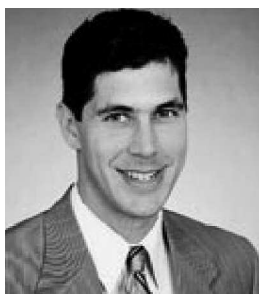


Confronting Healthcare Disparities in Holyoke, Massachusetts

On Thursday, October 18th Critical MASS in conjunction with its community partners in Holyoke convened its Second Annual Regional Forum on Health Disparities.

As a result of efforts at regionalization, Critical MASS partnered with local conference organizers in Holyoke to build upon existing community efforts to increase awareness and dialog around health disparities. In 2006, Lillian Santiago, a local community leader, staged Holyoke's first community forum on health disparities, *Ending Health Disparities: Health is for Everyone*, with the intention of brining attention to the health inequities plaguing the community. The success of the conference spearheaded by Santiago, lead Critical MASS to partner with Holyoke community members on disparities initiatives the first of which was the October 18th conference, *Confronting Healthcare Disparities: Is Commonwealth Care the Answer?*

The day opened with a Keynote address by Jarrett Barrios, President of the Blue Cross Blue Shield Foundation of Massachusetts; followed by two panels and a presentation on health care reform in Massachusetts by Dr. Michael Chin, a Senior Policy Analyst with the Commonwealth Health Insurance Connector Authority. The first panel highlighted health disparities in Western Massachusetts –more specifically Holyoke and the second panel reported the progress of Commonwealth Care and it potential



Jarrett T. Barrios, JD, President,
Blue Cross Blue Shield of Massachusetts Foundation

as a strategy to reduce racial and ethnic health care disparities. The day also included a screening of a clip from 'Unnatural Causes' entitled 'Not Just a Paycheck.' Unnatural Causes was produced by California Newsreel with Vital Pictures, and

involves members of the Harvard Center for Society and Health as scientific advisors and participants in the episodes. The program is one piece of a national public impact campaign that will stimulate a broad debate on recognizing and reducing socioeconomic and racial health inequities. John Auerbach, the Commissioner of the Massachusetts Department of Public Health, was the closing keynote and emphasized the Department's commitment to addressing health and health care disparities in the state.

A timely question, the theme of the conference was chosen to illustrate an important point. Access to care, although it may reduce health care disparities, will not eliminate them and it certainly will not decrease the health disparities that disproportionately impact Latinos—predominantly Puerto Ricans in Holyoke, many of whom already have insurance. Conference presenters and panelists explained that although many would benefit from the new insurance legislation, insurance status is by no means correlated with health care quality. That is to say that getting in the door isn't enough, if racism, discrimination, stereotyping and bias lie beyond the threshold. Furthermore, all the coverage in the world is not going to change the social and economic determinants that produce the inequitable health outcomes experienced by Latinos in Holyoke, and other racial and ethnic minorities in the urban centers of the Commonwealth.

The dialog that took place at the conference was an important starting place for the community in terms of future disparities efforts. Critical MASS is now working with partners to plan the next steps that will focus on sustainable efforts that address the social determinants of health, more specifically asset-based policy and programming. ❖

Critical MASS www.enddisparities.org

Unnatural Causes www.unnaturalcauses.org

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CCHERS Mission

The mission of CCHERS is to promote the development of "academic community health centers" that integrate service, education and research to influence and change health professions education, improve health care delivery, and promote health systems change, to eliminate racial and ethnic disparities in health.

Executive Director's Corner

In October, my appointment, along with five others, to the Council of Public Representatives (COPR) to the Director of the National Institutes of Health (NIH) was confirmed with Dr. Elias Zerhouni asserting, "these new members bring a wealth of knowledge and professional experience in the areas of rural and community health, patient advocacy, health policy, nursing education, and communications, along with a strong commitment to enhancing public participation in the biomedical and behavioral research enterprise. I am delighted to welcome them to the Council and greatly value the significant advice I receive from COPR."

In my very first meeting with Dr. Zerhouni I told how I had been a health center director and an advocate for the underserved in the community health center movement for 30+ years and how I had become focused on the Boston biomedical and behavioral research enterprise when I read the front page story, above the fold, in *The Boston Globe* on February 18, 2002, in which it was reported that Boston had become the number one city in the country for capture of NIH research dollars. I thought immediately how little difference that made in the lives of the patients of our community health centers, the residents of public housing in the communities we served, and the health status of underserved racial and ethnic minority populations of our city. Those most impacted by disparities in health and health care, leading to decreased life expectancy, increased infant mortality, high morbidity from all chronic diseases, and thousands of unnecessary excess deaths annually.

Dr. Zerhouni talked of the four P's of medical research: developing interventions that are predictive, pre-emptive, personalized, and participatory and articulated his belief that the need for transformative, innovative research is urgent, particularly when it came to addressing racial and ethnic disparities in health and health care. His leadership has resulted in the NIH Roadmap <http://nihroadmap.nih.gov/> and the Clinical Translational Science Awards <http://www.ctsaweb.org/> which are seminal elements to the transformation and innovation he envisions. At the heart of the four P's is participation of the public and the role of COPR to increase awareness and inspire action for greater public involvement in research. COPR members believe that there are several ways an enhanced public role in research can make a difference:

- First, an enhanced dialogue between patients, health-care providers, and researchers can help people take charge of their own health: preventing illness, preserving quality of life, and conserving costs.
- Second, public involvement at many levels provides a voice for underrepresented populations to inform priority-setting endeavors

relevant to the broader health research agenda.

- Third, a diverse spectrum of public voices enhances research methods by pointing to cultural and environmental factors that impact findings.
- Finally, a strong public-researcher relationship is a critical link for disseminating research findings to real people all over this country.

For me and the work of CCHERS on the local level this translates to promoting a community derived and directed research agenda for the elimination of racial and ethnic disparities in health and health care in the communities and populations served by our partner community health centers. Looking forward to my tenure on the COPR, I expect to play a significant role in enhancing the public's understanding of NIH and its participation in NIH activities. For me, this ranges from increasing public participation on advisory boards of the 27 institutes and centers that comprise NIH; to creating a role for the public in the "peer" review process; as well as having NIH hold its extramural grantees accountable to the local public (community) for the same. ❖

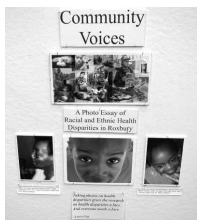
For further information contact: Elmer Freeman, Executive Director at: e.freeman@neu.edu.

CCHERS Model for Community Based Research in Health Disparities

- Bridge gaps between community residents, health centers, and research institutions to facilitate interaction and development of relationships.
- Build partnerships that expand community involvement in biomedical research in Boston to eliminate racial and ethnic disparities in health.
- Determine the baseline of community participation in NIH funded research in Boston.
- Educate academic biomedical researchers about potential roles for the public in research.
- Educate communities of focus about the biomedical research process and enterprise and potential benefits and challenges of participation.
- Provide guidance and technical assistance to applicants/grantees on community engagement and community based participatory research.
- Identify and disseminate best practice models of community engagement and public participation.

"Community Voices" Photo Essay on Health Disparities Available for the Community

After four months of work, "Community Voices: A Photo Essay of Health Disparities in Roxbury" is available for display. This photo essay was developed by seven Boston area high school students during CCHERS's first Community Voices summer program. The seven students focus on how Diabetes, teen pregnancy and HIV/AIDS reflect issues of racism and health disparities.



The Community Voices program employs students to work in community health centers and to develop a photo essay of racial and ethnic health disparities in the community. CCHERS, in partnership with Health Careers Academy (HCA), Boston Area Health Education Center, and ACT Roxbury, received funding for the program from Johnson & Johnson and

the Society for Arts in Health Care in the Fall of 2006. The goal of the program is to address health disparities and to encourage a diverse group of students to pursue health careers.

The first full presentation of "Community Voices" took place on November 13th at the John D. O'Bryant African American Institute at Northeastern University. The large audience of health care workers, educators, artists, and community members listened as the seven students presented their writing, photographs and research on health disparities in the community. Verola Jeanty, an 11th Grader at HCA, stated, "We have all learned so much this summer about health disparities in our communities, and we have to keep educating others. We hope that we can encourage others to spread their voice just as we are spreading ours."

The Community Voices program was included in the American Public

"Community Voices" continued on page 5

Investigating how racism harms health: new approaches and new findings

by Nancy Krieger



Does racism harm health? Although this may seem like an obvious question – with an obvious answer – relatively little research to date has tested the hypothesis that racism harms health.

One reason for this dearth of research is the long history of racial injustice in the US. A key tenet of slavery was that blacks and whites were biologically distinct groups and that white superiority and black inferiority were “natural” consequences of innate biology. The idea of racial inequality came to be treated as a “scientific fact,” embraced by the majority of researchers and physicians seeking to document and explain “racial” differences in health.

To be sure, not everyone adopted these views. Even before the Civil War, abolitionist physicians and researchers—both black and white—challenged the idea of innate biological difference and inferiority. Offering alternative explanations for the comparatively poorer health of the US black population, they pointed to the health-damaging hardships caused by slavery and by economic poverty. Their evidence, however, was dismissed by the politically more powerful majority who benefited from the belief that racial inequality—and white superiority—were “natural.”

Jumping forward a century-and-a-half, the debates continue. For some, the answer(s) to why there are racial/ethnic disparities in health lies first and foremost in our genes. Demonstrating that scientific racism persists to this day, Dr. James Watson, who won the Nobel Prize for helping to unravel the genetic structure of DNA, this past fall claimed that blacks genetically are less intelligent than whites; he went on to state that the reason development programs in Africa fail is because they are based on the faulty assumption that everyone is equal. Fortunately, Watson’s comments were roundly condemned as lacking any scientific basis by leading researchers, including by the director of the US National Institutes of Health (NIH)—a sign of both scientific and social progress since the 19th century.

One additional sign of this progress is a small but rapidly growing body of research that is beginning to provide evidence for the alternative view: that social conditions – including racial discrimination – shape people’s ability to live healthy lives. One key idea in this work is the notion of “embodiment.” This term refers to how we literally—biologically—embody our experiences. This embodiment of experience in turn shapes our chances of staying well or becoming sick.

Stated another way, differences in biological characteristics between groups, such as black/white differences in average blood pressure, can be a result of black/white disparities in living and working conditions, not innate biology. The social relationships of inequality between groups can shape the health of individuals within the groups and show up as disparities in health between these groups. What’s measured in the body as a health outcome or suffered as a disease can be socially-shaped, not merely genetically programmed.

The new research on racial discrimination and health is thus focusing attention on the many ways that social inequality can become embod-

ied, across the lifecourse, from birth to death. Pathways from social injustice to poor health can include adverse exposure to:

1. Economic and social deprivation;
2. Toxic substances, pathogens, and hazardous conditions;
3. Discrimination and other socially-inflicted trauma (mental, physical, and sexual, directly experienced or witnessed, from verbal threats to violent acts);
4. Targeted marketing of commodities that can harm health, such as junk food and psychoactive substances (alcohol, tobacco, and other licit and illicit drugs); and
5. Inadequate or degrading medical care.

The way that people respond to different adverse exposures, including social trauma, also can affect health. These responses can range from internalized oppression and harmful use of psychoactive substances to reflective coping, active resistance, and community organizing for social change.

“What’s measured in the body as a health outcome or suffered as a disease can be socially-shaped, not merely genetically programmed.”

One example of this new vein of research is a recent study we did on racial discrimination and risk of low birthweight and preterm delivery (see: Mustillo S, Krieger N, Gunderson EP, Sidney S, McCreath H, Kiefe CI. Self-reported experiences of racial discrimination and black-white differences in preterm and low-birthweight deliveries: The CARDIA Study. *Am J Public Health* 2004; 94:2125-2131). In our investigation, we drew on data from the US CARDIA study, a multi-city population-based longitudinal investigation concerned with black/white differences in risk of cardiovascular disease.

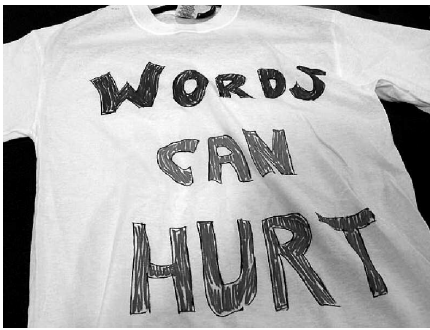
Our study included a group of 367 women who gave birth between Year 7 and Year 10 of the CARDIA study. From the Year 7 exam, we obtained data on self-reported experiences of racial discrimination, socioeconomic position, and other relevant characteristics;

from the Year 10 exam, we obtained data on the birth outcomes. What we found was:

- 1) Overall, black women were 2.5 times more likely to have a preterm delivery than white women.
- 2) In analyses that took into account other major risk factors for preterm delivery—such as income, education, smoking, alcohol, and depression—controlling for these risk factors somewhat reduced the black/white difference, but black women were still about twice as likely to have a preterm delivery.
- 3) When we additionally took into account the data on racial discrimination, there was no longer any racial/ethnic difference: black and white women were at equal risk. Moreover, compared to women who reported no racial discrimination, women who reported experiencing racial discrimination in one or two versus no situations were twice as likely to deliver a premature baby, and women who reported racial discrimination in three or more situations were at triple the risk of having a preterm delivery.

Our results showed—for the first time—that experiences of racial discrimination not only predict risk of preterm delivery but also could explain the higher risk of black compared to white women that conventional risk (such as the kinds of variables we controlled for, i.e., income,

“How Racism Harms Health” continued on page 5



Health Disparities Related to Experiences of Domestic Violence

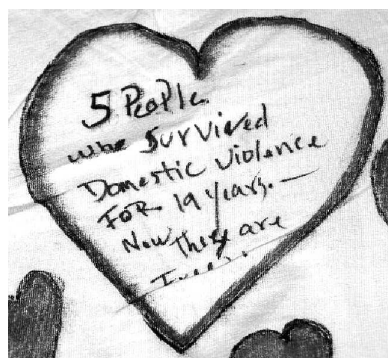
Like many other health issues, disparities exist in domestic violence care—access to services, interventions, and outcomes — across various social strata, including race and ethnicity, age, and socio-economic status.

While data to date are limited, research is beginning to clarify the contribution of domestic violence to health disparities for teens and women of color. Some examples include the following:

- Population-based data from 26 states indicates that African American and Native American women are at greater risk for intimate partner violence than other racial groups around the time of pregnancy (Silverman, 2006).
- The risk of maternal mortality is three times greater for African American mothers in an abusive relationship; specifically, African American mothers experiencing abuse are three to four times more likely to die than their white counterparts (Boy & Salihu, 2004).
- Biases in the prenatal care setting are exposed by data showing that health care providers were more likely to discuss physical abuse with women who were African American, Hispanic, young (under 20 and between 20-29 years of age), had a high school education or less, and received prenatal care coverage through Medicaid (Durant, et al, 2000).
- Women of color who are injured as a result of domestic violence have been found to be overrepresented in presentations to hospital emergency departments (Tjaden & Thoennes, 2000).
- Among African American women between ages 15-24 years, domestic violence is the leading cause of premature death from homicide, and injury from non-lethal causes (Rennison and Welchans, 2000).

Fortunately, research is also starting to show some mediating factors:

- Stronger social support has been shown to reduce the risk of adult revictimization for low-income African American women with a history of child maltreatment (Bender et al, 2003).
- Higher levels of spirituality and religious involvement among African American survivors of domestic violence have been found to be associated with higher levels of social support as well as lower levels of depression (Watlington & Murphy, 2006).



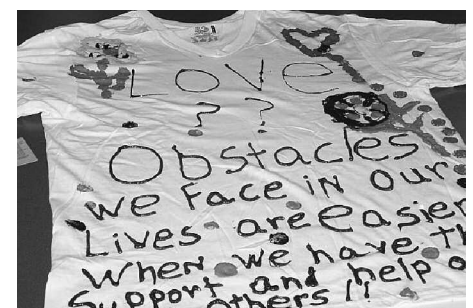
In October, during Domestic Violence Awareness Month, CAP's Community Outreach Coordinator led t-shirt making activities at CAP partner health centers and Neighborhood Health Plan as part of developing our own Clothesline Project honoring survivors of dating and family violence.

Governor Patrick and the First Lady kicked off Domestic Violence Awareness Month with a community forum on domestic violence hosted by CCHERS Community Advocacy Program partner Dorchester House Multi-Service Center. Others pictured are: (left to right) Kevin Burke, Secretary of Public Safety, Dr. JudyAnn Bigby, Secretary of Health and Human Services, Governor Deval Patrick, Sue Chandler, MPH, MSW, Director, Community Advocacy Program, Center for Community Health Education, Research and Service, and First Lady Diane Patrick.



Research efforts to date are in the early stages, but are beginning to inform promising areas for additional study and intervention. Some strategies identified for strengthening data collection include: evaluating the cultural relevancy of standardized assessment tools with different client populations, incorporating culturally appropriate language into inquiry and screening questions about experiences of violence, and expanding the scope of inquiry and screening questions to include not only current or recent, but also lifetime exposure and multiple forms of victimization. Domestic violence will continue to demonstrate how victimization is a pathway to health disparities and how ethnicity and culture must be an integral aspect of interventions to reduce health disparities. ❖

(Sources: Dr. Linda Chamberlain, Dr. Phyllis Sharps, Dr. Jacquelyn Campbell, and the Family Violence Prevention Fund)



education, smoking, alcohol, and depression) could not. And, because most prior research controlled only for these conventional risk factors, scientists interpreted their results of an unexplained higher risk among the black women (that is, not explained by these conventional risk factors), as meaning that there must be some additional underlying innate biological difference that caused the black women to be more likely to have a preterm delivery. But our study shows the limitations of this sort of interpretation because, by probing into experiences of racial discrimination, we could explain the observed black/white disparities.

This is a very powerful finding. Our results, coupled with those of other new studies showing links between racial discrimination and such outcomes as cardiovascular disease, smoking, alcohol and drug use, and mental health, further supports the hypothesis that the source of racial/ethnic disparities is the injustice in our society, not innate biology.

That said, the new research on racial discrimination and health is still in its infancy. Much more work is needed, such as refining the methods to measure exposure to racial discrimination and determining the pathways by which injustice is embodied. But the implications of this new work are already clear: there is nothing “innate” or “natural” about racial/ethnic inequalities in health. Finding and eliminating the causes of these health disparities will require not more high-tech genetic research but rather the far more ambitious task of guaranteeing racial equality and social justice. ❖

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Additional resources:

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Krieger N. Discrimination and health. In: Berkman L, Kawachi I (eds). *Social Epidemiology*. Oxford: Oxford University Press, 2000; 36-75.

Krieger N. Stormy weather: “race,” gene expression, and the science of health disparities. *Am J Public Health* 2005; 95:2155-2160.

Mays VM, Cochran SD, Barnes NW. Race, race-based discrimination, and health outcomes among African Americans. *Annu Rev Psychol* 2007; 58:24.1-24.25

Paradies Y. A systematic review of empirical research on self-reported racism and health. *Int J Epidemiol* 2006; 35:888-901.

Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. *Am J Public Health* 2003; 93:200-208.

Health Association Annual Expo and in the “Confronting Healthcare Disparities” conference in Holyoke, and has been featured in the Boston Globe and on Neighborhood Network News. Additionally, the program was part of the Boston Public Health Commission’s “Connecting for Change Youth Summit” on December 8, 2007. Currently, Community Voices participants are developing a booklet of the photo essay, which will be available in January, 2008. ❖

For more information on the program and photo essay, please contact Katherine Rushfirth, CCHERS Project Coordinator, 617-373-5787 or k.rushfirth@neu.edu

Disparities Action Network (DAN) Update



Alexandra Puckerine, Dr. Deborah Prothrow-Stith, photo courtesy of “Health Care for All”

In early October, CCHERS participated in the Disparities Action Network’s Health Disparities Advocacy Day at the Massachusetts State House. The event was a key advocacy event for the coalition, with nearly 50 member organizations attending and turning out hundreds of supporters to advocate for comprehensive disparities reduction legislation, and the elimi-

nation of health disparities. The DAN rallied specifically in support of HB 2234, An Act to Eliminate Health Disparities in the Commonwealth.

Representative Byron Rushing led the day along with DAN Co Chairs Elmer Freeman and April Taylor and Harvard School of Public Health’s Dr. Deborah Prothrow-Stith. Representative Gloria Fox, Representative Peter Koutoujian, and Senator Dianne Wilkerson also delivered remarks on this important issue. The program was further punctuated by Worcester resident Fatima Mohamed who spoke about the importance of cultural competence in hospitals, and 15 year old Community Voices

student Alexandera Puckerine from Mattapan, who made remarks on her experience as a young person concerned about the health outcomes she sees in her community. ❖

If your organization is not a part of the DAN, this is a wonderful time to get on board. Contact Camille Watson at cwatson@hcfama.org or Lucy Clarke at lu.clarke@neu.edu to join the movement to eliminate health disparities.

BPHC evaluation of the Mayor’s Disparities projects

Year Two of the Boston Public Health Commission’s funded Disparities Project is being evaluated by the team at CCHERS. Based on the summary recommendations of the 2005 Mayor’s Task Force to Eliminate Racial and Ethnic Disparities in Health and the summary of Year One completed projects, fourteen projects were funded by the Commission in Year Two. CCHERS is engaged in conducting and providing descriptive evaluations of the 8 Food Access and Obesity Prevention projects; 4 Patient Navigation projects and 2 Workforce Diversity projects. Evaluation findings are expected to inform the agenda and direction of Year Three projects. ❖

Conference on Health Disparities and Higher Education—Tufts University, November 17th

Around 300 students and health professionals alike gathered at Tufts University on Saturday, Nov 17th to bring to light the issue of health disparities. The purpose of the conference, *Health Disparities and Higher Education*, was to raise awareness about the pathology of health disparities and the underlying social, political and economic factors that create and exacerbate the health divide. Also, the conference aimed to discuss the latest research that has investigated the manifestation of disparities and the barriers that prevent various racial and ethnic groups from seeking care. Most importantly, panelists discussed what will be necessary in order to ameliorate disparities and shared some insights into their successful initiatives. ❖

News of Our Partners

BUSM Names Associate Dean

Dr. Sharon Levine was named Associate Dean for Academic Affairs at Boston University School of Medicine (BUSM) replacing Dr. John McCahan who was a founding member of CCHERS and served on its Board of Directors

Bouvé College Announces Search for Department Chair

The Department of Health Sciences within

the Bouvé College of Health Sciences' School of Health Professions seeks a Chairman

Boston Public Health Commission Funded REACH US

Boston is one of 18 grantees selected by the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health Across the U.S. (REACH U.S.) program to operate as a Center of Excellence in the Elimination of Disparities (CEED). REACH U.S. is a national program to eliminate racial

and ethnic health disparities. It builds upon the knowledge initiated by projects funded under Racial and Ethnic Approaches to Community Health 2010 (REACH 2010). The Center of Excellence will draw upon the disparities work of the Boston Public Health Commission and city of Boston to support communities that are working towards the elimination of racial and ethnic health disparities. The work will focus on the impact of cardiovascular disease and breast and cervical cancer disparities on black residents.

Upcoming Events

Disparities Action Network (DAN) Statehouse Screening

On January 30th (10am-12pm) the Disparities Action Network will host a disparities briefing in the Member's Lounge of the State House. The event will highlight the latest Massachusetts disparities data and educate legislators about the DAN's legislative and budget advocacy efforts aimed at eliminating disparities.

Please contact Camille Watson at 617.275.2936 or cwatson@hcfama.org for more information.

Michael Moore's film "Sicko"

The Center for Community Health Education, Research and Service, Inc. (CCHERS) will be sponsoring a screening of the film "Sicko" at the Raytheon Ampitheater on Wednesday, January 16th, 2008 at 6:00 p.m. For more information please call 617.373.5787 or email k.rushfirth@neu.edu.



**Center for Community
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