
GEORGES C. BENJAMIN, MD, Executive Director, American Public Health Association

JOSE RAMON FERNANDEZ-PENA, MD, MPA President-elect, American Public Health Association

TIA TAYLOR WILLIAMS, MPH, CNS, Director, Center for Public Health Policy and Center for School Health and Education, American Public Health Association

CAMARA PHYLLIS JONES, MD, MPH, PhD, Past President, American Public Health Association, Evelyn Green Davis Fellow, Radcliffe Institute for Advanced Study, Harvard University

AMANI ALLEN, PhD, MPH, Executive Associate Dean, University of California Berkeley School of Public Health

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P-R-O-C-E-E-D-I-N-G-S

(2:00 p.m.)

DR. BENJAMIN: Thank you for joining us today for today's webinar entitled "Racism: The Ultimate Underlying Condition." I'm Dr. Georges Benjamin, the executive director of the American Public Health Association.

This first webinar in our Advancing Racial Equity series is incredibly timely. Inequities within the COVID-19 pandemic and the uprising over police violence underscore racism as an ongoing public health crisis that needs our attention now. Silence and turning a blind eye are no longer acceptable if we want to make meaningful progress towards racial and health equity.

APHA is pleased to provide this platform that we hope will inspire you to take action to foster the changes necessary to create the healthiest nation.

I also want to acknowledge that earlier today George Floyd was laid to rest in Houston, Texas. Would you please join me in taking a moment

of silence in his honor?

(Moment of silence.)

DR. BENJAMIN: Thank you.

Now I will turn it over to president-elect of the American Public Health Association, Dr. Jose Ramon Fernandez-Pena.

DR. FERNANDEZ-PENA: Thank you, Dr. Benjamin. And hello and welcome, everyone.

In 2015, APHA launched the webinar series entitled "The Impact of Racism on the Health and Well-being of the Nation." That was the year Natasha McKenna, Christian Taylor, Freddie Gray, Sarah Lee Circle Bear, Sandra Bland, Amilcar Perez-Lopez, and Antonio Zambrano-Montes were killed by the police.

That was the same year nine African Americans were killed in Emanuel African Methodist Episcopal Church in Charleston, South Carolina.

Today, in 2020, in the shadow of the brutal killings of George Floyd, Tony McDade, Ahmaud Arbery and Breonna Taylor, and in the larger context of the global COVID-19 pandemic in which

one more time people of color are grossly over represented in the mortality and morbidity data, we launch a new series of webinars entitled "Advancing Racial Equity."

Racial injustice is a shameful part of the history of this nation. The genocide that started in the earliest days of the republic, along with the scars of human trade and slavery, the indignity of the internment of Japanese and Japanese Americans during World War II, and the disgraceful caging of Latino children at the U.S./Mexico border, are all part of the legacy that has shaped the nation and its ethos since its foundation.

On a more personal note, the events of the past three weeks bring me back to 1968. I was a young boy living in Mexico City when I learned that Martin Luther King, Jr. had been assassinated. I was aware of his existence because our 6th grade teacher had taught my class about him and we had read his "I Have A Dream" speech.

I had a small poster of Dr. King on my

bedroom wall next to another poster of the upcoming Olympic Games that would take place in my hometown later that year.

And just a few months later, protesters in the student movement of which my brother was an active member were cornered by Mexico secret police. Over 300 of them were either assassinated or disappeared.

My brother was unharmed, but I remember the fear for the actions of a repressive government more concerned about protecting attendance to the Olympic Games than with the safety of peaceful protesters.

The images of my mother crying for fear her son could have been shot dead remain vivid in my mind. Fifty-two years later, we're still fighting the same fight for equity and social justice.

For almost 150 years, APHA has been working to improve the health of the public and to achieve equity in health. Part of our work includes denouncing the impact of these events on

the nation's health and working with communities to develop evidence-based strategies to redress them. Sometimes we react quickly, sometimes we take longer to respond, but we get there.

So as we start this new series, I invite us all to take a moment to remember that race isn't a determinant of police violence or COVID-19 or HIV or maternal mortality or diabetes or gun violence or heart disease. Racism is.

This fundamental reframing of the analysis leads us to a very different set of options and actions, and we will hear much more about this from our two distinguished speakers today. I hope you will join us for the rest of the series and I also look forward to partnering with you in the work ahead. Thank you.

And now I will turn it over to our moderator, Tia Taylor Williams, director of the Centers for Public Health Policy and School, Health and Education at the American Public Health Association.

Tia?

MS. WILLIAMS: Thank you, Dr. Fernandez-Pena. And thank you all for joining today's webinar. It looks like right now we have over 7,000 people logged in today and we had over 12,000 people registered for the event, a testament to the appetite for having these difficult conversations and really thinking about actionable strategies that we can undertake to be anti-racist and to advance racial equity.

Before we get started with the presentations, I do have a few housekeeping items to go over. Closed captioning is available for the webinar. Instructions for accessing closed captioning should be appearing in the chat.

Today's webinar has been approved for 1-1/2 continuing education credits for CHES, CME, CNE and CPH, and none of the speakers have any relevant financial relationships to disclose.

If you want CE, you must be registered with your first and last name and participate for the entire activity and that means viewing the entire activity. All registered participants

will receive an email within a few days from CPD@confex.com with information on how to claim credits and relevant deadlines.

This webinar is being recorded. All registrants will receive a follow-up email with the link to the recording and slides which will also be posted at apha.org/racial-equity within the next week.

We will take questions at the end of all presentations. You can enter a question by, you can ask a question by entering it in the Q&A function. The chat function should be disabled for participants and used for announcements only.

At the end of the webinar, you will be redirected to a survey. Please take a moment to fill out this short but important questionnaire to help us improve our future webinars, and follow the conversation on Twitter using #RacismOrHealth and #APHAwebinar.

Now I'd like to introduce our first presenter. Dr. Camara Jones is a family physician and epidemiologist whose work focuses on naming,

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measuring, and addressing the impacts of racism on the health and well-being of the nation.

She is the 2019-2020 Evelyn Green Davis Fellow at the Radcliffe Institute for Advanced Study at Harvard University and a past president of the American Public Health Association. Her career has included both teaching and public health practice.

Dr. Jones will be presenting twice today and her first presentation is really going to be setting the context and laying some groundwork for the rest of the webinar and also the rest of this series. Now I'll turn it over to Dr. Jones.

You may begin.

Unmute.

Dr. Jones, we can't hear you.

DR. JONES: I hope that you hear me now. Well, Tia, do you hear me now?

MS. WILLIAMS: Yes, we do.

DR. JONES: I am so sorry. Anyway, I am delighted to be here for this second, very important, webinar series on racism that the

American Public Health Association has launched.

And many of you will all remember that when I was president of the American Public Health Association in 2016, I launched our Association in as many communities and partners as would join us on a national campaign against racism, with three tasks: To name racism, that is to say the whole word exactly as Dr. Fernandez-Pena said, race is not the problem, it is racism. Then to identify the levers for intervention by asking the question, how is racism operating here? And then organizing and strategizing to act.

So during this webinar I'm going to equip us with some tools for doing all three things, but for my first little ten minutes of presentation, the tool I'm going to give you is one allegory to help us name racism.

This is the something that I want you to whip out of your brain when you meet somebody who is in staunch denial that racism exists, who is in staunch assertion that this is a land of equal opportunity. And this allegory that I call Dual

Reality: A Restaurant Saga is based on my own real-life experience like many of my allegories, so let me tell you this story.

As a medical student -- first-year medical student, very studious -- one Saturday, I was in my apartment studying long and hard as was my wont, and some friends came over. So what did we do? We all started studying long and hard.

And it got late and we got hungry and I had no food in the apartment, which is quite typical for me so my friends understood, and they were like, all right, Camara, never mind. Let's go into town and find something to eat.

So we do. We walk into town and we find a restaurant and we walk in and we sit down and the menus are presented and we order our food and the food is served and here we are eating.

So this is not a very illuminating story yet, but as I sat there with my friends eating I looked across the room and I noticed a sign and the sign was a startling revelation to me about racism.

So now I've intrigued all of you and

you're like, Dr. Jones, what did the sign say? What did the sign say? The sign said open. So now I know I've lost many of you, so let me recap. Here we are sitting in a restaurant eating. I look across the room and I see a sign that says open.

And if I hadn't thought anything more about it, I would have assumed that other hungry people could walk in, sit down, order their food and eat. But because I knew something about the two-sided nature of that sign, I recognize that now because of the hour the restaurant was indeed closed.

But what that meant was that other hungry people just a few feet away from me but on the other side of the sign would not be able to come in, sit down, order their food and eat, and that is when I understood that racism structures open/closed signs in our society. That racism structures, if you will, a dual reality.

And for those who are sitting inside the restaurant at the table of opportunity eating and they look up and they see a sign that says open, they

don't even recognize that there's a two-sided sign going on because it is difficult for any of us to recognize a system of inequity that privileges us.

It is difficult for men, for example, to recognize male privilege and sexism. It is difficult for white Americans to recognize white privilege and racism. In fact, it's difficult for all Americans to recognize our American privilege in the global context. But those on the outside are very well aware of the two-sided nature of the sign because it proclaims closed to them, but they can look through the window and see people inside eating.

So back inside the restaurant to those who ask is there really a two-sided sign? Does racism really exist? I say, I know it's hard for you to know when you only see open. In fact, that's part of your privilege not to have to know. But once you do know, you can choose to act.

So it's not a scary thing to name racism, it's actually an empowering thing to name racism. It doesn't even compel you to act, but it does equip

you to act so that if you care about those on the other side of the sign, which is an if, then you could even talk to the restaurant owner who is, after all, inside with you, and you could say, "Restaurant Owner, there are hungry people outside. Open the door again, let them in. You will make more money and oh, the conversations we could have."

Or maybe what you'll do is pass food through the window or maybe you'll try to tear down that sign or break through that door. But at least what you won't be doing is sitting back saying, "Huh, wonder why those people don't just come on in and sit down and eat," because you'll understand something about the two-sided nature of that sign.

So this story has been to illustrate in a way that all of us are familiar with that racism is structuring two-sided or multisided signs in our society, that it's creating a dual or multifaceted reality.

And, actually, I could start a three-hour conversation right now, because it's happened in the past two or three times, by asking

the question, how could people who are born inside the restaurant know something about the two-sided nature of that sign, because there are many, many, many ways to know.

And, actually, I think what we see in our nation right now is that all of a sudden people got a taste of that. People are now wondering why have they been saying black lives matter? Don't they know all lives matter? Well, people now are getting a sense of why people are saying black lives matter.

But I have to say that the opposition is very strong. The racism is not just the sign. It's the sign. It's the door. It's the lock. All of that. And the opposition to naming racism and to dismantling the system is very strong, so we do not need to underestimate the opposition.

So I want to round up my few minutes by giving a definition of racism. So when I say the word "racism" I'm clear I'm talking about a system. It's not an individual character flaw or a personal moral failing or even a psychiatric illness as some

people have suggested, but it's a system of power.

Although it does manifest in personal action as it did for Chauvin, the police officer who cold-bloodedly snuffed the life out of George Floyd, for example, but it's also a system that's manifesting in differential disproportionate impact of COVID-19 on black and brown and indigenous people and in infant mortality and the like. We'll talk about that a little more.

It's a system of doing what? Well, it does two things. It structures opportunity and it assigns value. And on what basis does it structure opportunity and assign value? It's based on so-called race, which is the social interpretation of how one looks. That it's race, it's not biology.

Race, the social interpretation of how one looks is the substrate on which racism operates historically and day to day with three impacts. It unfairly disadvantages some individuals and communities. That's usually how we think about racism when we do at all.

But every unfair disadvantage has its

reciprocal unfair advantage, so racism is also unfairly advantaging other individuals and communities. We hardly ever talk about, you know, unearned white privilege in this society because it makes some people, especially some people who are living as white, uncomfortable.

And what I say to that I used to say, you know, shake off the discomfort, but now what I say is lean in, because for each of us the edge of our comfort is our growing edge. But most profoundly, racism is sapping the strength of the whole society through the waste of human resources.

Not only do black lives matter, black lives are precious and brilliant and artistic and all, and when we structure opportunity and devalue people's lives in the ways that we have in our response to COVID-19 and the response to the many, many vigilante murders, we are sapping the strength of the whole society.

To share my Gardener's Tale allegory in which I describe and then illustrate three levels of racism: Institutionalized or structural

racism, which is the constellation of structures, policies, practices, norms and values that taken together result in differential access to the goods, services and opportunities of society by race.

The second level being personally mediated racism, some people call it interpersonal. I understand racism as a system, so I say personally mediated. This is a system mediated through people, which I define as differential assumptions about the abilities, motives and intents of others by race and then differential actions based on those assumptions. That's what most people think of when they hear the word "racism," the different idea, the prejudice, and then the different action, the discrimination.

And the third level, internalized racism, which I define from the point of view of members of stigmatized races as acceptance by members of stigmatized races of negative messages about our own abilities and intrinsic worth. And from the point of view of people who are living as

white, internalized racism manifests as a sense of entitlement.

So I won't be able to go deep, but if you're interested, and this is sort of like it's now a cult classic. It was published 20 years ago. It's a four-page paper you can find here or you can see an 18-minute, very nicely edited video where I describe the levels of racism and tell another allegory, the Gardener's Tale, to illustrate them and what we need to do.

So now I would love to turn this back over, well, over to my colleague, Dr. Amani Allen, who is going to be introduced.

MS. WILLIAMS: Thank you, Dr. Jones, for setting the context and giving us a shared understanding of language and terms that informs how we approach this work.

Our next presenter is Dr. Amani Allen. Dr. Allen is the executive associate dean and associate professor of Community Health Sciences and Epidemiology at the University of California Berkeley School of Public Health where her research

focuses on race and socioeconomic health disparities and the measurement and study of racism as a social determinant of health.

Dr. Allen, you may unmute yourself and begin.

DR. ALLEN: Thank you, Tia. And good morning to those of you on the West Coast, good afternoon to everyone else, and thank you to APHA for hosting this important discussion and to everyone for tuning in.

So I was asked to talk about the physiological impacts of racism and toxic stress on health and health disparities.

And it is indeed important to understand the direct physiologic effects of racism on the body, but for some reason as I was preparing this talk despite that being a central aspect of my research, that didn't feel quite satisfying and in many ways felt inadequate in light of the current social, and as a consequence, public health challenges we are facing as a country. And I realized that's because to biologize racism is to

ignore its full impact on the human body.

That said, much of the research on racism and health conceptualizes racism as a stressor, and as a result focuses on the stress process as a primary mechanism by which racism gets into the body. As depicted here, our bodies have a natural way of adapting to environmental or daily stress. We call this our "flight or fight" response.

So upon the presentation of an environmental demand, energy stores are mobilized from less essential parts of our bodies to more essential parts of our bodies allowing us to operate optimally in the presence of stressors. For example, some of the less essential parts of our bodies include our digestive and reproductive systems, and some of the more essential parts of our body include our cardiovascular system and our respiratory and musculoskeletal systems.

And this energy mobilization is characterized by the up regulation of a variety of stress hormones such as cortisol and

catecholamines, and blood proteins such as proinflammatory cytokines, providing the energy we need for an acute stress response. We become more alert and experience an elevated heart and respiratory rate, among other things, and this all happens very quickly within a matter of seconds to just a few minutes.

However, the idea is that over a period of time, either once the stressor is removed or once we become accustomed to the presence of the stressor, we come back down to resting state and physiologic balance is restored.

So as shown in the top box here, we activate and we recover. This process as many of you may know is called allostasis, which is defined as maintaining stability through change. Our bodies change or adapt in order to maintain physiologic stability or optimal functioning in the presence of stressors.

The four bottom boxes depict what we call allostatic load, the wear and tear on the body from repetitive experiences of stress or the

prolonged circulation of stress hormones in the body. So although the body's stress response process is a natural form of adaptation, it's meant to be transient or temporary. It's not meant to occur continually.

So although helpful in the short term, prolonged circulation of stress hormones can become toxic to our bodies, compromising our body's ability to regulate key biological systems such as our cardiovascular, neuroendocrine and immune systems.

Now in thinking about racism as a stressor, the majority of African Americans report exposure to racial discrimination at some point in their lifetime, with most reporting multiple experiences. So we can think of the repeated hits box, here, as the chronic stress box.

And we can see that although we are properly activating and recovering, we are being hit one after another, after another, with repeated stress experiences that the end result is still prolonged elevation and circulation of stress

hormones in the body.

Another example of allostatic load is prolonged response where we activate but don't recover. We stay in this heightened sense, this heightened state of cognitive-affective and therefore a biological stress. And given recent events, I'm sure many on this call can attest to the fact that they haven't come down yet.

So whereas, for example, our cortisol, which is part of the body's primary stress response, typically spikes first thing in the morning to get us ready for our day. We should experience a gradual decline in cortisol throughout the day with the lowest levels occurring during our normal rest periods which for many of us is at night.

But we hear many reports of poor sleep quality among those reporting high levels of stress and see that African Americans, for example, have a flatter cortisol slope throughout the day due in part to the lack of cortisol dipping we typically see at the end of the day. Most African Americans report chronic experiences of

racial discrimination over their lifetime, many reporting it as a daily occurrence and saying that it's, quote, just another part of your life as an African American. As a result, there may be a chronic state of stress experienced either due to repeated stress experiences or what we call "chronic hypervigilance" or "anticipatory stress" which is commonly reported by African American women, for example.

Now it's worth noting that stress is not inherently bad. Stress is a state of imbalance due to pressure or tension that alters equilibrium in the body requiring some sort of adaptation or change in response to those demands.

Importantly, we're all exposed to daily and other stressors. However, the degree to which these stressors result in allostatic load, this dysregulated physiologic state, depends in large part on how we appraise those stressors.

Chronic perceptions of threat are associated with the kinds of physiologic responses I was just describing and can lead to allostatic

load, a state of physiologic susceptibility due to the imbalance created from chronic environmental demands perceived to exceed one's ability to cope with or manage those stressors.

On the other hand, perceiving stressors as challenging or motivating is associated with a more salutogenic physiologic response. So stress appraisal or perception and coping are essential components of the stress response process and, importantly, threat appraisals are associated with the depletion of psychological resources compromising one's ability to effectively cope.

Now numerous studies show that blacks have higher allostatic load compared to whites with black women being particularly vulnerable. The particular study shown here shows that black women have up to fivefold higher odds of allostatic load compared to white men and women and compared to black men.

And so what does that mean? Well, we assess allostatic load by measuring a variety of biomarkers that indicate functioning across

multiple bodily systems such as the cardiovascular, neuroendocrine, metabolic and immune systems. So allostatic load then is a measure of multisystem, physiologic dysregulation or what has been called "weathering" of the body.

And so what accounts for this heightened weathering among blacks and particularly black women? Here we see that racial discrimination on the horizontal or x axis is associated with allostatic load shown on the vertical or y axis, but that association differs by level of educational attainment.

So, for example, for the low education group shown here with the dotted line reporting higher racial discrimination is associated with higher allostatic load compared to reporting moderate levels of racial discrimination. However, among this group reporting lower levels of racial discrimination is also associated with higher allostatic load, so we see this V shape.

Now many scholars have hypothesized and my own research suggests that this may be due to what

we call "passive coping strategies," such as denial or acceptance of racism where people may report experiencing low levels of racial discrimination, but with a physiologic response indicative of more frequent or severe experiences.

In other research I've done with African American women, for example, when talking about their racial discrimination experiences, some report accepting it and learning to, quote, not trip off of it. They report, quote, putting it in a different place and learning to, quote, overlook it.

In another analysis using the same data, led by one of my former master students, Alexis Reeves, now a doctoral student at the University of Michigan, we looked at both general stress and racial discrimination stress, and for each looked at both stress events as well as stress appraisal in relation to blood pressure.

Now, there were no significant findings for stress events, for either general stress or racial discrimination. So the results shown here

are for stress appraisal. And the findings show, looking at general stress, the solid line at the bottom, we see that reporting a general stress event as not at all stressful is associated with lower blood pressure, compared to recording it as somewhat stressful.

And then looking at racial discrimination stress, the dotted line at the top, we see that reporting a racial discrimination experience as quite or extremely stressful, as well as reporting it as not at all or a little stressful, are both associated with higher blood pressure.

And this curvilinear response is actually anticipated, given what we know about moderate levels of stress being salutogenic.

The point here is that there is evidence suggesting that one, racial discrimination matters, and can be quite harmful to health. And two, perception of threat, more than just the occurrence of events, matters. In other work we also found that coping matters.

In this analysis which was also among

African American women, we examined various facets of being a superwoman or strong Black woman. And found that constant striving and an orientation towards nurturing and taking care of others in the face of chronic or high levels of racial discrimination can be harmful to health. In this case, resulting in higher allostatic load.

Another common measure of physiologic disregulation, or more accurately, physiologic aging, is telomere lengthening. Telomeres are the repeated sequences of non-coding DNA that cap the ends of chromosomes, thereby preserving the integrity of our cells, which is important for proper physiologic functioning.

A number of studies have demonstrated a link between stress and telomere degradation. For example, perception of threat alone, and in particular social threat, has been linked to an enhanced cortisol response, which has in turn been associated with impaired telomere maintenance.

Telomere attrition is a hallmark of aging. Telomeres shorten with each cell

replication.   And as we age, we experience more and more cell replication.

So it's intuitive that as shown here, telomeres shorten with increasing age. As we age, we also accrue more stress experiences, which we also know is associated with telomere attrition. And shortened telomeres can result in instability of our cells, also compromising our body's ability to function. And has been associated with chronic disease and early mortality.

Here we see two different studies. On the left we see that compared to Whites, Blacks have a faster rate of telomere attrition over time. And in the study to the right, we see the same thing for both Black and Latinx individuals. So despite where people start out, for example, several studies have shown that African-Americans have longer telomeres at birth, although the data are somewhat mixed.

However, despite where they start off, there is consensus in the literature that over time, African Americans lose telomeres at a faster pace,

implicating something environmental as the cause of these disparities.

Confirming that hypothesis, several studies have shown that social determinants, the social context in which we are born, and which we live, grow, and age, play a critical role in shorter telomeres among Blacks.

The left diagram here shows that among those more biologically sensitive to their environments, which is measured here by the expression of certain genes, those living in disadvantaged social environments, shown in the lighter colored bars, have shorter telomeres, whereas those in the more advantaged circumstances, have longer telomeres, suggesting that environment matters.

And to the right we see that having a high school diploma has a significantly greater impact on telomere length among Blacks than among Whites.

And previous studies importantly have demonstrated that social status or social

hierarchies develop as early as kindergarten. That's about age five. And that being on the lower end of the social hierarchy is associated with developing more biological sensitivity to the environment. And we call that biological sensitivity to context.

And so having established biological sensitivity to context, turning to racial discrimination and some of my own previous work, led by my colleague, David Chae, we found a link between racial discrimination in both hypertension and telomere length among African American men. With the greatest impact among those with an anti-Black bias, or what we might call, going back to Dr. Jones' gardener's tale, internalized racism.

On the other hand, having a pro-Black bias, or a positive sense of racial identity, is protective. So lots of things going on in thinking about the biology of racial discrimination.

Overall, there is a strong consensus in the scientific literature that racial discrimination has a significant negative impact on

physiologic functioning.

Now some would like us to believe that racism can be cured pharmacologically. One major problem with this argument is that it suggests that racism is primarily facilitated through individual actors, and if we can just fix those bad people, everything will be fine. Well, racism I would argue, won't be cured by a pill. And that's because what we're talking about is systemic.

Dr. Jones described what happens between individual actors as personally mediated racism, arguing that it's really structural and systemic racism being mediated through individual actors.

Individual actors are just part of an overall system that endorses racist practices, norms, values, and beliefs. So what happens at the individual level is symptomatic of a much larger systemic problem.

We see that for example with COVID-19, where Black Americans are over represented in COVID-19 deaths. And we see the same pattern

across the majority states where data on race have been collected and reported.

On average, non-Hispanic Blacks have a rate of COVID-19 deaths approximately four-and-a-half times that of non-Hispanic Whites. While Latinos have a rate approximately three-and-a-half times that of non-Hispanic Whites.

We also see it unfolding with indigenous Americans. Non-Hispanic American Indian or Alaska Natives have a rate approximately five times that of non-Hispanic Whites in some places.

And while Latinos are dying from COVID-19 at a rate similar to their share of the population, they're dying at rates above their population share in many states. So for example in New York, Latinos comprise 19 percent of the population. But have suffered 26 percent of deaths.

One challenge has been testing disparities. Here we see the proportion of confirmed cases, much higher among Blacks then

among Whites. And what's striking here, is the difference in the number of Blacks that have been tested, which is much lower compared to Whites. Testing in communities of color and low income communities has been particularly problematic.

This is a map of Chicago. On the left is the number of cases by ZIP code. Darker colors reflecting a higher number of cases. And on the right, the rate of those tested for COVID-19, where darker colors reflect a higher COVID-19 testing rate also by ZIP code.

What we expect to see, is that the ZIP codes that are darker on the left, should be the same ZIP codes that are darker on the right, since we expect higher testing rates in areas with the greatest need, i.e., ZIP codes with the higher number of cases.

However, that's not what we see. Instead, we see that in the racially diverse low income areas, and in the predominantly Black low income areas, a higher number of cases on the left, and a relatively low testing rate on the right.

Whereas in the predominantly White higher income areas, we see a lower number of cases on the left, but a high testing rate on the right. This is not an equitable distribution of resources.

In fact, it's misalignment of resources, leaving the most vulnerable groups less likely to get tested, and increasing the likelihood of more severe disease and delayed treatment once a positive case is identified.

Turning to the present day civil rights crisis in this country, the continued state-sanctioned killing of unarmed Black and Brown bodies, is another, yet sadly, familiar manifestation of systemic racism.

A study led by one of my former doctoral students, Dr. Marilyn Thomas, now a post-doc at UCSF, used data from the Washington Post to examine the risk of being shot and killed by police by armed status, being armed versus being unarmed for Black and White men.

The Washington Post, for those who are less familiar, maintains an online database of all

on-duty police-involved shooting deaths since January of 2015. And this analysis that I'm going to share with you, used data from 2015 through 2018.

When we look at the sample distribution of all police killings at the top, we see a higher number of Whites being killed. Which makes sense, since Whites make up the majority of the population.

However, when we disaggregate this by armed status, we see a different picture. Looking at the bottom left, among those who are armed, again we see a sizable Black/White disparity.

However, when we look among those who were unarmed, the racial disparity is greatly reduced. Suggesting that compared to White men, Black men maybe more likely to be shot and killed if they are unarmed, compared to being armed.

Here we see the actual risk prediction estimates. So for those, again, who are less familiar, in all of the charts, there is a horizontal line at 1.

This is the line of equality, where the risk of being shot and killed when armed versus

unarmed is the same for Black men as it is for White men. Any estimates below that line indicate that Black men are less likely to be shot and killed when armed versus unarmed, compared to White men.

So starting with the unadjusted estimates in the top left graph, we see that Black men were 47 percent less likely to be shot and killed by police if they were armed, versus if they were unarmed. Or we can think of it as Black men being more likely to be shot and killed if they are unarmed.

Looking over to the right, after accounting for a number of potential confounders, we still see a significantly lower risk of Black men being shot and killed when armed, versus being unarmed.

We also see that regardless of race, older age groups and those with mental illness, are also less likely to be shot and killed if they're armed versus if they're unarmed.

Then finally, looking at the bottom left, since we know mental illness matters, we

condition on mental illness. And here again, we see Black men at lower risk of being shot and killed if they are unarmed. I'm sorry, if they're armed.

And conditioning on age, we see the lowest risk of being shot and killed when armed versus unarmed among middle-aged Black men and among those with mental illness.

And so we can take a few things away from this analysis. First, the risk of being shot and killed when armed versus unarmed is smaller for Blacks, compared to Whites. In other words, Black men are more likely to be shot and killed by police when they are unarmed compared to White men.

Second, the disparity in armed status is exacerbated among Black males perceived as mentally ill, and among those over the age of 44.

Some have suggested that focusing on policing policies may help reduce the heightened risk of being shot and killed while unarmed among Black versus White men.

But in another study also led by Dr. Thomas, she found that while several policies

helped reduce police killing rates for White men, those indicated here in bold, such as having a mission statement, and using videos, such as body and vehicle cams, none of the policies showed a significant impact on reducing the killing rate for Black men.

So why do we continue to see these disparities? When we look at racial attitudes, we see some interesting patterns.

These data show recent 2019 polling data from the Pew Research Center. Starting in the top left corner, we're looking at the percent in each racial group that believe that being Black either helps or hurts Black people's ability to get ahead in life.

Here we see that 45 percent of Whites and 49 percent of Latinx believe that being Black helps people's ability to get ahead in life. Fifty-five percent, over half of Whites, say being Black hurts people's ability to get ahead in life.

Moving to the right, if we look just among those who indicated in the previous chart that

being Black hurts people's ability to get ahead, more Blacks than Whites say it's due to discrimination, including access to good jobs and schools. Whereas more Whites say it's due to things like family instability and lack of motivation to work hard. Classic victim blaming.

In the top right corner, we see that less than half of Whites say that being White has helped them get ahead in life. And then jumping to the bottom right, 62 percent of Whites say the country has either been about right, or gone too far in providing equal rights for Blacks. The diagram in the bottom left may help explain that.

The vast majority of Whites say racial discrimination is an individual level problem rather than a systemic and institutional problem. And among Blacks, only 40 percent say the problems that Blacks face is due to systemic and institutional racism.

So what we see is a lack of national recognition of the role of systemic racism on the opportunities or advantages of some groups versus

others.

Just this past Sunday, Attorney General William Barr stated that he believes there is racism in the U.S., but he does not believe that our law enforcement agencies are systemically racist.

The racial attitude data just presented is one reason why strategies like this, populations-at-risk approach, where we target resources toward those most in need, are challenging. Because there is not wide spread acceptance of the role of institutional and structural racism.

So the goal here with this approach is to bring in the tail of the distribution that is most at risk.

Another approach is proportionate or targeted universalism, where resources are distributed according to need. With this approach, there is a more equitable distribution of resources. The groups doing worse get more, but everyone gets something.

In closing I'd like to read an excerpt

from Dr. Martin Luther King's 1967 speech to the American Psychological Association.

Dr. King stated, quote, the policy makers of the White society have caused the darkness. They create discrimination. They structured slums. And they perpetuate unemployment, ignorance, and poverty.

It is incontestable and deplorable that Negroes have committed crimes. But they are derivative crimes. They are borne of the greater crimes of the White society.

When we ask Negroes to abide by the law, let us also demand that the White man abide by law in the ghettos. Day in and day out, he violates welfare laws to deprive the poor of their meager allotments.

He flagrantly violates building codes and regulations. His police make a mockery of the law. And he violates laws on equal employment and education and the provisions for civic services.

The slums are the handiwork of a vicious system of the White society. Negroes live in them,

but do not make them any more than a prisoner makes a prison.

Injustice anywhere is a threat to justice everywhere. A genuine leader is not a searcher of consensus, but a molder of consensus.

Our most urgent task is to find the tactics that will move the government, no matter how determined it is to resist. I am sure that we will recognize that there are some things in our society, some things in our world to which we should never be adjusted.

There are some things concerning which we must always be maladjusted if we are to be people of goodwill. We must never adjust ourselves to racial discrimination and racial segregation.

Thus, it may well be that our world is in dire need of a new organization, the International Association for the Advancement of Creative Maladjustment. And through such creative maladjustment, we may be able to emerge from the bleak and desolate midnight of man's humanity to man into the bright and glittering daybreak of freedom

and justice.

And I note that although this speech is from 1967, it is still relevant today, more than 50 years later.

Thank you. And I'll turn this back over to Dr. Jones.

DR. JONES: Thank you very much, Dr. Allen. That was fabulous. And it's so stimulating that before I go into what I was going to say for the second part of this, I just wanted to say an amen to the targeted universalism.

It's consistent with three principals for achieving health equity that I've distilled. The first being to value all individuals and populations equally. The second to recognize and rectify historical injustices. And the third, to provide new sources according to need, not equally, but according to need.

I also wanted to echo actually the importance of us understanding that structural racism, institutionalized racism is the level at which we must act if we're going to make any change.

And to note that the most profound impacts of racism happen without bias, because they're manifest as inaction in the face of need. Which is one of the huge ways that structural racism manifests itself.

So I told you that when I launched a national campaign against racism in 2016, a campaign that has had many little seedlings from the seeds that it lay, and I'll talk about some of those in a bit, but that there were three tasks.

The first, to name racism. And I gave you some tools, and Dr. Allen's given you data. And we've all given you frames to name racism, which is especially important when we are in the context of widespread denial that racism continues to exist.

And even though we're at a blip in our nation's history for the past, maybe, two months, or maybe two-and-a-half weeks, where more and more people are acknowledging that racism exists, we've been there before.

We've been there with the assassination of Martin Luther King for example. We've been

there with all of the -- you know, with Hurricane Katrina and when the levees broke. And it was mostly Black and Brown folks on the roofs that had not been able to get out of the city.

We've been there naming racism when we witnessed the poisoning of the public water supply in Flint, Michigan. But after each time, we have fallen back into what I am now describing as the somnolence of racism denial.

And I am intent, and I am hoping that all of us listening to this will be intent, that we will not allow this nation to drift back into the somnolence of racism denial. Now that we have eyes to see, we need to engage in a national campaign against racism.

So the first task is naming racism. The second task is to take this question, how is racism operating here? And use it to identify the mechanisms of the system.

Because racism is not a cloud, it's not a miasma, it's not you know, just some kind of flimsy, something that we can't get our hands on.

Racism is a system with identifiable and addressable mechanisms which are in our structures, policies, practices, norms, and value, which are actually the elements of decision making.

So structures are the who, what, when, and where of decision making. Especially who's at the table and who's not. And what's on the agenda and what's not.

And whenever any of us sits at a decision making table, I charge you henceforth to take a look around and say, who is not here who has an interest in this proceeding?

And then your job is not just to represent their interest, although in the short term that might be what you have to do, but your job is actually to create space at the table.

And if structures are the who, what, when and where of decision making, policies are the written how of decision making. Practices and norms are the unwritten how of decision making, which are sometimes harder to discern then the written how. And values are the why.

And so what I'm suggesting is that we can take this question, how is racism operating here, to all of the places that we inhabit. How is racism operating here in my child's school? In this city? In the police killings of unarmed Black and Brown men and women in this nation and the world.

And so I'm going to give you some examples of the utility of this question. Because honest to God, if I'm asked to do a talk and say it's about the inclusion of people of color in research studies, all I do is I sit for ten minutes and take this question, how is racism operating here looking, at the elements of decision making, the who, what, when, where, how and why. And I generate a menu of levers for intervention, a target for intervention that that group can then use and focus on.

So how is racism operating here in the police killings of unarmed Black men and women and Brown men and women and Indigenous men and women?

This slide is actually like, you know, a ten-year-old slide. But these things are here.

But people have started thinking even more deeply about this.

And that's what we need to do. We need to go with the protests, sustained protests, and then identifying the mechanisms for action.

Whether the presence or absence of civilian review boards in a given city is something that could be -- something that could be put in place or, you know, addressed as a structure.

The use of the grand jury system in most places to even indict police officers. It's not enough to say that that officer had a gun, shot the gun, that person's dead. Or that officer sat with his knee on the neck of this person, and now he's dead, to indict them. I'm grateful that we were not sent down that rabbit hole in the case of the murder of George Floyd.

In terms of practices, the over-policing of communities of color in the first place, which then causes more accidental and unhelpful interactions. And that's what's being addressed right now when people are calling for

defunding the police, or even abolishing the police.

The blue code of silence. The very well-known practice if a police officer sees somebody doing something -- another officer doing something wrong, they don't react. In fact, they said they didn't see anything.

But we saw the complicity in the murder of George Floyd. And so that's -- people are going there too. And at least those other offices have also been charged.

And then the view of Black men as a value. The view of Black men as being -- seen as being inherently threatening or dangerous. Which then makes the excuse of police officers, I felt as if I were in danger, something that people like, oh, okay.

So if you take this question now, looking at structures, the who, what, when and where of decision making policies, the written how practices and the unwritten how on values, the why, into your city where you are right now as you're

trying to think about, what can we do right now on the excess police presence in our communities, you can generate about 50 other potential targets for action.

I also wanted to show the utility of this question when we're trying to consider the excess deaths of Black and Brown and Indigenous people from COVID-19, which is actually a twofold phenomenon.

We are more likely to become infected because we're more exposed and less protected. And once infected, we're more likely to die, because we're more burdened by chronic diseases with less access to health care. And all of these things are very much tied into racism. You know, it's not because we're more susceptible in some kind of biological way, because race is not biology. We've mapped the human genome. There's no basis in the human genome for biological subspeciation. And in fact, we know that in December 2019 there was no human in this planet that was immune to this virus, right?

And it's not that we don't care or that

you know, we just want to gain weight, so how is racism operating here with regard to excess deaths of Black people and others from COVID-19?

Well, in terms of the who, what, when and where of decision making, the structures of racial segregation of housing, which have resulted in racial segregation of educational opportunities that have resulted in racial segregation of job opportunities, explains why we are more in front line jobs, which are now being heralded as essential, but still underpaid, still unprotected. And disproportionate incarceration also as a structural mechanism for us being more exposed.

In terms of policies, the written how, so the limited personal protective equipment for low wage essential workers.

So even as the essential nature of our work as postal workers or delivery drivers, or grocery workers, or trash collectors, or the maintenance people in the hospitals cleaning up the rooms that have been infected, that's a lip service only type of thing, because we've not been equipped

with the personal protective equipment we need, or the paid sick leave we need, you know, and the like.

In terms of practices, here what Dr. Allen showed as the mismatch between the burden of infection in the cities versus the testing availability is -- that practice is because what we saw especially at the beginning, testing centers placed in affluent areas, or requiring a car to get there.

Or requiring a doctor's order when many people in dis-invested actively neglected communities that have been racially segregated and poisoned and the like, don't have access to a primary care physician.

And then even the testing strategies, which still in most parts of this country, not everywhere anymore, and it's much better, but requiring people to be symptomatic, but then peoples' symptoms being disregarded. People being sent home to die in the very early days of the pandemic. And -- (audio interference) -- those are the norms. I'm going to talk more about this.

But the narrow focus on the individual, the ahistorical stance in our nation, the myth of meritocracy, which makes people go to individual level explanations for the disproportionate infection rates and death rates of Black and Brown and Indigenous people, because it makes systems and structures invisible and irrelevant and it makes us not name racism as being -- having anything to do with anything.

And finally, values. And I think this values piece has been something that we have to pay attention to in New York and New Jersey, the hard hit states. And as the nation now starts to boil and roil with increasing infection rates, we have to worry about how our resources are going to be distributed if there are areas of local scarcity of ventilators or emergency dialysis and the like.

And so there have been crisis standards of care that have been articulated, which have a hierarch built into them of valuation by work role or age or existence of chronic diseases.

And people have been quite skeptical

about a lottery as the basis for rationing scarce resources. But I tell you what, if we did institute a lottery as the basis for the rationing of scarce resources, you know, those multiple scarcities would be adjusted right away, because if a head of a hospital all of a sudden understood that really, really, she or he was not going to be guaranteed that ventilator in case they needed it, just because they were the head of the hospital, they would make sure there were enough ventilators.

So now the third element in this national campaign against racism. First, to name racism. Second, to take this question, how is racism operating here. Looking at elements of decision making to identify targets for action, levers for intervention. Now, we need to organize and strategize to act. And a lot of people are wondering, after the protests, what?

So I would like to share with you a framework for an anti-racism collaborative with eight collective action teams that I actually proposed first during my year as APHA President.

I want to share with you for each of these eight collective action teams, very briefly, some guiding questions, and then some early ideas for action.

Wherever you are, you might want to take one of these eight collective action teams right now and say, oh, I think I can get a group of people who can work on this.

But we all have to be together. If we just work on one problem, if all of us just worked on defunding the police, do you know that racism is such a fancy system that it would just whoop, reconfigure itself and manifest itself more in education and housing and, you know, disproportionate incarceration and the like.

So we need to each take the problem that is in our wheelhouse, we have to use the tools that are in our toolbox, but we also need to be in very strong connective collectivity so that we can all organize and strategize to act.

So starting with a community -- I mean, a communication and dissemination work group. How

can we support the naming of racism in all public and private spaces? And what tools and strategies are needed to start community conversations on racism?

So early ideas in that area would be to develop a communication toolbox. I've been contributing allegories into that toolbox. The billboards and films and podcasts, songs, tweets, webinars, right?

We also need to think about putting racism and anti-racism on community agendas. So establishing anti-racism chats. Weekly spaces within even academic places where students and faculty and community can come together. No set agenda, except that it's going to be about anti-racism. Civic dinners, town hall meetings and the like.

For the second of these eight collective action teams, education and developing. Guiding questions can include, how can we support training around issues of race, racism, and anti-racism at educational institutions of all levels? What does

effective anti-racism curriculum look like?

And so early ideas would be to convene anti-racism scholars and activists to develop curriculum, not only for schools of public health and medicine and social work and law, but also to develop curriculum for the K-12 education.

And perhaps in partnership with the American Public Health Association, others of you who are listening to this webinar, can say we want to -- we want to invest in APHA and all of us together convening such an activity.

We also -- I've thought about publishing each of my 20 to 30 allegories that I have on my computer, four or five in the public domain, but to publish each one of them as an individual children's book. So if there's somebody who wants to help me with that, if there's a publisher out there, I'm all ears.

The third, global matters. How can we use the International Convention on the Elimination of all forms of Racial Discrimination, I-C-E-R-D, or ICERD, to support anti-racism work in the United

States?

Many of you may not even know that ICERD is an international anti-racism treaty that was adopted by the U.N. General Assembly in 1965. And was actually, we, the U.S. signed it in 1966. And 28 years later in 1994, the U.S. Senate actually ratified that.

And so we have international treaty obligations to do right under this treaty. So the first thing we need to do is let people know about this treaty. And then we can also look because every time we, every six years when we submit a report about how we're doing on anti-racism, the State Department does this. I'm not making this up.

This is a real thing. Just google ICERD, and you'll get all into the UN's Office for the High Commissioner for Human Rights. And you'll see all of that.

But we get reports back from the committee that looks at our reports. And they tell us that we -- thank you for your report, United

States, we remain concerned about disproportionate incarceration, about the achievement gap in education, you know, health disparities and on and on and on. And we can use that.

And also what can we learn about anti-racism work in other nations? So early ideas. If this is some area of your interest, is to inform the U.S. public about U.S. obligations under that international anti-racism treaty.

To examine anti-racism efforts in other countries as well. Australia, Brazil, Cuba, New Zealand, Rwanda, South Africa, others. Countries that have had, you know, truth and reconciliation efforts. Countries that have actually implemented reparation efforts and the like. And to participate in global conversations on social justice.

In terms of guiding histories, if your area of interest is in history, guiding questions include, what is the history of successful anti-racism struggles in the United States and around the world, and how can this history guide our

anti-racism work today?

We need to be studying long and hard right now. Because we are at a crossroads, right now. We have the chance to take the United States onto a path of social justice and racial equity, and we need to be studying it right now. What is the history? What can we learn about successful as well as unsuccessful anti-racism struggles?

And also how can we institutionalize attention to history in all of our decision making processes?

So early ideas include teaching our full histories. I really applaud the 1619 Project of the New York Times. Textbooks, museums, school curricula, after school problems, you know -- I mean, programs.

We cannot -- there is no excuse for what I heard in 2014 at a medical school that I was associated with, when people were talking about the Black Lives Matter movement after Mike Brown was killed in Ferguson, and a student, a medical student actually said, well at least our generation is the

first generation to do something about these issues.

And I just shook my head and said, we, the generation that lived during the earlier civil rights movement, have failed because we have not taught -- we lived through this, and we thought our children would know.

Also I think we need to hire historians to assess city councils, state legislatures, U.S. Congress, because if you are trying to solve a problem -- if you're trying to untie a knot, it would really behoove you to know how that problem was put in place; how that knot was tied. So we need to look at history as we are trying to solve present day problems.

In terms of liaison and partnerships some guiding questions include, what anti-racism work is happening right now at the community level? What anti-racism work is happening in other sectors?

Here the American Public Health Association is sponsoring this, but I'm sure we have

representatives from many sectors online, and how can we create linkages?

So early ideas for action include cataloging and connecting local anti-racism efforts throughout the nation and around the world. And drafting an anti-racism commitment agreement for communities, for businesses, and organizations across sectors.

In terms of organizational excellence, this is where we have to answer, where are you right now? So not only how is racism operating here in my city, but how is racism operating here right now in my school or in my organization, in my community? How do we answer that question in each of our settings? By examining structures, policies, practices, norms and values.

And so I have actually developed, identified four classes of policies, the written how, that I think are quite good. And my ongoing work is to develop how do you look at structures.

But the four classes of policies, for example will include policies that allow

segregation of resources. And then policies that create inherited group disadvantage or its reciprocal inherited group advantage. Policies that favor the differential valuation of human life by race. And policies that limit self-determination.

And if I had time to go deep, I would give you examples of each of these policies. But for each of those elements of, you know, how is racism operating here, I want to do a similar distillation of, how do we look at structures? How do we look at policies? Here's a start. How do we look at practices? How do we look at norms? And how do we look at values? And I'm going to give you a little bit of my early work on values in just a moment.

In terms of the seventh of the eight collective action teams, guiding questions, if you are interested in looking at policy and legislation are, what are our current policy and legislative strategies to address and dismantle racism? And what new strategies should we propose?

So early ideas include cataloging

formal anti-racism policies that have been adopted by U.S. jurisdictions across the land. You know, so I'm aware of things over the years in Maryland, Milwaukee County, New Mexico, Seattle, King County.

Many of you might know that now there are at least five counties and four or five cities that I'm aware of that have declared racism to be a public health crisis.

It's a little thing to declare racism to be a public health crisis, but it's a stake in the sand. Because if you as a county government in Milwaukee County, Wisconsin, in Dane County, Wisconsin, Allegheny County, Pennsylvania, Franklin County in Ohio, City of Pittsburgh, City of Columbus, City of -- oh, me, just outside of Cambridge. Oh, I can't remember now. It starts with an S.

But many cities and counties are doing this. And states. I know they're talking about it in Minneapolis, in fact.

It's a stake in the ground. It has to be followed by actions, but we can do that. And

develop and disseminate model legislation addressing the many mechanisms of structural racism. In the same way that other groups have modeled legislation to dismantle affirmative action or whatever, we need to develop model legislation for identifying and addressing the mechanisms of structural racism. And we need to disseminate those across local and state governments as well.

And finally, guiding questions for science and publications. What research has been done to examine the impacts of racism on the health and well-being of the nation and the world?

Thank you, Dr. Allen for giving us a nice, just quick touch of many of the areas that are at the forefront right now.

What intervention strategies have been evaluated? Because, you know, it's all good to say we have more and more proof that racism is a threat to the health and well-being of the nation, but now we need to start evaluating intervention strategies and what new measures and methods are needed. And

I work in that area in terms of developing methods for the pairwise comparison of continuous distribution and measures of racism.

So early ideas include putting measures of racism on population-based surveys. So there was a six question reaction to race module on the BRFSS. It was there from 2002 to 2014, and was used by -- you know, 43 times by 29 states. It was taken off when I left CDC. I thought it was institutionalized, but you still need somebody there.

But anyway -- so we could put it back there. And also National Health and Nutrition Examination survey, YRBS and others.

And we need to develop the science and practice of anti-racism. If we understood -- if we had been doing the science of anti-racism and been looking at history, we might not have been surprised by what happened with the election in 2016. So we need to be thinking about that.

So now I am going -- I'm coming around to the close. But I told you that I've been

thinking a lot about the values targets.

So this is what I'm going to go back to. I have defined racism as a system of structuring opportunity and of assigning value.

And we know a lot of the opportunity structural targets that we need to address. And we need to address the school-to-prison pipeline. We need to address residential segregation by race. And we need to address the, you know, environmental racism and the fact that there are even terms called sacrifice zones, when you have people living around known polluting industries.

We need to address policing. We need to address the incarceration, you know, the disproportionate incarceration.

People are talking about abolishing prisons. We need to address all of those structures.

But on the value side of it, I'm not sure that we have done a lot of work there, trying to think about, what are the values targets?

So I used to call these things societal

barriers to achieving health equity. Or, you know, structural whatever -- I mean, barriers. But now I'm going to call these the targets -- the values targets for achieving health equity, or for achieving social justice.

The first three of these are what makes it very easy for this nation to fall back into the somnolence of racism denial, even when some people have been awakened.

The narrow focus on the individual makes systems and structures invisible or irrelevant. I'm just going to -- you can read. So I'm just going to pick the top points on these.

The fact that we as a nation are ahistorical, which makes the present seem to be disconnected from the past. And we act as if the current distribution of advantage and disadvantage is just a happenstance.

The endorsement of the myth of meritocracy, if you work hard, you'll make it, as the, you know, the pull yourself up by your bootstraps. You know, this is the land of equal

opportunity. That myth. Well, I give you that most people who have made it have worked hard. But not everybody who's made it has worked hard, because we have some very prominent examples of that.

But even as I acknowledge that most people who have made it have worked hard, we must all acknowledge that the many, many, many other people working just as hard or harder, who will never make it because of an uneven playing field, which has been structured and is being perpetuated by racism and other systems of structured inequity.

So that when we deny racism, we are endorsing that myth of meritocracy that says that this group didn't make it or that person didn't make it because they're lazy or stupid.

And there are many ways to deny racism. One way to deny racism is to say, I don't think racism exists, or at least not anymore. But a more insidious way to deny racism is to never say the word racism.

It's important to talk about implicit bias and discrimination disparities,

disproportionality, even race. But if we talk about all of those things without saying the whole word, racism, getting the ism out, because the ism is the system piece. If we never say the word racism in the context of widespread denial, we are complicit with that denial.

So these first three of my seven barriers are all about what makes people comfortable in racism denial.

The fourth thing, the myth of the zero-sum game: if you gain, I lose. Which fosters competition over cooperation. It masks the costs of inequity. It masks the reality that racism is tapping the strings of the whole society through the waste of human resources. It hinders the efforts to grow the pie.

It's almost as if somebody feels like they have a potluck dinner, but they don't want you to come, because they think that you are going to eat all of their food. And they don't recognize that you are coming laden with pies and cakes and roasts and all of that. And they think that because

they do not value us.

The fifth of these seven barriers is our limited future orientation. And I tell you that the children and the planet are the parts of the future that we can touch today.

Within this nation we have a very -- we have a disregard for our children. We don't, as many American Indian nations do, have a seven-generations perspective when we're trying to do decision making.

We don't have a 100-year plan when we're trying to, you know, what is going to be the impact seven generations hence. And we do not, as many East African people do, greet one another with, how are the children?

You know, Maasai people might say not hi, how are you doing? But how are the children? And the answer they want to get back is, all the children are well.

We don't even ask about the children in this country. And we certainly, if we did, would not get the answer back that all the children are

well.

And our relationship with the planet is quite usurious.

The sixth of the seventh barriers is myth of American exceptionalism, which makes us disinterested in learning from others and gives us a sense of U.S. entitlement.

And finally, the seventh, which is also the core, is White supremacist ideology. This notion, this false notion that there is a hierarch in human valuation, and then the worst insult on top of the false notion is that if there were such a hierarchy, putting White as the ideal or the norm or the top of that hierarch.

But this White supremacist ideology gives people who are living as white a sense of entitlement. It has resulted in the dehumanization of people of color, which we saw manifest when people learned that COVID-19 was disproportionately impacting people of color, they were like, oh, okay. Well, let's open the country again; free Michigan, free Virginia. Right?

And also we saw at the interpersonal and personally mediated level, at the murders of, you know, George Floyd, Breona Taylor, Ahmaud Arbery, and on and on and on. And fear at the browning of America is what is at the base of our current politics today.

So what can we do today? I'm just going to go back to that image that I started us with, inside the restaurant.

And very quickly say that we need to be actively looking for evidence of two-sided signs. Is there something differential going on here by race, by gender, by language, by ZIP code, by whatever?

We need to burst through our bubbles of experience to experience our common humanity across town. Because all of us are living in some kind of bubble.

Some of the bubbles are big expansive bubbles with thin soap bubble boundaries. Some of them are small bubbles with thick plexiglass boundaries that now are being tinted and polarized,

right?

But whatever kind of bubble we're in, we need to understand that just across town there are people who are just as kind, funny, generous, hardworking, smart as we are, who are living in very different circumstances.

So we need to burst through our bubbles to experience our common humanity. And institutions can create bubble bursting opportunities.

We need to be interested in the stories of others, believe the stories of others, and join in the stories of others. And finally, that is what we're seeing with the very diverse representation at our protest right now.

We need to develop a sensitivity to the absence of, who is not at the table? What is not on the agenda? What policy is not in place, that if put in place could make things much better?

And we need to reveal inaction in the face of need. Because that is the way that structural racism and institutionalized racism

most often operates these days.

But then I was doing a talk like this. And I was like, oh my God. All of my action steps are over there inside the restaurant. So we who are outside need to know our power. We need to recognize that action is power. And we need to especially recognize that collective action is power.

So it is my delight now to turn this over so that we can have time for questions and answers. Thank you very much.

MS. WILLIAMS: Thank you so much, Dr. Jones, for providing that framework and strategies that will assist all of us in becoming more seasoned in the practice of anti-racism.

I also want to take this time to share an APHA resource. It's a book, Racism: The Science and Tools for the Public Health Professional.

This important publication builds on the racial health equity work that public health advocates and others have been doing for decades. And it's available on the APHA website.

I also wanted to note that this series, this advancing racial equities series has been in the works for a while, and it's also evolving.

We want to be responsive to current events and the needs of the field. This slide includes just a few topics that we'll be considering for upcoming webinars. And we welcome your feedback on additional topics via the post webinar survey. That -- so when you close out of the webinar, you should be redirected to the survey. We want to hear from you.

So now we're going -- I'm going to invite the panelists to start their videos. And we'll get to your questions.

So we'll do our best to answer as many questions as possible. We're running up against time.

And we will be preparing responses, drafting responses to some of your questions, and including them in a FAQ and discussion guide document that we will be sharing after the event.

DR. JONES: Tia, now you're muted.

MS. WILLIAMS: Yep. So the first question that -- here we go, let me start my video. My -- here we go.

The first question we have is for -- I will start with Dr. Jones.

Have you seen any discourse or media on the lack of universal health insurance coverage in the U.S. as an example of structural racism? Do you think it would be beneficial to discuss universal health insurance coverage as a part of dismantling racist institutions in this country?

DR. JONES: People are not making it so much as part of institutionalized racism. But people get even narrower than that.

So they've been looking at the lack of expanding Medicaid in southern states. Right? So it hasn't even gone all the way to, you know, Medicare for all or universal health insurance.

I think that that's useful. But my first three -- my top three policy items on an anti-racist policy agenda are reparations to descendants of Africans enslaved in the U.S.,

abolition of prisons or decarceration, and then massive investment of communities of color, especially -- so around housing and all of that, but especially around children and families so that the phrase, disadvantaged child, would never have a meaning. So you couldn't even imagine describing a child being born into a disadvantage.

But certainly, I think that when you talk about reparations, and it might involve free healthcare and free secondary education and all of that, I don't think that descendants of Africans enslaved in the U.S. are going to get that unless everybody gets it.

So, I mean, it's another way of getting it.

DR. ALLEN: And, Tia, if I could just add to that. I think it's important to also recognize that while health and access to healthcare, right, is one thing. Access to quality healthcare is something very different.

And we know that. And this is not an argument against universal health coverage. I

absolutely think that we need that.

However, I don't think that that is going to make a tremendous impact in the disparities that we're seeing. Because we know that there are numerous, hundreds, if not more studies demonstrating that once in the healthcare system that Black and Brown bodies -- Black and Brown people are treated in an unequal manner, in ways that adversely impact their health. There have been several Institute of Medicine reports on this. And just numerous studies about this overall.

And so I think that access to care is one thing, but once in the healthcare system there is tremendous scientific evidence about existing bias within the healthcare system that disadvantages Black and Brown people.

DR. JONES: And the last thing to say is that health is not created within the health sector. And so that's why we have to have the investment in other things, because health is not created within the health sector.

MS. WILLIAMS: Thank you both. Here's

another question that we got in that is really timely right now. And participants are really interested in your thoughts on defunding of police. And whether you think it will beneficial?

Just your overall comments or thoughts on defunding of police.

DR. JONES: I'll start. I think that defunding of police associated with funding of education and mental health care and beautiful communities, yes.

I think that we do not have to be policed. We are fully human. So I don't think -- I think that -- but just defunding of police without anything else, you know, it has to be a shift in response.

DR. ALLEN: And I would agree with that. And I would also -- I remember when I was working at the DC Department of Health, and you know, there are instances when our institutions are not operating the way that we should. And they can go into receivership.

So that's another strategy. Is to

place our institutions that are not functioning properly in receivership. Meaning that they are being monitored by somebody to ensure that they are operating the way that they're supposed to operate.

And so I think that defunding is one conversation, I don't think it's the only conversation. I think we can have other conversations that would push our institutions to operate in a more equitable manner.

MS. WILLIAMS: Thank you both. This question I'll pose to Dr. Allen first. How can researchers and educators counteract the false narrative that racial bias can be treated or solved through individual-level practices?

And going back to what you spoke about in terms of pharmacological treatments, especially given that there was published research perpetuating that belief.

DR. ALLEN: Well, I think -- so I think this is an emerging area of research. There haven't been that many studies. In fact, the three studies that I've put out were the only three that

I was able to find on it. However, there is a conversation about that.

What I will say is that there is a lot of research that's starting to emerge on this idea of racial sentiment, racial animus. Kind of, how do racial sentiments in places, in counties, and states and cities impact the well-being of people of color and other disadvantaged communities living in those areas?

And so what some of this research is demonstrating is that regardless of what happens at the individual level, because we can statistically control for those things. Right?

There are a lot of things that we can do statistically to try to disentangle what happens at the individual level from what happens kind of -- we talk about it as kind of being in the air, or we call it the surround.

And just living in a climate that is, that is hostile towards your racial group is associated with poor mental and physical health outcomes, regardless of what happens at the

individual level.

So both matter. But one is not necessary for the other one to happen.

DR. JONES: And I just want to tie in that I've been thinking quite a bit about developing a measure of racial climate. Which would include the pertinence of race.

What are the categories and the sorting rules into race? And then what are the goodies that are associated with each race?

And so that's the same thing. We're swimming through this water and unaware of that the water is polluted. And so we need to be measuring that racial climate. And the IAP, the -- oh, I can't even remember, you know, the --

DR. ALLEN: The implicit-association test?

DR. JONES: The implicit-association test, IAT. The IAT, as you said, is better at that kind of aggregate level then, because it's hard for somebody to change their own IAT score.

But you can use it, as you said, to look

at the impacts, I think on -- we should look at it on infant mortality, maternal mortality, all of those things.

DR. ALLEN: And I also think that Dr. Jones in her presentation was talking about the invisibility of racism. Right?

And so that's the juice that they're trying to get us to drink, is that when it doesn't happen to us individually that it's not operating. But that is the insidiousness of racism, is that it is always operating whether we realize it or not.

The fact that I wasn't -- the fact that I don't have the same job or employment opportunities. The fact that the schools that my children go to are not going to be the same quality or have the same resources as schools that other people's children go to. The fact that Black neighborhoods have a higher percentage of off-premise liquor establishments than grocery stores. All of these things matter, and that doesn't require someone to individually treat you unfair. Right?

These are experiences that, at least in my own research, African Americans describe happening at very early ages. And it just continues throughout their life course.

So there's kind of this learning of the devaluation of you and your racial group overall. And you cannot come out of that unhinged -- unimpacted.

MS. WILLIAMS: Great. Thank you. I am afraid that we are at time. We got a lot of questions that we were not able to get to, so we will regroup and think about how we can get some responses out to the individuals who asked those questions. And also share them more broadly with the participants.

I think the discussion, the presentations, and the engagement that we've had among the participants really just echoes for us and underscores the importance of doing this work right now.

And so I want to thank the presenters for being here and for participating today. For the

APHA staff who have worked tirelessly to produce this event. And many thanks to all of you for your thoughtful questions.

Our hope is that your activism doesn't begin -- doesn't end here, and that you will join us in being actively anti-racist and invent being racial equity.

I want to remind everyone that the recording and slides will be available at APHA.org/racial-equity. And you will also receive an email once the recording is available.

We are going to close out the webinar now. You'll be redirected to the survey. And, everyone, please take good care of yourselves. Thank you for tuning in today, and this concludes the webinar.

(Whereupon, the above-entitled matter went off the record at 3:32 p.m.)