

UNNATURAL CAUSES ...is inequality making us sick?

A four-hour series as seen on PBS and a national public engagement campaign

Edited Interview with Dr. Camara Jones Research Director on Social Determinants of Health, Centers for Disease Control

WORKING TO MEASURE RACISM

I'm a family physician and Ph.D. epidemiologist by training. Here at the CDC, I'm Research Director on Social Determinants of Health, within the Division of Adult and Community Health. My work includes doing research, developing measures of racism, convening the Measures of Racism working group here at CDC, and speaking widely across the country, communicating some of our research results and also ways for people to understand that racism still exists and how it can be impacting health.

I was recruited here to CDC, within the Chronic Disease Center, because I wanted to bring attention to the impacts of racism on the health and wellbeing of the nation. The racism work is still a very small bit of what we're doing. We're starting out by developing these measures and trying to get them on a lot of our national data collection instruments.

But it's really about naming this elephant in the room. Racism is right smack up in our national living room, and yet we tip around it, and sometimes we are able to talk about race, but we don't go further and say "racism." Sometimes we talk about discrimination, sometimes we talk about disparities and all, but I think that if you really want to get to the root, you need to talk about racism, which is the system that's creating all this.

It's very clear relationship between stress and health. And it's clear that racism causes stress. So we are building this bridge that is showing us that racism, through stress, can impact health. And I think that's an important thing, because it gives us one idea of where you can intervene, which would be on a stress mechanism.

However, I have to say that if that's all we did, was teach people to relax or whatever it was going to be, without changing the situation that is stress-inducing, then I think that we would be doing all of us a disservice. There are different ways to reduce stress. There's the one where you have the individual try to block out the stressful environment, and the other is where you intervene on the stressful environment and change it.

LEARNING TO ASK THE RIGHT QUESTIONS

The social determinants of health are the social and cultural things that determine how healthy you are. They're things that are outside of your genes. They're things that are outside of what you do as an individual. And they include how much money you make, things about your neighborhood, the grocery stores that are available, the kinds of billboards, liquor stores or not, transportation, the kinds of housing that you're in, whether there are trees or not, walking trails. They include things about your

neighborhood that seem even further away. Like is there a toxic dump site near you? Do you have a lot of air pollution in your area? And they also include opportunities. So social determinants of health include: How good are the schools in your neighborhood? Are the jobs available? All of those things.

So I think of the social determinants of health as those things that actually have a lot of influence on how healthy you are, that are outside of your individual personhood. They are really the context in which individual behaviors arise.

It's an important thing for people to realize that when we're dealing with health issues, you can't— the medical care system will not be able to make everybody well. All of our health issues will never be solved within the medical care system, or even within the public health system, because there are things that are happening in people's daily lives that are determining how healthy or sick they are, and if we're ever going to try to address health issues, we can't just do it only through the hospitals or through the doctors' offices, or even through CDC. We have to be working with the schools. We have to work with the justice system, transportation, housing, labor. All these sectors influence how well our population is.

Right now many people, in their thinking about health in our country, think about individual behaviors as the core of it. Eat less meat, don't smoke, and that kind of thing. But I think that we have to ask: Why are people behaving in certain ways? And so you have to enlarge the circle to think about the context in which those individual behaviors arise. And then you have to even go beyond that to ask: Why are there certain people in certain contexts? And why do we have the range of contexts that we have? And then outside of that: What creates different neighborhoods? What creates different classes? And then: What shunts different populations into these different classes? And there, you think about forces like racism, which is the basis of my work, which actually differentially shunts people of color into poverty while white folks remain differentially in the wealthier classes.

One of the main obstacles in our country right now is that people don't understand the importance, by and large, of the social determinants. Even in a lot of our routine data collection, we don't routinely collect some of the information like education or income on the individual level. People are now developing ways to measure neighborhood status, and so now we're able to take a person's address and geo-code to neighborhood, and so then you can have characteristics of the neighborhood, the mean income of the neighborhood. I would love it if we would have (you know) per-pupil spending per neighborhood or that kind of thing, and then start linking that back to the individual.

But right now I think it's that our systems still are very individually focused. And we as a nation are very individually focused, [laugh] I would say. We think that there's a lot of individual responsibility, and we don't think about the larger context in which individuals find themselves, and how those can constrain the options; they can constrain what a person can do about their health; they can constrain how far a person can go. And I think it's understanding that it's not all individual, "pull yourself up by your bootstraps;" that there are other things that determine what you can do as an individual.

OWNING RACISM

Many white people think of racism as something that happened in the past, and they wonder why you keep mentioning it. And I find that if you just walk into a room and say you want to start talking about racism, a lot of white people will feel as if you were getting ready to attack them and call them racist.

But when you talk about racism, you're not talking about an individual (you know) behavior or individual character flaw. I think of racism as a system, a system of structuring opportunity and of assigning value, based on the social interpretation of how we look.

I think some of the discussion about racism gets so hard because everybody's wanting to be a great person. Everybody wants to be fair. Everybody thinks that they love everybody. And that is true. I mean, people within their context are trying to do the best that they can.

But we have a system that has been built on historical insults to various people. You know. The native people, the American Indians (as we call them now, or Native Americans), their land was taken. I mean, that is the basis of the founding this country. West African people were kidnapped and brought against their will, with tremendous loss of life, even in the Middle Passage, to come here. And then their unpaid labor was coerced to help build this country. For many, many groups, you have historical injustices that are a core part of this society. And people are continuing to reap advantage or disadvantage, depending on their relationship to the groups that set these things up.

And it's hard for people who are born into that to own it. Because they say, "Well, maybe that was my great-grandfather, but it's not me." But they don't understand that the benefits from how things were structured continue to accrue to them, and that they're going to have to be addressed, that you're going to have to name the fact that there's an uneven playing field in this country.

But what will motivate white folks to engage in this? Naming racism is hard. The first thing they can see is: Well, okay, this system is unfairly disadvantaging some individuals and communities. So that's good for them to understand that. But at the point where they can also understand that the flip side of unfair disadvantage is unfair advantage, that might stop people. That might be the stopping point.

So then it's the third result of racism, which is that it's sapping the strength of our whole society, through the waste of human resources, and it's sapping the genius. We're not cultivating all of our genius. We're not valuing all of our young men in the efforts, what they could contribute to our society. We're not caring. We're not crying that Black men and women in this country, for example, are dying six to eight years earlier than white men and women, and what the loss that is to our society.

I think that it's there. Once we can start communicating that loss and measuring that loss, once people can start believing that it's really a loss, as opposed to think: "Well, we're getting along very well, thank you, right now as it is, why invest in those people?" At the point where people can understand it as a loss, then we'll have the whole society mobilized to dismantle the system.

RACIAL ASSIGNMENT AND HEALTH

People are not born with a race. People are born with parents and grandparents, and all behind them, they have a genetic ancestry, they have a cultural ancestry, which we might call ethnicity. But they're not born with a race. They are assigned a race in a given place and time.

Here in Atlanta, Georgia, which is where we're having this conversation right now, I am clearly Black. That's the race, that anybody walking near me would say, "She's Black." In Brazil, I'm told I would be clearly white. Clearly white. You know. No question about it. In South Africa, I'm clearly colored. So

even though I have the same appearance today, in all of these places, my race, the group to which I would be assigned, would be different in three different places.

Likewise, if you want to carry that line of thinking a little bit further, if I were to stay in any of those places long enough, then my health outcome, I bet, would take on that of the group to which I've been assigned, even though I'd have the same genes in all three places.

So I say that race is the social interpretation of how we look, because it's not something that people are born with. And I have very interesting data. I'd love to share it with you, the broad outline of it, which is that on the Behavioral Risk Factor Surveillance System, where we have a 6-question Reactions to Race module, one of the questions is: How do other people usually classify you in this country?

Most interesting to us was that for two groups - for self-identified Hispanic/Latino populations and self-identified American Indian/Alaskan Native populations - there were a sizable group in both who were usually classified by others as white. So we said: Well, wouldn't it be interesting to see whether, in the same self-identified Hispanic group, for example, there's a health difference between those usually classified by others as Hispanic/Latino and those usually classified by others as white? And there is. Also in the American Indian/Alaskan Native.

And what you see is, if you compare the Hispanics (self-identified Hispanics usually classified by others as Hispanic) with self-identified Hispanics usually classified by others as white, and with self-identified whites usually classified by others as whites, the Hispanic Hispanics have much lower self reports of excellent or very good health compared to the Hispanic whites, much lower compared to the white whites, and there's no difference between the Hispanic whites and the white whites. Same thing when you look at American Indian populations.

So what it is saying is that the socially classified race, the socially assigned race (how do other people usually classify you in this country) is having a stronger relationship with health than self-identified race/ethnicity.

WHAT ARE WE MEASURING WITH RACE?

You have two things that you can see with infant mortality. You can see that education, for example, predicts infant mortality for both Black women and white women. And the more educated you are, the less likely you are to have a low birth weight baby, a preterm baby, or an infant death.

On the other hand, those curves are different for Black women and white women, so that white high school graduates, only high school graduates, still have better birth outcomes than Black college graduates - which is an amazing thing. Income plays into it, education plays into it, but you still have this racial gap, which is not genetic.

I think we have to be very clear that race is not genes. (I mean) We already talked about race as the social interpretation of how we look. And also black people in this country represent a genetic admixture of African geographic genes and European and Native American and all of that. So there's not kind of (you know) a Black gene pool. In fact, the Human Genome Project has made it very clear

that there is no genetic basis for race or human subspecies. So when we talk about why is this happening, we already have ruled out genes. So we need to go further.

And when you think about what this variable “race” measures, there is some relation to socioeconomic status, but now we’re taking that out because we’re going to compare college-educated women. There’s culture that’s part of that, although again, there’s not one Black culture, like there’s not one white culture or Hispanic culture. Somebody could have just come from Ethiopia or from Haiti, or they’re raised in the rural South or the urban North, and have very different cultures in terms of diets and all of that. We recognize more easily that there’s not one Hispanic culture or Asian culture. But we are less likely to understand there’s not one Black culture or white culture.

So then, what is race measuring? So we have to start asking questions there. What is it there? Is it trans-generational disadvantage that’s taking a few generations to wash out? Is it the stress of not being treated respectfully when you go into the doctor’s office or even into the store, being followed around when you go shopping for clothes? Is it some of that everyday racism, that stress of that? You know, there’s a whole lot that we have to investigate.

And so I think, although I can’t give you the answer, I can tell you the question is, by looking at what are the differences in how we are treated in our exposures, in our experiences, and in our opportunities in society by race, that’s where we’ll find the answer.

HOW OFTEN DO YOU THINK ABOUT YOUR RACE?

In the Nurses’ Health Study II, in 1997, we were able to include the question: How often do you think about your race? Would you say never, once a year, once a month, once a week, once a day, once an hour, or constantly? And the results were really fascinating.

In white women, 50% never think about their race. In black women, 50% think about their race once a day or more frequently, with 20% thinking about their race constantly. So that’s quite a difference. It’s an eternity of experience apart.

Yeah, what is that? Well, first of all, we should be clear that people aren’t born thinking about their race. It has to do with what I’m calling the racial climate in a given place in time. “How often do you think about your race” is reflecting different groups’ experiences in this racial climate. So when white women say that they never think about their race, it’s because race is not pertinent to their daily experience. And in fact, they probably feel raceless. They may be thinking about other people’s races, but when they describe themselves, very few white women would say, “I am a white woman” if they were describing themselves on the phone.

For Black women, it’s completely different. They are aware that race has a lot to do with how they are interpreted in moving around constantly. When they walk into a high-end store, whether the person deigns to come over and ask if they need help or not; when they go into a physician’s office, the kind of respect that they get, the assumptions that are made about them just because of how they look. That’s just the interpersonal stuff. Then you get to the structural stuff of, what did race have to do with how their mother was able to position them? And what is race going to have to do with how they’re

able to position their kids? And what is race going to have to do with how they have to worry about their sons, and their daughters?

And so what you have is people with a different appreciation of there being a racialized society, and then different experiences within that racialized society. For white folks, it matters how often they think about their race. Even for white folks. You would expect that it wouldn't matter. But it does. In our data from 2004, when you look at "How often do you think about your race," most of the white people are saying "never." 60% are saying they never think about their race. But there are some that say (you know) all the way to "constantly."

And then you ask the question: Within each of those groups, how many report their health as excellent or very good? The best health outcomes are for white folks who think about their race about once a month. You look at Hispanic/Latino, it's the same thing. So it's not "never," in other words. When you look at Black folks in the same states, in the Behavioral Risk Factor Surveillance System, the best health is thinking about your race once a day.

What does that mean? We're still investigating this, but what does it mean? Does it mean that it's healthy to understand where you are, that you're in a racialized society, so that you can equip yourself to deal with it? It's very interesting. It drops off a little bit at "constantly," but it's not the "nevers." For black folks or white folks, it's not the "never thinking about your race."

Now, some people ask me: What would you want things to look like? You know. If you were to compare these different groups, and you said, "How often do you think about your race," what do you want things to look like? I think there're two stages we're going to have to go through. The first is, you don't want there to be a disconnect. You don't want one group saying 60% never thinking about their race, and the other group thinking about it 60% once a day or more frequently. You don't want a disconnect, because if race is pertinent in this society, then everybody needs to recognize that.

So first you want the two groups to have about the same distribution. But you don't want everybody always thinking about their race, because that's probably what you had in Nazi Germany, with everybody thinking about their race. What you want is everybody to understand that race is operating on people in the society, and then you try to move everybody, I would say, to "never." Because if everybody moves to "never," then race is no longer operating in this society; you have dealt with race as a way of structuring opportunity and assigning value, and it's no longer pertinent.

EVERYDAY RACISM AND ACCELERATED AGING

If you were to look at, say, Black and white children, they would have basically the same health profiles. But by the time you get people into the 20s, Black women would appear to be like 30-year-old white women. Actually there're several of us now who are working on this. Arlene Geronimus has what she calls her "weathering" hypothesis. I came to the same conclusion a very different way, through looking at blood pressure, and have what I call my accelerated aging hypothesis. And the elements are first of all that Black/white differences in health outcomes, across the board, are due to the accelerated aging of the Black population compared to the white.

And the second element is that that accelerated aging of the Black population is due to racism. We have evidence for that not only in terms of preterm births (in a lot of Arlene Geronimus' wonderful work), but we also look at: When do they screen people for glaucoma? You know. They recommend screening Black men, you know, for glaucoma at age 40, but white men at 50. When do we see the breast cancers? When do we see the prostate cancers? There's a gap that we see in many health outcomes, where Black people are exhibiting things about 8 to 10 years earlier than white folks. And so it suggests that we may be onto something there.

I'm not talking about physical appearance and looking older and haggard; I'm talking about what's happening inside the body, to our systems in the body, to our heart and lungs, to our pancreas and all of our hormones, all of that. And it's as if the body, on the inside, is just wearing out.

In fact, people who've looked at blood pressures, measuring ambulatory blood pressures for white folks and Black folks, young folks, see that the blood pressures might be the same during the day, but at night the white folks' blood pressures would drop, and the Black folks' blood pressures would stay the same. Everyday racism is like gunning the engine of a car, without ever letting up, just wearing it out, wearing it out without rest. And I think that the stresses of everyday racism are doing that.

THE GARDENER'S TALE – THREE LEVELS OF RACISM

This story is about a gardener who has two flower boxes, one which she knows to have rich, fertile soil, and one which she knows to have poor, rocky soil. And she has seed for the same kind of flowers, except some of the seed is going to produce pink blossoms and some's going to produce red blossoms. And the gardener prefers red over pink.

So what does she do? She takes the red seed and she puts it in the rich, fertile soil. And she takes the pink seed and she puts it in the poor, rocky soil. And three weeks later, she comes and she's looking at her flower boxes, and what she notices is that every single one of the red seeds has sprouted, and some of the red flowers are tall and strong and flourishing. The weak seed in the red at least has sprouted and made it to a middling height. But when she looks in the pink box, in that poor, rocky soil, the weak pink seed has died, and the strong pink seed is just struggling, struggling to make it to a middling height. And then those flowers go to seed.

And the next year the same thing happens. And then those flowers go to seed. And year after year, the same things happens, until finally, ten years later, the gardener's looking at her flower boxes and she says, "You know, I was right to prefer red over pink."

Now we'll interrupt that to say that this first part of the story is how institutionalized racism works. You had the initial historical insult of the separation of the seed into the two types of soil. You had the flower boxes, the contemporary structural factors, keeping the soil separate. And then through inaction in the face of need, perpetuation of that difference.

But now we're going to pick the story back up and say: Well, where would personally mediated racism be in this garden? Well, that's when the gardener's looking at her flowers and she says, "Those pink flowers are so scraggly and scrawny," and she plucks those blossoms off before they can even go to

seed. Or she might notice that a pink seed has blown into the rich, fertile soil, and she plucks it out before it can establish itself.

And then where would internalized racism be in this garden? Well, you have the pink flowers in their box, trying to make it, looking over at red, which is all flourishing and flaunted. And here come the bees. And the bees are minding their own business. They're just collecting nectar. But they're pollinating at the same time, so bees are buzzing around. Here come the bees to the pink flowers. "Bzz, bzz." And it comes over to this one pink flower, "bzz," and the pink flower says, "Get away from me, bee. Don't bring me any of that pink pollen. I prefer the red." Because the pink flower has internalized that red is better than pink.

So then the question arises: What do we do to set things right in this garden? Well, you could say: Well, let's address the internalized racism. So we're going to go over to the pink flowers and we're going say, "Pink is beautiful. Power to the pink!" which might make the pink flowers feel better, but that, in and of itself, is not going to change the conditions in which they live.

Or you could say: Well, okay, I understand that. Let's address the personally mediated racism. So let's go talk to the gardener. Or better yet, let's have a workplace multicultural workshop for the gardener, which is all good. But we're going to say, "Dear gardener, would you please stop plucking those pink blossoms?" And maybe she will, and maybe she won't. But even if she does, it's not going to change the situation in which the pink flowers find themselves.

What you really need to do if you want to set things right in this garden is to address the institutionalized racism. So you have to either break down the boxes and mix up the soil, or if you want to keep separate boxes, that's okay too, although to me it makes it easier to segregate resources. But if you want to keep separate boxes, then you have to enrich that poor, rocky soil until it's as rich as the rich, fertile soil. And when you do that, you know, the pink flowers will flourish. They will look grand and beautiful and wonderful. Maybe even better than the red, because they have, after all, been selected for survival and strength, which is a very, very interesting notion.

And then once those pink flowers are flourishing, they'll no longer be looking over at red, wanting to be red. So you'll have also addressed the internalized racism. And in addressing the institutionalized racism, you may even address the personally mediated racism. Now, the original gardener may have to go to her grave preferring red over pink. But her children, seeing the flowers equally beautiful, will be less likely to adopt that attitude.

So this story has very quickly been to illustrate these three levels of racism--institutionalized, personally mediated, and internalized--and to very strongly suggest that if we want to set things right in the garden, we have to at least address the institutionalized racism. We can address the other levels at the same time. But we have to at least address the institutionalized racism. And when we do, the other levels may take care of themselves.

There's just one last piece to this story, which is the important question: Who is the gardener? After all, the gardener is the one that I've given the power to decide, the power to act, and control of resources. And who is this gardener really? Well, certainly, government is part of the gardener. Sometimes I joke and say, well, maybe the rich people behind government are part of the gardener. Maybe we can be

our own gardener in communities if we have this power to decide, power to act, and control of resources, which is what I also describe as self-determination.

But whoever the gardener is, whoever's going to have this power, it's very important that the gardener be concerned with equity. If the gardener's not concerned with equity, then you'll have the scrawny-looking pink flower and the pretty red flowers, and the gardener will be thinking that the garden is beautiful when in fact it is not.

SOCIAL DETERMINANTS OF HEALTH VS. HEALTH DISPARITIES

When we think about intervening on health, there're a lot of things we can do. We can think about the health challenge as people at risk of falling off a cliff. And so if somebody falls off a cliff, certainly that person wants to have an ambulance at the bottom of the cliff to speed them on to care. But there are other interventions we can take before that. We could have a net halfway down the cliff to catch people, even after they've fallen, but to lessen the blow. We could have a fence at the edge of the cliff to keep people from falling in the first place. And we could also have something to move the center of the population away from the cliff face.

And so I describe each of these levels of intervention. The ambulance at the bottom of the cliff, that's your medical care. The net halfway down, that's some of your prevention. That's your safety net programs and kind of your secondary prevention.

So your medical care for infant mortality, that's your neonatal intensive care units. Your net halfway down, well, that's monitoring people during prenatal care, and then if they go into labor early, then getting them in the hospital, trying to make sure that baby hangs on for a few more weeks. The fence at the top, that's your primary prevention. That might be your WIC programs, trying to make sure that your pregnant women have adequate nutrition. Moving the center of the population away from the cliff face would be jobs, self-determination, better living conditions, all of that, to keep people from being at risk in the first place.

But even with this little cliff image, we haven't raised the health disparities yet. We have to think about, how do health disparities arise. So I'm going to leave your little cliff image for a minute and say, the health disparities arise on three levels. You have differences in the quality of health care, you have differences in access to health care, and you have differences in living conditions that make some populations and people sicker in the first place.

So now let's go back to this little image of the cliff. And now what we realize is that we don't have a flat, 2-dimensional cliff. We have a 3-dimensional cliff. And at some parts of the cliff, there may be an ambulance, but that ambulance may be slow, or it may go off in the wrong direction. Or maybe at some parts of the cliff there's not even an ambulance, nor a net, nor a fence. And usually, at those parts of the cliff, the center of the population is closer to the edge of the cliff in the first place.

Now, the question about health disparities: If the ambulance is slow or goes the wrong way, that's differences in quality of care. If there's no ambulance nor net nor fence, that's differences in access to care. And if the center of the population is closer to the edge of the cliff, that's differences in living conditions, making some people sicker or well.

What is the difference between social determinants of health and social determinants of health disparities? Addressing social determinants of health is moving the center of the population away from the cliff face. But that doesn't get into at all why we have a 3-dimensional cliff, or why there're differences in how resources are distributed along this 3-dimensional cliff, or why there're differences in who tends to live at different parts of the cliff. Those are the determinants of health disparities.

And so we need to address how close people are to the edge of the cliff, but also address what is the system that's making the cliff 3-dimensional, and making the resources unevenly distributed, and the population unevenly distributed. And when we do that, when we identify those things and intervene on those mechanisms, then we'll be addressing the social determinants of health disparities. And we have to do both.

HOPE FOR THE FUTURE

I would say that I am a person who believes that each child is born with unlimited potential. And so knowing that, then when these children die prematurely or aren't able to even understand, much less develop to their full potentials, that represents a loss to our society.

And I'm not talking about economics. I'm talking about the ability to create, the ability to think, the ability to innovate, the ability to love, the ability to bring people together. And we need to know that just as we would value, you know, the president's grandchild, we need to value each child. Because given the same opportunities, each child can have just as unlimited a potential.

We're a nation of really, really good people. And we're all hoping that we will have the opportunity equal to anybody else, and we're hoping that we're not trampling on other people. And so that's why sometimes we have to blind ourselves and not talk about things when we see so much inequity in our society, on a lot of different levels.

Because we want to hope that anybody who works hard will make it. And certainly a lot of people who make it have worked hard. But there are a lot of people working hard who still aren't able to make it because of structural barriers.

When we start talking about structural barriers, then we have to talk about: What is my role in maintaining those structural barriers? What is my role in dismantling some of these barriers? Why would I do that? I think it starts a whole new level of conversation. But it's engaging beyond the individual and beyond the family. It's saying that things as they are don't have to be, and that we can ask questions about the way our society is structured. And once we ask those questions, maybe there're things that we'd like to change.

I actually belong to a generation where we've had a lot of people who made it. They were born and they survived, and were trying to make it. But I think that the opportunities are changing again, and I think that the Oprah Winfreys that we see, the Colin Powells, the Condoleezza Rices, might have been infant deaths, had it not been for the policies that started to close the gaps. And I think that we're losing those children now. We can't even understand the loss. The next Martin Luther King may have just died here in Atlanta yesterday.

During my lifetime, the gap has closed a bit, and now it's widened again. And I think it's as a result of social policies. After the War on Poverty and the civil rights movement, we had social policies that were allowing people more opportunity, trying to equalize things. And then since then, we've had different emphasis in our social policies, and the gap is widening.

Now people are very much concerned about making it as individuals and for their individual families. And they're just happy that they're sort of clinging on themselves, and making it themselves, and a little bit afraid to reach out because what might it mean for them if they were to enlarge their thinking and include other people? But I think that's what we do need, is collective thinking, because we are not individuals. What does happen to my neighbor is going to affect me, either tomorrow or next week, but it is going to affect me. And so we need to understand that, and to understand that what's good for my neighbor is good for me, what's good for me is good for my neighbor, and all of us are in this together. So it's a shift back to collecting thinking, and a belief that we can have collective action.