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Determinants of Health

Determinants of Health explores the influences on health beyond an individual's biological or behavioral health. These influences include education, poverty, employment, and housing. Importantly, all of these influences are also determined by politics, racism, and discrimination. Readers will be encouraged to reflect on their own cultures and identities and the potential impact on others; to identify examples of systemic bias, institutional and individual racism and discrimination; and to analyze and discuss determinants of health.

Chapter Objectives

After completing this chapter, you should be able to:

- identify the determinants of health from a broader perspective than biomedical
- reflect on your own cultures and identities and their potential impact on others

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- identify examples of systemic bias, institutional and individual racism and discrimination
- analyze and discuss concepts of racism and discrimination and their impact on professional care.

Determinants of Health Explained

Ultimately, our goal for culturally safe health care and systems is health equity. To build our awareness, our sensitivity, and the safety of our practices and systems, an understanding of all of the factors that impact health and well-being is critical.

Health is determined by much more than biological influences as we have already noted in previous chapters. In fact, the health and well-being of individuals has less to do with an individual's diet and exercise and more to do with experiences of health care and social contexts including families and communities and the built environments in which we live.

There is a substantial body of literature relating to the 'determinants of health'. Most often these 'determinants' are described as the 'social determinants of health' to distinguish them from the purely biological contributors to health. The 'social' determinants are a way to explain the broader causal factors that lead to ill-health. These social determinants of health include factors such as access to education, housing, income, and employment and political factors (Dawes, 2020). These factors are collectively referred to as *socioeconomic status*, or SES, which is a *determinant* of health as it is critically important in understanding the current state of health. Particular groups of people are more likely to experience poor socioeconomic conditions compared to dominant or privileged groups.

However, keep in mind that low or poor socioeconomic conditions are a value judgment made through the lens of capitalism and wealth, in an economic sense, and may not necessarily reflect the diversity of notions of 'wealth'. Dominant culture perspective often defines what these determinants are, how they are measured and interpreted, and how they are judged and understood. Education for example, often implies Western education, with particular judgments of benchmarks, such as completion

of high school or higher education. Indeed, we refer to education past high school as 'higher', as if it is 'superior' or 'better' than other forms of education such as in the trades or arts or small businesses or even life experiences. Housing and employment are also defined by Western and capitalist ideas and values and are the metric for determining and judging health and well-being such as home ownership or whether someone is employed part-time, full-time, or self-employed.

Social determinants, however, are strongly linked to health outcomes, but not exclusively and not always for people who may conceive of an entirely different set of determinants of health. For example, Reid and Taylor (2011) discuss the importance of maintaining Indigenous core values to engage in the world. An individual who maintains their functioning through the key values of respect, reciprocity, and relationships, for example, may be considered healthy, even in the absence of employment, education, or shelter as conceptualized from a Western perspective. Determinants of health from other perspectives and worldviews need to be included in health and academic discourses. Let's now take a closer look at what has been described as the social determinants of health.

Readings

Dawes, D. E. (2020). *The political determinants of health*. Baltimore: Johns Hopkins University Press.

Marmot, M. (2015). *The health gap: The challenge of an unequal world*. Bloomsbury.

In 2005, the World Health Organization established the Commission on the Social Determinants of Health, which included a global network of researchers, policymakers, and civil society organizations (WHO, 2008). The Commission on the Social Determinants of Health focused on nine broad areas that contain themes. These themes are employment conditions, social exclusion, priority public health conditions, women and gender equity, early child development, globalization, health systems, measurement and evidence, and urbanization.

The Rio Political Declaration on the Social Determinants of Health was adopted in October 2011 at the World Conference of the Social Determinants of Health in Rio de Janeiro. This declaration includes five priority areas: enhancing health policies and decision-making, widening participation in policymaking and implementation, improving health care and services, strengthening international cooperation, and monitoring impact and progress (WHO, 2011).

The CDC describes the social determinants of health as the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes (CDC, n.d.). *Healthy People 2030* outlines five key areas of the social determinants of health including healthcare access and quality, education access and quality, social and community context, economic stability and neighborhood, and built environment. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Health outcomes are influenced by economic policies and systems, development agendas, social norms, social policies, and political systems (WHO, n.d.).

Health inequities, or the unfair and avoidable differences in health status that we see both within and between countries, are influenced by the social determinants of health. These determinants include income, education, employment and job security, food insecurity, the conditions of working life, housing, amenities and environmental conditions, social support and inclusion, structural conflicts, early child development and access to quality and affordable health care.

If we consider colonization and the history of policies that impacted many groups in the U.S., we might come up with a description of the social conditions that many people are likely to experience. For example, we might say that these groups are more likely to:

- die younger
- live with higher levels of chronic illness
- be under-educated, un- or under-employed, and economically disadvantaged
- be or have been imprisoned
- live in overcrowded or inadequate housing.

These experiences and social contexts have been documented and reported for many years. However, remember that although statistically a greater proportion of people from certain groups are likely to experience lower social and economic status, this does not mean it is true for everyone in those groups. We need to be aware of the potential for further biases and stereotypes to develop when we learn about various inequalities. Additionally, at least some statistics and data analysis are based on Western ideals and judgments that may not provide a balanced perspective. Even considering these issues, statistically there are differences between groups that certainly warrant attention or further investigation.

Culture and Identity as Determinants of Health and Well-Being

We have discussed culture and identity extensively already throughout this book. But how can someone's culture or identity *determine* their health and well-being? 'Culture dictates the language used to define issues, the identification of problems, the framing of those problems, the manner in which solutions are sought, and the methods for defining and measuring success' (Knibb-Lamouche, 2012). Culture, or identity, are the intersecting aspects of who you are, as a person, and the overlapping of these aspects with the people around you. This might include your relationships, your communication, how you see yourself, and how you relate to the world around you.

Culture or identity as a determinant of health and well-being relates to the 'fit' between you and all the places and spaces you engage with as you live your life. Maya Angelou (1986) wrote that 'the ache for home lives in all of us, the safe place where we can go as we are and not be questioned'. Some people have lots of 'safe places', but for others, these 'safe places' are few and far between. Frequent exposure to 'unsafe places' or places where your identity or culture are questioned, challenged, or, demeaned, can result in a range of health issues such as chronic physical or what are often described as 'mental illnesses'.

It's not difficult to understand then why it is so essential to ensure the cultural safety of people accessing health and human services. There is significant evidence to support what many have already known: that cultural maintenance and vitality adds to resilience. Our nation's history, however, is one of assault and disruption to cultures and identities, leaving people vulnerable and harmed.

How people feel in society—their sense of belonging, which is somewhat influenced by how they are treated by others—is an important element in determining the health of individuals, their families, and communities. When someone treats another person in a way that diminishes, disempowers, or demeans them then this treatment may be racist or discriminating, but most people are not willing to admit that their actions may be such. Many people in the U.S. experience racism and discrimination, which evidence shows has a damaging impact on health and well-being.

The chapter on History highlights the disturbing situation of government 'sanctioned' discrimination against various groups throughout our history and this discrimination continues, albeit, often more subtly. Although cultural safety asks us to treat people 'regardful' of their differences, *when different treatment is imposed or when it results in poorer outcomes, then that treatment is racist or discriminatory.*

Education

A major social determinant of health is an individual's educational levels. How do we define 'education'? Descriptions of people as 'uneducated' or 'illiterate' fail to acknowledge the social and cultural education that is so much a part of many societies. Discussions and assessments of 'education' almost exclusively relate to education as a formalized, Western, school education. In the following discussion, we will refer to education using this definition and we will consider the implications for health in that context.

Research indicates that every year of formal school education undertaken by a young woman can dramatically influence the health outcomes for her entire family. The links between health and education are

increasingly clear. Government policies that allowed for the exclusion or segregation of children based on race and ethnicity and gender, ensured educational disadvantage. There may be some readers of this book who are first in their families to attend formal education after high school. What might some of the barriers have been for others in your family in the past?

Just as with health, problems of access and acceptability in education continue to negatively impact educational levels. The cycle goes on, as we see in Fig. 7.1.

Fig. 7.1 Impact of educational disadvantage (Taylor & Thompson-Guerin, 2019)

Formal, Western education alone is clearly only one part of a still elusive solution. Much of the focus often seems to be on what people should or shouldn't do to improve their health. However, consider this: what 'education' might be required for people to shift from stigmatizing specific health service users to understanding and reinforcing the efforts people do make for their health?

The 2020 COVID-19 pandemic drastically changed the education environment, challenging many practices that had been normalized and inflexible for so long. Suddenly, home-schooling parents previously chided were highly sought-out experts. Long hours every day attending virtual schools increased concerns about 'screen time' and the need for social interactions, play, and general well-being, concerns that often had been taken for granted. Tests that had always been assumed necessary were now optional or no longer required. All these changes brought to the fore important questions about the purpose, value, and need for certain educational practices as well as broader societal inequities such as access to technology, the safety of home environments, and the availability of food.

Employment and Wealth

Employment conditions such as whether or not employees have access to sick leave, paid vacations, parental leave, health insurance, or a retirement plan are just a few of the factors that can influence health. The actual employment conditions such as working long hours, the stressfulness of the environment, the relationships between superiors and co-workers are other factors that contribute to people's health and well-being. We also might look at the time it takes to get to work or whether or not transportation to and from work is reliable and safe. Then, of course, there are the workplace health and safety hazards such as exposure to chemicals or physical demands such as heavy lifting. Ironically, it is those people who are in the lowest paying jobs that are most likely to get sick or injured who are most in need of health insurance and health care. Minimum wage in the U.S. has not kept up with the increasing costs of housing, food, clothing, and other basic necessities.

And what about unemployment? It would not be hard to imagine the challenges of losing a job and income on health. This book is not presenting figures but we encourage readers to conduct a search for national, state, and local figures. The rates of unemployment in some areas are dire and the ongoing impact means that there are sectors of the community who live in economically impoverished conditions, right here in the U.S., an economically wealthy nation. This level of disadvantage within a country can often go unnoticed or hidden as people struggle to maintain a veneer of 'normalcy'. When money is tight, the first things to let go of are often the very things that maintain health. When stress increases, the coinciding pattern of spending can be on things like tobacco, alcohol, or drugs. This does not mean that tobacco and substance abuse is always associated with the unemployed and low-income populations, but these can be symptoms of an individual or group in crisis.

Income or wealth are other contributors to health and well-being. It is not just the amount of money or wealth that someone has, although if you have 'enough' money, certainly, stressors related to being able to afford the basic necessities are eliminated. Patterns of wealth and poverty and the equitable distribution of resources also matter. Inequities in the distribution of wealth have been shown to be highly correlated with a range of health and social outcomes (Marmot, 2015).

Disparities in income, between people in the same jobs, is yet another concern that negatively impacts on health and well-being. Imagine finding out that a co-worker earns more than you—for the same job and the same qualifications. The American *myth of meritocracy* will have you believe that if you just work harder you will get there too, or that people who are very economically wealthy have 'earned' it. But someone who earns $500,000 per year does not 'work' 10 times harder, nor are they 10× 'smarter' than someone who earns $50,000.

Wealth in the U.S. is generally understood as material possessions, money, and resources or 'being rich'. But from a cultural safety perspective, remember that not everyone has the same understandings or values regarding 'wealth'. One indicator of social status, or wealth, for many people is demonstrated by questions about family and children. Those

without family, or with no children of their own, can be met with expressions of pity, as these are the hallmarks of 'wealth' in some settings, rather than material 'wealth'. Rich cultural practices and strong cultural identities are essential and protective to health and social and emotional well-being.

Housing, Overcrowding, and Houselessness

Housing has long been recognized as a critical factor contributing to health and well-being. The quality of the house that people occupy, housing tenure (whether you own your house or rent), and the neighborhood characteristics (for example, whether you have spaces or places for exercise or the safety of the neighborhood), all contribute to people's health.

The Flint Water Crisis drew attention across the country to issues of water quality, particularly in urban areas with old homes and lead pipes. Poor water quality can be corrosive resulting in the lead being leached from the pipes which causes a wide range of health concerns. Old homes can also contain asbestos, lead paint, high radon or carbon monoxide levels, and be poorly insulated and damp leading to mold and mildew. These problems can lead to cancer, asthma, kidney problems, neurological damage, and more. These old homes with these issues are more likely to be more affordable to someone on a lower income and they are generally located in neighborhoods with similar homes, leading to a vicious cycle of concentrated health issues. These neighborhoods are also disproportionately in areas with high levels of environmental hazards such as pollution, poor air quality, and other toxins. Similar to the cycle with education, we see a similar cycle in relation to housing: low income → affordable (and maybe poor quality) housing → health issues → compromised employment or unemployment.

Overcrowded conditions are known contributors to maintaining and complicating the eradication of various conditions such as skin infections, bacterial or viral infections, and eye disease. Overcrowded conditions can emerge due to people trying to save costs by living together but can also be cultural and a way to maintain family cohesion. There are

social benefits to having family and others living together. Some people might think that less people living in a house is 'better', or that bigger houses are necessary. These value judgments are reflected in a range of policies such as child welfare that suggests maximum numbers of children in bedrooms and places restrictions on room sharing between children of various ages. A more culturally safe option would be to consult with families about preferred ways of living and to collaborate regarding housing design. Whether in urban or rural areas, knowing how people function in their homes is important to appropriate design.

Another area of concern in the U.S. is houselessness or homelessness. Some prefer the use of the term houselessness because though someone is not living in a house does not mean they do not have a home. Rather than learning just about how many people are homeless, ask yourself why are they homeless? What are the structural or personal contexts that lead to homelessness? There are enough houses empty in the U.S. for everyone to have a roof over their head.

As with education, the COVID-19 pandemic showed that policies and practices that were seen as acceptable now needed a major overhaul. For example, mortgage companies suddenly were able to be more lenient, landlords could not just evict people in the middle of a pandemic when people had lost their jobs and could not pay their rent. Suddenly, money was available for emergency relief. Not surprisingly, COVID-19 had a disproportionate impact on lower income people and their families while middle and higher income families with more secure housing even benefitted in the midst of a crisis. But the 'crisis' was arguably one that had always been there for low income, housing insecure, people and their families.

Reading

For a thorough read about the impact of toxic environments on human development and functioning, see Harriet Washington's meticulously researched book: Washington, H. A. (2019). *A terrible thing to Waste: Environmental racism and its assault on the American mind*. Little, Brown Spark.

Activity
What is the minimum wage for your state? Calculate how much income that equates to for a month. Search your local area for apartment or house rentals. You might use an app such as Trulia or Zillow. How much per month does a one or two-bedroom apartment cost? How much might you need to budget for transportation, whether that is public transportation, or a private car and car insurance and parking costs? What would you estimate food to cost per month? How about phone, internet, electricity, water, garbage, etc.? Could you afford to live independently on the minimum wage in your state or in your local area?

Films
Cooked: Survival by Zip Code is a PBS film about the 1995 heatwave in Chicago in which 739 people died of heat-related causes, most of them poor, elderly and African American.

Leave No Trace is a 2018 film based on a true story about a veteran with PTSD living in the woods with his daughter in Oregon.

Racism and Discrimination

While there is substantial evidence to show that social and economic conditions contribute a great deal to health disparities between groups in the U.S., there is also a curious discrepancy—even when social and economic conditions are taken into consideration, the health and social conditions of particular groups in the U.S. are worse when compared to other groups.

To what do we attribute these differences? Historically, they were often attributed to biological differences, but we know that this explanation has no scientific basis. Could it be that poorer health and social outcomes are because, on the whole, healthcare providers provide poorer health

care? Could it also be that the healthcare system disadvantages some groups (and privileges other groups) in systematic ways, or are there other factors at play?

Many terms exist enabling us to talk about or describe these differences in treatment and structures. While it is a good idea to understand this terminology, it is also important to remember that using some of these terms to describe people (for example, 'racist') can serve to perpetuate the very behaviors and attitudes that we are trying to stop.

Discrimination is when people treat other people differently (and unfavorably) because of their race, ethnicity, class, geographic location, mental status or substance issues, age, migration status, culture, religion, gender or sexual orientation. Racial discrimination is when people are treated differently because of presumed racial differences that are judged based on differences in skin color, hair, and other physical features.

Stereotyping, however, is when people use categories to create or maintain ideas about those categories. A *prejudice*, on the other hand, is making a judgment or holding a certain attitude (usually negative) about people based on their culture or identity. But if a person is prejudiced (holds attitudes or judgments) about certain groups, they do not necessarily discriminate (i.e., actions or behavior) against them.

Differences in healthcare treatment and structures that are due to or can be attributed to someone's ethnicity or race and that result in poorer outcomes can be described as *racist*. *Racism*, at an individual level, is when someone believes that people of a different 'race' are fundamentally inferior to those of another 'race'. '… Racism can be defined as phenomena that results in avoidable and unfair inequalities in power, resources and opportunities across racial or ethnic groups' (Berman & Paradies, 2010).

Privilege is about what others see in you. It's not about what you feel or understand about yourself. You may not come from a privileged background, but relative to another person, you may become privileged. For example, you may get served before someone because you are tall, or male or older or younger, or well-dressed. Privileges are the benefits someone gains from the ways in which they are perceived. Privilege is also ever-changing depending on the circumstances. Privilege is not a stable, enduring, or internal quality or characteristic.

Because of the complexities and diversity of people in racial and ethnic groups, and as a way to understand, for example, why there are health differences between groups of people, some researchers have looked to another concept—*visible minorities*. *Visible minorities* are people from non-dominant groups who are, in one way or another, 'visible' to the dominant population (Colic-Peisker, 2009). For example, Muslim women who veil would be visible minorities in a community where veiling is uncommon, but Muslim women who do not veil may not be 'visible' in the same sense in such communities. As for race or ethnicity, a Black American with dark skin would, according to this line of thinking, be more 'visible' (and therefore possibly a greater target for racial discrimination) than a Black American with lighter skin. It is an interesting concept that has not gone without criticism. The concept of visible minority is used widely in Canada and has come under attack from the United Nations as a concept that perpetuates racism (CBC News, 2007). The issue is complex, but certainly warrants discussion and debate.

Structural racism or *institutional racism* are the terms used to describe the systematic disadvantaging of racial and ethnic groups through systems or institutions or between institutions. This can include barriers (language, transport) or collective failure to provide appropriate services to people because of their race, culture, or ethnic origin. There is growing attention toward these concepts, and toward holding the systems or institutions responsible for their racist practices. For example, if a health service collects data that shows that overall, certain groups of patients received different treatment and that their health outcomes were worse compared to other patients, then the institution has a responsibility to modify its practices in order to achieve a more equitable outcome. Often, however, as with all forms of racism, structural or institutional racism can be difficult to identify.

As an example, consider that a lot of money and effort has gone toward smoking cessation campaigns and programs and smoking rates have decreased dramatically—but more so for certain groups of people—suggesting that the interventions have inadvertently disadvantaged particular groups and benefitted others, or that the information has not been effective for reducing smoking in certain groups. If the programs were designed by people from certain groups, then it should not be

surprising that the interventions would benefit those groups and not others. This could be seen as an example of systemic racism, but the racism is in the processes and procedures and reflected through the outcomes.

Another important concept is that of internalized racism. *Internalized racism* is defined as 'the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves' (Taylor & Grundy, 1996; Williams & Williams-Morris, 2000, p. 255). This acceptance can result in a 'self-fulfilling prophecy' of the beliefs and expectations of others. Internalized racism can also lead to rejection of culture and identity. While it is important to recognize internalized racism as an important part of the bigger picture of racism, we also need to be mindful of the possibility of *blaming the victim*.

This then brings us to the concept of *anti-racism*, which is more about what is done to actively combat racism. Anti-racism can include changing policies, providing anti-racism education or interventions, or 'anything that decreases the existence or practice of racism' (Paradies, 2007, p. 75).

Reading
Kendi, I. X. (2019). *How to be an anti-racist*. New York: One World, Random House.

In order to understand how, and if, racism or discrimination is at work in the U.S., we also need to understand the concepts of *equity* or *inequity* and *equality* or *inequality*. These are not the same things but are often used interchangeably. When we consider the gaps in life expectancy between various groups, this is an inequality—which relates to status, opportunity, or capacity (Leeder, 2003). However, *equity* has been defined as:

> … An ethical concept grounded in the principle of distributive justice … Equity in health reflects a concern to reduce unequal opportunities to be healthy [which are] associated with membership in less privileged social

> groups, such as poor people; disenfranchised racial, ethnic or religious groups; women and rural residents.
>
> … Pursuing equity in health means eliminating health disparities that are associated with underlying social disadvantage or marginalization. Equity … focuses [our] attention on socially disadvantaged, marginalized or disenfranchised groups within and [among] countries, but not limited to the poor. (Braverman & Gruskin, 2003, as cited in Leeder, 2003)

Figure 7.2 illustrates the differences between equality, equity, reality, and liberation. As you can see, each person has the same size box regardless of the persons' height in the equality frame. We introduced this in chapter one. Everyone gets the same thing, it is equal, but not everyone can see the baseball game.

In the equity frame, we see that the shortest person gets two boxes, the middle person gets one box, and the tallest person doesn't get a box. Equity is based on fairness. They each get what they need to be able to see the baseball game. In the reality frame, we see that the tallest person has lots of boxes, even though they do not need them to be able to see the game. The middle-sized person has one box and can see the game, but the shortest person not only doesn't have a box but is in a hole!

How might that translate to reality as you know it? In the liberation frame, no one has a box because the fence has been removed! Did you even notice the fence? The fence in all of the other frames can signify sources of oppression. Liberation is about removing oppression. Kant (2015) proposes a liberation health framework that includes personal, cultural, and institutional factors that influence peoples' lives and identifying sources of oppression.

Activity

Can you think of another box or other experiences that could be depicted? Go to the website for Story Based Strategy, the 4th Box, for more activities and discussion around these boxes and think of possibilities for change. There is also a game app for your phone.

https://www.storybasedstrategy.org/the4thbox.

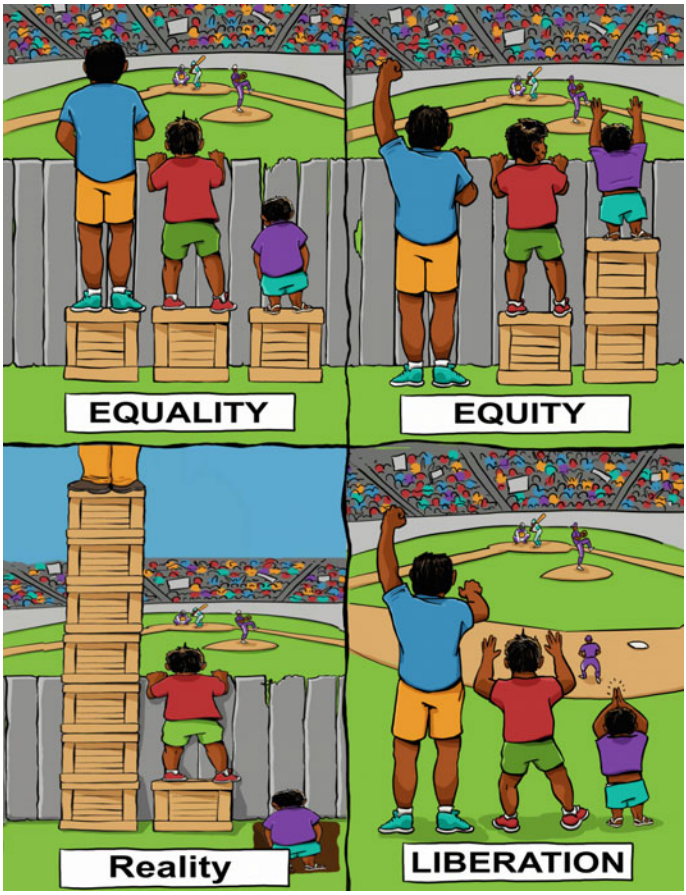

Fig. 7.2 A visual of the differences between equality, equity, reality and liberation (Image credit: #the4thbox Equality/Equity/Liberation image collaboration between *Center for Story-based Strategy* and *Interactive Institute for Social Change*. Reality panel created by Andrew Weizeman)

Scenario

A participant in a workshop shared her story of discrimination. As a Muslim woman, Amina chose to wear a headscarf when out in public. She described the open hostility and discriminatory treatment

she received whenever she wore her scarf and eventually made a choice not to wear it when she went out. She recognized an obvious change in treatment for the better.

- What messages did Amina receive about discrimination?
- What did she have to do to reduce the risk of discrimination?
- How do you feel about Amina's experience and what she has had to do to 'fit in'?

In this scenario, Amina was able to make an external change in order to reduce her risk of being a target of discrimination. How might this make her feel and how might it be different when the discrimination is on the basis of skin color?

Can you think of an instance when you felt discriminated against?

Cultural Safety and Racism and Discrimination

Cultural safety as a philosophy does not just ask health professionals to consider the impact of their interactions with those who differ from them on the basis of race. Cultural safety also requires professionals to examine their conscious or unconscious attitudes toward anyone who differs from them on the basis of gender, religion, age, abilities, or sexual orientation. Avoidance or anxiety in encounters with those who are different can be demonstrated through things like not looking at clients, cutting the consultation short, or providing less information than would be provided to others. These subtle differences can make a difference in health outcomes.

Health and human service professionals potentially hold great power over clients in their care. This power carries with it enormous responsibility. Understanding that power and reflecting on the historical and current abuses of this power relationship will hopefully help to improve care and reduce the current gaps in health that other measures have failed to reduce.

Some students find that learning about racism and discrimination brings out feelings of guilt or anger—guilt that maybe you or people

close to you have intentionally or unintentionally treated people in discriminating ways, and anger that you are being, or might be, accused of behaving in such ways. However, learning about racism and discrimination for those in the psychology and health and human services field is critical. We know the impact of these elements on health and well-being. We all need to be able to examine the factors that influence our attitudes, assumptions, beliefs, behaviors and practices and, as professionals, taking responsibility for (and changing if necessary) these things that influence health and social care and their outcomes. Access to health and human services is more than just being able to get people through the door or having tokenistic artwork on the wall.

We all may be able to draw upon personal experiences of discrimination, and many of us may have actually been subjected to discriminatory policies that were sanctioned by law, as we saw in earlier chapters. For example, same-sex attracted people have been subjected to discriminatory laws and policies and, while some gains have been made toward equity, there are still areas in which the law discriminates.

It wasn't until 1964 with the Civil Rights Act and the passing of Medicare and Medicaid in 1965 that segregation in hospitals was prohibited. Health care for American Indian and Alaska Natives is provided through the Indian Health Service (IHS) but this is only provided on reservations and only a minority of AI/AN people live on or near reservations to gain access. Similarly, while many military veterans may access health care through the Veterans Administration (VA), not all are eligible for those services and complicated bureaucratic systems can significantly impact access.

Things taken for granted by many Americans, such as access to swimming pools, hotels, and cinemas have been legally denied to Indigenous Peoples and Black Americans until relatively recently. However, the changing of laws to prevent discrimination does not automatically remove discrimination; there are numerous examples today that are perhaps simply more covert in their implementation. For example, although segregation in a hospital would be unheard of today, have you, in your experiences in hospitals or medical clinics, ever noticed a separation, intentional or otherwise, of patients? The legal sanctions today,

while possibly preventing overtly discriminating acts, may have inadvertently created a more subtle and covert kind of discrimination that is much harder to identify, label, and therefore prosecute.

Sexism and gender-based discrimination is another damaging aspect of daily interactions that have been difficult to fight. Read the following piece, identifying any elements of racism, sexism, and other forms of discrimination, while keeping in mind the impact of such experiences over a lifetime.

Scenario

Below is a true story by Chevara Orrin. Readers should be aware of the sensitive nature of the content of this story.

I don't do it all the time. Only when I feel safe.
And that shit's relative. Safety, I mean.

First time, I was at a traffic light. It was early morning. Daybreak. They were gathered on the corner, at an intersection near my neighborhood. Day laborers waiting for a chance to work. A group of 20 or so. Smoking cigarettes. Shooting the breeze. I'd see them most days on my way to catch the sunrise over the St. Johns River.

Usually, I don't get stopped by the light and turn before they even notice me.

Not this morning.

My ritual: convertible top down, meditation music on deck, water with fresh lemon, raw, unsalted almonds and a ripe banana.

"Hey baby, I got something else to put in your mouth."

I glance to my right. I say nothing but slowly lower the banana.

"Yea YOU, sexy bitch!"

The others laugh.

I feel violated. Womanhood interrupted by the Patriarchy. I wonder how many seconds before the light turns green. I contemplate closing my convertible top.

I glance to my left. There's a gas station and sometimes police cars.

Not today.

A few moments later, the light changes and I drive away. I'm scared and pissed. I don't get far.

I've thought about it before. Exactly what I'd say. I even practiced in the mirror.

But each time, I'd freeze. Feeling overwhelmed with the ordinariness of it all.

Not today.

I abruptly turn around in the middle of the street, burning a little rubber.

There's an abandoned lot across the street from the day laborer spot and I pull in. I zig zag through oncoming traffic, my eyes focused on the one with the smart, dirty mouth.

They see me coming and give each other high fives.

I walk up, extend my hand.

"Hi, I'm Chevara. What's your name?"

He looks startled and grins. Like maybe I'm about to ask for his seven digits.

He says his name is T.J. I don't ask what it stands for. I don't care.

"I assume that what you were trying to do was say 'good morning' but somehow the right words failed you."

Before he has a chance to respond, I ask if he's ever heard of poet, essayist, and activist, June Jordan.

His blank stare answers my question before he begins to shake his head from left to right.

They've crowded around us now. It feels like spectator sport. I imagine I'm in a boxing ring. Except I'm not feeling much like a champ. I feel as though I might suffocate. I feel small. I'm wearing sneakers and not my trademark stilettos.

Spears of light pierce through clouds as the sky brightens and I feel a sliver of safety.

Before I lose my nerve, I tell him that June Jordan wrote a piece about Mike Tyson called "Requiem for a Champ." I read it in college.

She writes about the horrific conditions of poverty and oppression under which Tyson learned the "rules" of interacting with a girl...of talking...to a girl. I tell him that June Jordan says "the choices available to us dehumanize."

I'm not sure if he understands the quote or the enormity of the moment.

I ask him where he grew up, if he was raised with a momma, sisters, aunties or a grandmother. I ask if he has brothers, uncles, a dad or grandfather. I ask if he has daughters. He says his grandmother reared him. He says he grew up in the church and had a paper route. He says his little girl is three.

The other men are silent. A few have wandered away to stand on the periphery.

I tell him I live blocks away and that I shouldn't have to detour to feel safe. Not in my neighborhood nor anywhere in this world.

I tell him I'm an incest survivor. I ask them all if they know what that is. Now, it's really uncomfortable. A few lower their heads. One nods.

"It means that my father's semen was on my thigh when I was 10."

I say it slowly. I want them to hear it. I want them to feel the pain in my words.

I tell him that his morning greeting almost f***** up my day. Disrupted my spirit. That his words felt violent and hurtful and disrespectful and mostly made me sad.

Something changes. The air is lighter and heavier at the same time. He looks like he might cry.

He tells me again that his daughter is three. He calls her name.

I tell him that I don't need him to see me as his mother or sister or daughter. I need him to see me as human.

He asks if he can give me a hug. I walk into his outstretched arms.

I leave him with June Jordan, whispering: "I can stop whatever violence starts with me."

I don't do it all the time. Only when I feel safe.

And that shit's relative. Safety, I mean.

I've done it with construction workers at a city job site and college students in a grocery store near the frozen waffles and corporate executives in a towering office complex.

Irrespective of status or profession or age or geography.

The struggle is real. The intersection of my identity as a Black woman.

The struggle is real. Navigating toxic masculinity on a daily.

The struggle is real. Layers of unbalanced power and complicity of men in causing harm and maintaining misogynistic structures.

The struggle is real. Demanding autonomy of voice and power of agency in a world filled with men who never learned how to talk to a girl.

Today, I awakened channeling June Jordan's spirit:

"...I am the history of battery assault and limitless armies against whatever I want to do with my mind and my body and my soul...

...and I can't tell you who the hell set things up like this but I can tell you that from now on my resistance my simple and daily and nightly self-determination may very well cost you your life."

I don't do it all the time. Only when I feel safe.

And that shit's relative. Safety, I mean.

I am not the one. I believe in necessary disruptions. You will be held accountable on my watch (Fig. 7.3).

Fig. 7.3 Chevara Orrin

**I received a few questions and comments about the scarf I'm wearing. I'll provide context.

The scarf is from the Freedom Collection that I created in collaboration with fiber artist, Laurie Phoenix Niewidok, that honors the Freedom Riders of the 1960s.

Art is often an access point. Connecting us despite of, and because of, our differences. Engaging even the most cynical among us. Throughout the ages, artists have used canvas to create social and political change. Artists have used

prose to record memories, resist oppression and inspire revolutions. Artists have danced for freedom and awakened us to the realities of racial injustice. There is redemptive power in the voice of the artist.

My father (whose image is on the scarf next to my white, Jewish mother) was on the first bus that arrived in Jackson, MS on May 24, 1961. The "colored only" sign is reminiscent of Jim Crow laws that mandated the segregation of public schools, public places, and public transportation, and the segregation of restrooms, restaurants, and drinking fountains for whites and blacks. Facilities for Black people were consistently inferior and underfunded, compared to the facilities for white Americans; sometimes there were no Black facilities.

My father, James Bevel initiated, strategized, directed, and developed SCLC's three major successes of the Civil Rights era: the 1963 Birmingham Children's Crusade, the 1965 Selma voting rights movement, and the 1966 Chicago open housing movement. Grammy and Academy award-winning artist, Common portrays my father in the critically acclaimed film, *Selma*.

My father is also perpetrator of my incest.

Jim Crow:

https://m.youtube.com/watch?v=wL2gjxx9qa4.

My father:

https://breachofpeace.com/blog/?p=85.

Incest trial: Carpenter, L. (2008, May 25). A Father's Shadow: He was a hero of the civil rights movement, but he was something else too—A man who preyed on his daughters. *Washington Post*, p. W16, accessed 4 November 2020 from

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Critical Thinking

- What can we learn from Chevara's story about intergenerational trauma? The impacts of harm continue, whether those traumas relate to any part of our identities, we see in this story how 'hurt people, hurt people'.
- Previously, we discussed diunital logic. How can this be applied to Chevara's relationship with her father? She can appreciate that her father was an important part of the civil rights movement and also that he hurt her and his other daughters.
- 'I don't need him to see me as his mother or sister or daughter. I need him to see me as human'. What does this line say to you about cultural safety?

Making It Local

What examples, if any, can you identify from your internships, placements, or experiences at health services of possible systemic bias or institutional racism?

What, if any, racial tensions or issues are current in the areas where you live or work? You might find these in your local newspaper.

Conclusion

We have explored how to examine the impact of dominant cultures on non-dominant cultures and how we might diminish any potential harm that results. Cultural safety requires professionals to examine any taken-for-granted place of privilege and the realities of racism and discrimination in order to challenge these in professional practice. Health and human services professionals can only hope to play a role in closing

the gaps in the health and social outcomes by considering *all* determinants of health: biological, psychological, social, political, spiritual, and cultural.

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