

Why Racial Integration Remains an Imperative

by Elizabeth Anderson

In 1988, I needed to move from Ann Arbor to the Detroit area to spare my partner, a sleep-deprived resident at Henry Ford Hospital, a significant commute to work. As I searched for housing, I observed stark patterns of racial segregation, openly enforced by landlords who assured me, a white woman then in her late twenties, that I had no reason to worry about renting there since “we’re holding the line against blacks at 10 Mile Road.” One of them showed me a home with a pile of cockroaches in the kitchen. Landlords in the metro area were confident that whites would rather live with cockroaches as housemates than with blacks as neighbors.

We decided to rent a house in South Rosedale Park, a stable working-class Detroit neighborhood that was about 80% black. It was a model of cordial race relations. Matters were different in my place of employment, the University of Michigan in Ann Arbor. At the time, a rash of racially hostile incidents targeting black, Latino, Native American and Asian students was raising alarms. Although overtly racist incidents got the most publicity,

they did not constitute either the dominant or, in aggregate effect, the most damaging mode of undesirable racial interactions on campus. More pervasive, insidious and cumulatively damaging were subtler patterns of racial discomfort, alienation, and ignorant and cloddish interaction, such as classroom dynamics in which white students focused on problems and grievances peculiar to them, ignored what black students were saying, or expressed insulting assumptions about them. I wondered whether there was a connection between the extreme residential racial segregation in Michigan and the toxic patterns of interracial interaction I observed at the university, where many students were functioning in a multiracial setting for the first time.

My investigations led me to write my book, *The Imperative of Integration*, which focuses primarily (but not exclusively) on black-white segregation. Since the end of concerted efforts to enforce *Brown v. Board of Education* in the 1980s, activists, politicians, pundits, scholars and the American public have advocated non-integrative paths to racial justice. Racial justice, we are told, can be achieved through multiculturalist celebrations of racial diversity; or equal economic investments in *de facto* segregated schools and neighborhoods; or a focus on poverty rather than race; or more rigorous enforcement of anti-discrimination law; or color-blind-

ness; or welfare reform; or a determined effort within minority communities to change dysfunctional social norms associated with the “culture of poverty.” As this list demonstrates, avoidance of integration is found across the whole American political spectrum. *The Imperative of Integration* argues that all of these purported remedies for racial injustice rest on the illusion that racial justice can be achieved without racial integration.

Readers of *Poverty & Race* are familiar with the deep and pervasive racial segregation in the U.S., especially of blacks from whites, which was caused and is currently maintained by public policies such as zoning, massive housing discrimination and white flight, and which generates profound economic inequalities. Segregation isolates blacks from access to job opportunities, retail outlets, and commercial and professional services.

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Elizabeth Anderson (eandersn@umich.edu) is John Rawls Collegiate Professor of Philosophy and Women’s Studies at the Univ. of Michigan, Ann Arbor. She prepared this précis from her 2010 book, The Imperative of Integration (Princeton Univ. Press).

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It deprives them of access to public goods, including decent public schools and adequate law enforcement, while subjecting them to higher tax burdens, concentrated poverty, urban blight, pollution and crime. This depresses housing values and impedes blacks' ability to accumulate financial and human capital. If the effects of segregation were confined to such material outcomes, we could imagine that some combination of non-integrative left-liberal remedies—color-blind anti-poverty programs, economic investment in disadvantaged neighborhoods, vigorous enforcement of anti-discrimination law, and multiculturalist remedies to remaining discrimination—could overcome racial inequality.

Non-Integrationist Remedies Are Insufficient

Such non-integrationist remedies are insufficient because they fail to address the full range of effects of segregation on group inequality. *The Imperative of Integration* documents three additional effects that can only be undone through integration: social/cultural capital inequality, racial stigmatization, and anti-democratic effects. These effects recognize that segregation isn't only geographic, and so can't be undone simply by redistrib-

uting material goods across space. More fundamentally, segregation consists of the whole range of social practices that groups with privileged access to important goods use to close ranks to maintain their privileges. This includes role segregation, where different groups interact, but on terms of domination and subordination.

Everyone knows that who you know is as important as what you know in getting access to opportunities. This idea captures the social capital effects of racial segregation. In seg-

Avoidance of integration is found across the whole American political spectrum.

regated societies, news about and referrals to educational and job opportunities preferentially circulate within the groups that already predominate in a given institution, keeping disadvantaged groups off or at the back of the queue. Cultural capital also matters: Even when the gatekeepers to important opportunities do not intentionally practice racial discrimination, they often select applicants by their "fit" with the informal, unspoken and untaught norms of speech, bodily comportment, dress, personal style and cultural interests that already prevail in an institution. Mutually isolated communities tend to drift apart culturally, and thereby undermine disadvantaged groups' accumulation of the cultural capital needed for advancement. Integration is needed to remedy these inequalities.

Segregation also stigmatizes the disadvantaged. When social groups diverge in material and social advantages, people form corresponding group stereotypes and tell stories to explain these differences. These stories add insult to injury, because people tend to attribute a group's disadvantages to supposedly intrinsic deficits in its abilities, character or culture rather than to its external circumstances. Spatial segregation reinforces these demeaning stories. Ethnocentrism, or favoritism towards

those with whom one associates, induces self-segregated groups to draw invidious comparisons between themselves and the groups from which they are isolated. They create worldviews that are impervious to counterevidence held by members of out-groups with whom they have little contact. They tend to view extreme and deviant behaviors of out-group members, such as violent crimes, as representative of the out-group. Role segregation also creates stereotypes that reinforce out-group disadvantage. People's stereotypes of who is suited to privileged positions incorporate the social identities of those who already occupy them. Occupation of dominant positions also tends to make people prone to stereotype their subordinates, because dominant players can afford to be ignorant of the ways their subordinates deviate from stereotype.

Popular understandings of racial stigma and how it works lead people to drastically underestimate its extent and harmful effects. We imagine racially stigmatizing ideas as consciously located in the minds of extreme racists. Think of the KKK member who claims that blacks are biologically inferior and threatening to whites, proclaims his hatred of them, and discriminates against them out of sheer prejudice. Most Americans despise such extremists, disavow explicitly racist ideas, and sincerely think of themselves as not racist. Most say that racial discrimination is wrong. It is tempting to conclude that negative images of blacks are no longer a potent force in American life.

Tempting, but wrong. While the old racist images of black biological inferiority may have faded, they have been replaced by new ones. Now many whites tend to see blacks as choosing badly, as undermining themselves with culturally dysfunctional norms of single parenthood, welfare dependency, criminality, and poor attachment to school and work. Since, on this view, blacks are perfectly capable of solving their own problems if they would only try, neither whites nor the government owe them any-

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Understanding Health Impact Assessment: A Tool for Addressing Health Disparities

by Saneta DeVuono-powell & Jonathan Heller

Health is a big topic of concern these days. Despite outperforming all other developed nations on health care, our nation ranks 26th in life expectancy. In recent years, we have witnessed growing obesity, diabetes and asthma rates, in addition to numerous other health problems. Not surprisingly, these health problems have a disparate impact on vulnerable communities, with people of color and those in poverty bearing a disproportionate health burden. For example, infant mortality rates for African Americans are more than twice the national average, and the life expectancy gap between poor African-American men and affluent white women is more than 14 years. For advocates who work with these communities, health disparities are not new. What is new is the emerging consensus that health outcomes will not improve unless we address social and environmental factors traditionally understood as unrelated to health. Improving access to health care and trying to change behaviors are not enough; we must address the decisions and policies that are not traditionally thought of as associated with health.

For the past few decades, public health agencies focused on trying to improve health by addressing individual behavior related to poor health outcomes. At the same time, social and economic inequalities continued to increase and we witnessed growing and persistent health disparities. Today, the life expectancy gap between the most and least affluent is increasing, and the areas with the greatest social and economic inequali-

ties have the worst life expectancy and mortality rates. Studies repeatedly show that even when you control for individual variables, external factors like where people live, the quality of their housing and education, income attainment and stress levels correlate with depression, chronic disease, mortality and health risk behaviors. Given this knowledge, health advocates have begun to realize that they cannot improve health conditions

HIA addresses the determinants of health.

without addressing these factors, which are known in public health circles as the social determinants of health. Health Impact Assessment (HIA) is a tool that can help highlight these links and mitigate health disparities because HIA addresses these determinants of health. Although HIA has been practiced outside of the United States for many years, its use here is just beginning to gain traction. In 2007, a study found just 27 HIAs had been conducted in the U.S. In the subsequent four years, an additional 92 HIAs have begun or been completed.

A Health Impact Assessment is defined as “a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a proposed project, plan or policy on the health of a population and the distribution of those effects within the population.” HIA aims to increase the consideration of health in decision-making arenas that typically do not consider health. HIA also identifies appropriate actions to manage those effects. There are two desired outcomes of an HIA. One is to *influence* plans policies and projects in a way that improves health and diminishes health disparities. The other is to *engage* community members and other stakeholders so they understand what is impacting community health and how to advocate for improving health using a *transparent and evidence-based* process.

- A typical HIA includes six steps:
1. Screening—Determines the need, value and feasibility of an HIA;
 2. Scoping—Determines which health impacts to evaluate, the methods for analysis, and the workplan for completing the assessment;
 3. Assessment—Provides: a) a profile of existing health conditions; b)

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The Relationship between HIA and Environmental Impact Assessment (EIA)

The National Environmental Policy Act (NEPA) of 1969 (42 U.S.C. §4321 et seq.) requires that proposed federal activities consider the environment and establishes Environmental Impact Assessment as the mechanism for doing so. Although NEPA requires health to be considered in EIA, too often health is not evaluated meaningfully as part of the process. HIA can complement EIA either by integrating HIA into EIA, as has been done, for example, in Alaska, or as a stand-alone process and report that is submitted as commentary on the EIA. Unlike EIA, barring a few limited State examples, no legislative requirements trigger HIA, so the EIA process is a good entry point, enabling HIA to elevate health concerns.

Saneta DeVuono-powell (saneta@humanimpact.org) is a Research Associate at Human Impact Partners.

Jonathan Heller (jch@humanimpact.org) co-founded Human Impact Partners in 2006.

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- evaluation of potential health impacts;
4. Recommendations—Provides strategies to manage identified adverse health impacts or enhance positive health impacts;
 5. Reporting—Includes development of the HIA report and communication of findings and recommendations; and
 6. Monitoring—Tracks impacts on decision-making processes and the decision, as well as impacts of the decision on health determinants.

Within this general framework, approaches to HIA vary as HIAs are tailored to work with the specific needs, timeline and resources of each particular project. This article briefly describes two HIAs as examples of how and when an HIA can be conducted and then discusses strategies for using HIA to address health disparities.

Case 1: Long Beach Downtown Development Plan

In 2010, the City of Long Beach in Southern California proposed plans for extensive new development in their downtown area. The Long Beach Downtown Plan proposed including 5,000 new residential units, 1.5 million square feet of office, civic and cultural spaces, 384,000 square feet of new retail space, and 5,200 new jobs. The plan, however, did not mention affordable housing or job creation for the current residents of the area. This oversight was particularly troublesome given the demographics of Downtown Long Beach, an area that is currently populated by an ethnically diverse and predominantly low-income population whose current employment and housing needs are not being met (the list for Section 8 housing is currently closed and has a ten-year wait).

Concern about the potentially adverse impacts this plan would have for

local residents led local organizations to decide to conduct a rapid Health Impact Assessment. The HIA, conducted by East Yard Communities for Environmental Justice, Californians for Justice and Human Impact Partners (HIP—an Oakland-based non-profit) in early 2011, focused on measuring what impacts the proposed plan would have on housing and employment and how these changes would affect the health of residents. Because the advocates wanted to be able to use the HIA to respond the Draft Environmental Impact Report (EIR), there

A typical HIA includes six steps.

was a short timeline. This necessarily limited the scope of the HIA, but it was still a useful tool for concerned community advocates and local organizations. Fortunately, there was a proposed Community Benefits Agreement, which allowed the HIA to focus its recommendations as well as point to a specific and feasible alternative course of action. Over a three-month period, staff worked together to gather data on: (1) existing health, housing and employment conditions in Downtown Long Beach; (2) the potential impacts of the proposed plan; and (3) the potential impacts of proposed community benefits.

The availability of affordable, quality housing and adequate employment opportunities have direct health impacts. The Long Beach HIA cited studies showing that the nature and stability of housing and employment impact a variety of health indicators, including mortality rates, infectious disease, depression and substance abuse. Based on the analysis of the existing demographics and conditions in Downtown Long Beach, the HIA found that the diverse residents (Long Beach is the most ethnically diverse city in California) were already facing a shortage of quality affordable housing and adequate employment opportunities and suffering from associated health problems. For example, the HIA found that 46% of renters

were spending more than the recommended 30% of their income on rent and 25% were spending more than 50% of their incomes on rent, and that overcrowding was already a problem in Long Beach. Not surprisingly, the rates of asthma, heart disease and other health issues (which can be related back to housing cost and quality and to jobs) in Long Beach are significantly higher than the county average.

The HIA findings indicated that, as proposed, the Downtown Plan was likely to have negative impacts on a variety of health-related indicators, including: overcrowding, population displacement and unemployment. The HIA also found that the adoption of the proposed Community Benefits Agreement would mitigate some of the negative impacts resulting from the proposed Downtown Plan by providing additional very-low-income and moderate-income housing units and increasing employment opportunities. The HIA recommended that the plan adopt these benefits. The HIA in Long Beach was in response to a city development plan, was submitted as a comment on a Draft Environmental Impact Report, and was limited in scope to impacts on housing and jobs. Findings from the rapid HIA were highlighted in local media campaigns focused on the proposed Downtown Plan. The City of Long Beach is expected to respond to comments on the EIR in the coming months.

Case 2: Paid Sick Days Policies

In most developed countries, paid sick days are a given. In the U.S., however, there is no federal law mandating paid sick days and about 4 out of every 10 workers do not have paid sick days. Not surprisingly, low-wage workers, mothers and those who work in the food service industry are much less likely to have paid sick days than most white-collar workers. In 2007, San Francisco became the first jurisdiction in the U.S. to mandate paid sick days for employees. Subse-

quently, various jurisdictions have introduced legislation that would do the same, including California in 2008 and Congress in 2009—neither of which passed. Surprisingly, although access to paid sick days has clear health implications, initially health was not part of the discussion surrounding efforts to mandate paid sick days. The main frame through which decision-makers viewed this legislation was that of economic impact of requiring employers to provide paid sick days.

From 2008-2010, a series of Health Impact Assessments that looked at paid sick day requirements were conducted. In 2008, an HIA of the California Healthy Families, Healthy Workplaces Act (AB 2716, entitling employees to accrue one hour of paid sick time for every 30 hours worked) was completed by Human Impact Partners and the San Francisco Department of Public Health (SFDPH) at the request of the Labor Project for Working Families. The following year, HIP and SFDPH conducted an HIA of the federal Healthy Families Act of 2009. The California and Federal Paid Sick Days HIAs looked at the potential health outcomes for workers, families and communities, including impacts on recovery from illness, use of preventative health care services versus emergency rooms, as well the transmission of infectious disease in restaurants, schools and workplaces. The HIAs found that paid sick days has many positive health outcomes, including: improved food safety in restaurants; reduced transmission of the flu in childcare settings and nursing homes; and reduced emergency room usage. The HIAs showed that legislation that would entitle more workers to paid sick days would be good for everyone's health—workers themselves, as well as people whose lives are touched by the same workers.

Paid Sick Day HIAs were used by coalitions of proponents of the various paid sick days legislation. Although neither the California nor Federal legislation passed, the HIA helped advocates articulate a public health rationale for the policy, thereby

By coupling the HIA with extensive legal comments on the environmental impact report and an economic analysis, we have proven that affordable housing and local hiring community benefits are legally appropriate, economically feasible and would improve the health of Long Beach residents.

— Susanne Brown, Legal Aid Foundation of Los Angeles

changing the public discourse about the issue from a question of labor rights or employer costs to the issue of improving the health of all people. At the same time, the HIA offered a rationale for public health officials to

Two complementary strategies: focus on process, focus on outcomes.

support paid sick days, a policy they may not have previously engaged. This health framing was picked up in other jurisdictions, and Milwaukee advocates used the California HIA along with Milwaukee-specific data to inform public opinion on a local 2008 paid sick day ballot measure. Legislative advocates publicized health facts through the local media, and the initiative passed with the support of two-thirds of the votes of Milwaukee residents. More recently, Connecticut became the first state to pass paid sick days legislation. In making their argument, advocates in Connecticut focused on the health benefits the bill would provide.

Strategies for Using HIA to Address Health

There are a wide variety of projects, policies and plans where an HIA can be useful, and the first step of any HIA helps determine whether it is an appropriate tool. Conducting an HIA requires six steps (as outlined above). During the first two steps (screening and scoping), those involved assess the need for an HIA as well as which health measures to evaluate. HIAs start with hypotheses

that are informed by scientific review as well as by lived experience of communities and stakeholders, and then research informs whether the hypotheses are true. This process allows those involved to think about the health of a particular community and understand the variety of ways that social factors are implicated in health.

The HIA on the Downtown Plan in Long Beach and the HIA on paid sick days highlight how advocates can use a health lens. Framing the issue of equity around health can be a very powerful tool. Because HIA addresses social determinants of health, advocates and communities may find that the use of an HIA can create headway around a social issue. Often a health lens makes it more difficult for opponents to argue against addressing the real needs of a community. Using an HIA as a strategy for developing a health lens can be particularly effective because HIA is a research-based tool that provides scientific data in addition to assessing mitigation strategies.

The differences between the two above case studies highlights two complementary strategies for using HIA to address health disparities: focus on process, and focus on outcomes. Ideally, an HIA utilizes a robust process of multi-stakeholder participation, and also uses robust data analysis to influence the outcome of the project it is assessing in a manner that produces good health outcomes. However, HIA can have powerful impact even if it ends up being more outcome- than process-driven, or vice versa.

In Long Beach, advocates were concerned about a land use plan and wanted a tool they could use to weigh

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in on an existing, fast-moving process. Although the HIA process was important, given the short timelines, what mattered most was to have an impact on the proposed plan. HIA was appealing because it could produce an evidence-based report, highlighting potential health consequences, to submit as a comment on the Draft Environmental Impact Report that was being prepared. In this case, this created a time constraint, which limited and therefore deemphasized the HIA process. HIAs provide stakeholders with multiple ways to weigh in at various stages in a decision-making process, almost always with the goal of influencing the final decision. The HIA can be used to legitimize or assuage concerns, and can offer a mechanism to introduce recommendations or alternatives.

Although HIAs are typically set up in a way that allows them to have some impact on outcomes, there are also reasons for conducting an HIA that focuses more on process. Through conducting an HIA, structured opportunities for capacity-building, relationship-building, transparent and democratic process (e.g., stakeholder participation), community organizing, and developing messages are available. Regardless of outcome, an HIA can be useful and impactful because of these opportunities.

Often, the process of engaging multiple stakeholders in HIA actually brings about change in the decision.

In addition to quantitative data, HIAs often include community surveys or focus groups, which help lend a voice and credibility to concerns about the issue. In the Paid Sick Days HIAs, the material gathered from focus groups was useful for highlighting the health concerns of workers, giving a personal voice to the issue, and for engaging more people in the policy-making process. The process of gathering these narratives and combining them with more quantitative (e.g., statistical) data creates a story about the people impacted by the proposed plan, project or policy. As this story emerges, powerful messages that can be used for advocacy also emerge, as

HIA can build capacity and relationships.

do powerful spokespeople. Although the HIAs on paid sick days did not lead to the immediate passage of new legislation mandating paid sick days, their impact was felt through the narratives that emerged during the process. The health frame that was established through the data and personal stories has been picked up by other paid sick days advocates and was used in recent legislative victories.

Because HIA is a collaborative process, when effectively executed it can build capacity and relationships. HIA is a tool in which multiple stakeholders have an opportunity to engage, allowing for deepening relationships but also building the capacity of these

stakeholders to engage meaningfully. The process of the HIA can be so important that the skills and opportunities for advocacy it provides become primary goals and are as important as outcome-related goals. When a group of community organizations in West Oakland decided to learn about HIA, they decided to conduct a rapid HIA on a proposed neighborhood development. Although they were initially more interested in the HIA process than in any specific outcome, during the HIA they began to work with the developer and as a result the project ended up adopting many of the HIA recommendations to protect future residents from air pollution and pedestrian injury from traffic.

In another HIA conducted in Los Angeles, a community organizing group successfully engaged community members in data collection as well as advocacy. The HIA, conducted on a development project in South Central Los Angeles, involved multiple stakeholders, including the developer, the public health agency and the redevelopment agency from the beginning, which led the stakeholders to agree to changes based on the community findings. Here, the process and outcome were both considered important, and the success of the outcome depended on the success of the process.

Another potential use of HIA is as a litigation tool or as a tool to prevent litigation. For a plaintiff, an HIA can serve to: (1) provide notice of potential harm, and (2) show the feasibility of alternatives. Alternatively, where steps have been taken to address concerns raised in an HIA and recommendations are adopted, the HIA could insulate projects from subsequent litigation by showing that health was seriously considered and that necessary steps were taken to address legitimate concerns. After adopting mitigations to address environmental health concerns for low-income housing raised in an HIA in Pittsburg, California, City agencies then used the HIA to defeat NIMBY efforts to eliminate that housing.

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Partial List of HIA Topics

Advanced Metering Initiatives (Smart Metering)	Living Wage Legislation
Agricultural Policy	Metropolitan Transportation Plans
Area-Specific Land Use Plans	Natural gas pipelines
Carbon Cap and Trade Regulation	Pay Equity Legislation
City Growth Policies	Permits for a waste facility
City Redevelopment	Public Housing Redevelopment
County General Plan Updates	School Discipline Policies
Farm-to-School Legislation	School Funding
Freeway Expansion	State Budget
Housing Development	Transit Plans
Housing Vouchers	Water Conservation Laws
	Zoning and Land Uses for Light Rail

Health Equity for Asian American, Native Hawaiian, and Pacific Islander Children and Youth: What's Racism Got to Do With It?

by Laurin Mayeno, Joseph Keawe'aimoku Kaholokula, David MKI Liu,
Lloyd Y. Asato & Winston Tseng

● Since entering high school, Kekoa, a 16-year-old obese Native Hawaiian male with type 2 diabetes, has become depressed and taken up cigarette smoking and drinking on a daily basis.

● In 2007, Seung-Hui Cho, a 23-year-old Korean American college student with mental illness, killed 32 people and wounded many more, before committing suicide.

These are two individual examples of health inequities that threaten the well-being of Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) children and youth. In this commentary, we highlight these health inequities and pose the question: "What's racism got to do with it?" We begin by presenting data on health inequities and briefly discuss existing investigation and theory. We then explore, through the stories of Kekoa and Seung-Hui, how the health

Laurin Mayeno (laurin@mayenoconsulting.com) is an independent consultant dedicated to building healthy multicultural organizations and communities.

Joseph Keawe'aimoku Kaholokula (kaholoku@hawaii.edu) is Assoc. Prof. & Chair, Dept. of Native Hawaiian Health, John A. Burns School of Medicine, Univ. Hawai'i at Manoa.

David MKI Liu (kliumd@gmail.com) is Medical Director of the Moloka'i Community Health Center.

Lloyd Y. Asato (lasato@apiahf.org) is Director of the Community Capacity Program at the Asian & Pacific Islander American Health Forum.

Winston Tseng (wtseng@apiahf.org) is Senior Research Associate at the Asian & Pacific Islander American Health Forum.

of children and youth of AA and NHPI communities is shaped by pervasive racism in our society. While focusing on the fundamental problems that contribute to health inequities among AA and NHPI children and youth, we also discuss the supportive role that fam-

Hawaii's ethnic/racial hierarchy continues today.

ily, community and culture can play in fostering their health and well-being.

Disaggregating AA and NHPI

NHPI and AA communities have distinct histories, cultures, experiences and health challenges. The arbitrary grouping together of NHPI and AA for data collection and funding purposes creates barriers to understanding and addressing their health issues. Within both the NHPI and AA categories, there are numerous communities whose acculturation experiences, socioeconomic status and health issues are very different. Therefore, when possible, we will make distinctions between different ethnic groups that fall under these broader classifications and respect each group's cultural and classification preferences.

Recognizing Health Inequities

Before we can address AA and NHPI health inequities, they must be acknowledged. Over the past few de-

acades, AA and NHPI advocates and researchers have increased visibility for health inequities that impact their communities. NHPI communities have worked to have their health issues become visible and recognized as distinct from those impacting AAs. AA communities have worked to dispel the myth of the model minority and, with the use of disaggregated data, have demonstrated that not all AAs are healthy, particularly recent immigrant and low-income AAs. (Native Hawaiians and other Pacific Islanders are people whose origins are from three main groups of Islands in the Pacific: Polynesia, Micronesia and Melanesia. Native Hawaiians are the largest group of Pacific Islanders in the U.S. Other major Pacific Islander groups in the U.S. include Samoans, Guamanians (Chamorro) and other Micronesian Groups (Federated State of Micronesia, Republic of the Marshall Islands and Republic of Palau). Asian Americans are persons with ancestry from Asian countries and islands in the Pacific Rim who live in the United States. The largest Asian-American populations are Chinese, Filipino, Asian Indian, Vietnamese, Korean and Japanese, each of which number over 1 million. Cambodian, Laotian, Pakistani and Hmong number over 200,000 each.) Although much of the data is focused on adults, there is recently a growing body of evidence that health inequities do indeed exist for AA and NHPI children and youth. Here are some examples:

Native Hawaiian and Pacific Islander Children and Youth

● From 2003-2005, NHPI mothers in California and Hawaii had higher
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- rates of low birth weight and pre-term birth than Whites (4.1% LBW and 7.5% pre-term birth), with rates for Marshallese mothers among the highest: low birth weight 8.4% and pre-term birth 18.8%.
- 54% of Samoan children (5th graders) in California followed by "Other" Pacific Islander (42%), Guamanian (35%), Native Hawaiian (35%) and Tahitian (34%) children are not within the Healthy Fitness Zone according to their body mass index, compared to the state average (32%) and Whites (23%).
- Native Hawaiian youth are also more likely to be obese and smoke cigarettes. compared to youth of other ethnic groups.
- 30% of NHPI adolescents (ages 12-17) in California were diagnosed with asthma in 2003-2005, compared with the state average (20%).

Asian-American Children and Youth

- From 2003-2005, Cambodian and Laotian mothers in California and Hawaii had higher rates of both low birth weight (8.8% and 9.2%, respectively) and pre-term birth (14.0% and 13.7%, respectively), compared to Whites (4.1% LBW and 7.5% pre-term birth).

- 28% of South Asian adolescents (ages 12-17) in California were diagnosed with asthma in 2003-2005. compared with the state average (20%).
- 30% of Filipino and 29% of Laotian children (5th graders) in California are not within the Healthy Fitness Zone according to their body mass index, compared to Whites (23%).
- 36% of sexually active Chinese adolescents or their partner in California, followed by Filipino (49%), Korean (50%) and South Asian (51%) adolescents or their partner, used any type of birth control the last time they had sex, compared to the state average (72%) and

Cultural competency training is critical for all service providers.

Whites (79%).

In order to address these health inequities, there is a need to understand the broader social framework that shapes children's lives and health. Some researchers have articulated that racial constructions, exposures to racism, and other environmental and psychosocial stressors interact with biological systems to increase health risks and problems among adults.

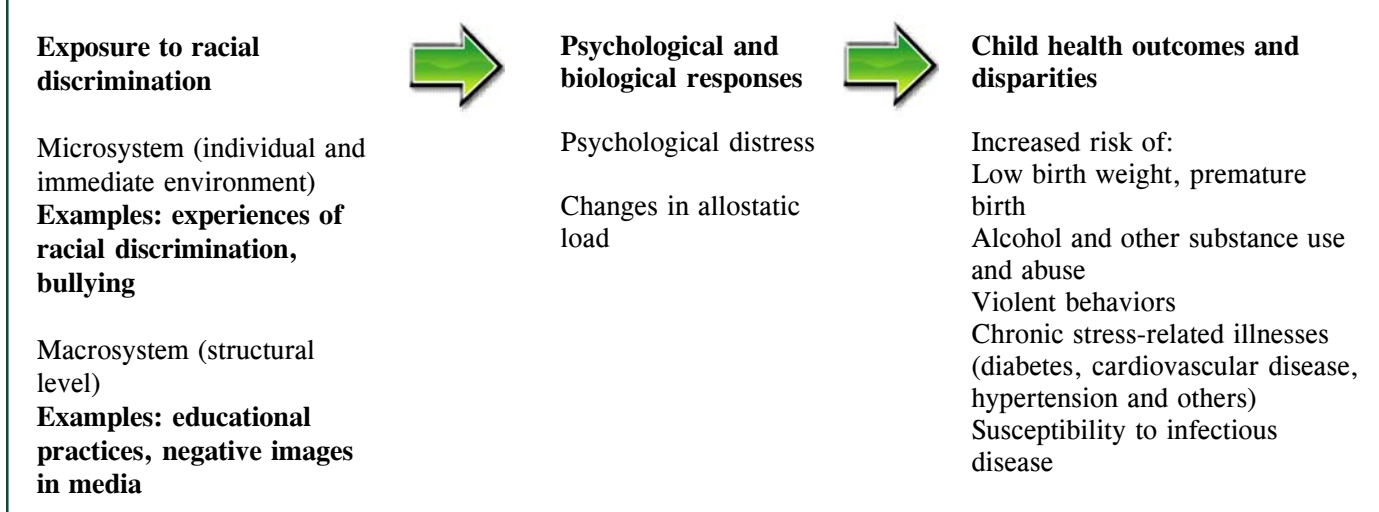
We next discuss existing frameworks that explore the impact of racism

on children's health. There have been few studies investigating the role of racism in children's health, including a few focused on racism and mental health among AA adolescents. Huge gaps exist in research on racism and children's health for both AA and NHPI communities. There is a dire need for more work on this topic in order to document community assets and needs, and develop effective intervention strategies and policies.

Theoretical Framework

To conceptualize the role of racism in child health, K. Sanders-Phillips and colleagues propose a general framework that draws from different theoretical models. From ecological theory, they discuss the role of a child's immediate environment (microsystem) and larger social environment (macrosystem). They suggest that institutional racism at the macrosystem level, such as educational and housing policies that put a particular racial/ethnic group at a disadvantage, can impact variables at the microsystem, such as family functioning and neighborhood health conditions that increase behavioral and biological health risks for children of color. From social stratification theory, they suggest that a group's historical and current place in the social hierarchy can impact experiences and exposure

Table 1. Model of Racial Discrimination and Child Health



to risk factors. From theories of racial inequality and social integration, they posit that racial discrimination has an impact on individuals' judgments, decisions and behaviors. There are multiple resulting consequences for children and their parents, which ultimately lead to inequities in biological, behavioral and social functioning. Protective factors mentioned in the model include racial awareness, racial socialization and certain parenting styles that protect against the negative impact of discrimination.

In the Sanders-Phillips model (Table 1), exposure to racial discrimination at both the microsystem and macrosystem levels creates psychological responses, such as decreased self-efficacy and depression, and biological responses through changes in chronic stress and allostatic load, which in turn may produce decreased immune function and higher, or paradoxically blunted, cortisol levels. This, in turn, results in disparities or inequities in child health outcomes. A simplified version of Sanders-Phillips model is shown on the previous page.

In the section that follows, we explore two case examples of health inequities among NHPI and AA youth using Sanders-Phillips' framework as a point of reference.

Case Studies

The stories of Kekoa and Seung-Hui give us a window into how racism interacts with other social and cultural factors to impact the health of some AA and NHPI children and youth. These two examples do not represent the full spectrum of the AA or NHPI experience. However, they do bear witness to health issues and social dynamics that we cannot afford to ignore.

Kekoa's Story

Kekoa, a 16-year-old Native Hawaiian male, lives in a Hawaiian homestead community with his par-

ents and three siblings and attends a nearby public high school in urban Honolulu.

Exposure to Racial Discrimination. Racism and colonialism are difficult to disentangle in the Pacific, as racism can be considered the ideology that has informed and justified the contagion of colonialism across the Pacific. Kekoa's story illustrates how present-day colonialism continues to structure the distribution of power, resources and money largely along racial and ethnic lines. His ancestors were dispossessed of their land and resources and became second-class citizens in Hawaii's ethnic/racial hierarchy—a social ranking that contin-

Kekoa does not feel valued as a Native Hawaiian.

ues today. The Hawaiian homestead he and his family reside in is the result of a settlement to return Native Hawaiians back to their lands after the occupation of Hawaii by the U.S. However, many Hawaiian homesteads are among the most impoverished and obesigenic neighborhoods in Hawai'i.

Kekoa often hears his parents' wish for Native Hawaiians to regain political autonomy from the U.S. so they can improve their quality of life. He also learns from his parents of how the U.S. illegally took over Hawai'i and made Native Hawaiians second-class citizens in their own homeland. Most neighbors in his homestead community share similar thoughts and frustrations and struggle to make ends meet. Ironically, most or all of this communication occurs not in the Hawaiian language, but in English, a further result of colonization.

Kekoa's family has an annual household income of \$35,000, which is barely enough to pay the bills and provide for the four children, in a state with one of the highest costs of living. He experiences the frustration and sense of helplessness of his parents in trying to make ends meet. Because of their economic hardship and result-

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ing stressors, his father often turns to alcohol to deal with the stress and frustration. After drinking, his father sometimes physically abuses his mother.

Kekoa's social environment at home and in his homestead community, where a majority is Native Hawaiian, is in sharp contrast to his school environment. Although a large number of students are Native Hawaiian and other Pacific Islanders (35%), the faculty of the school is predominantly of Asian descent (50%), with only a small minority (8%) being Native Hawaiian and other Pacific Islander. At school, Kekoa does not feel comfortable or accepted by his teachers and peers, who are of other ethnic groups. He prefers hanging out with other Native Hawaiian students whom he can better relate to. As a result of these and other factors, the public school system in Hawai'i has been accused of inadvertently maintaining the poor social and economic condition of Native Hawaiians and other Pacific Islanders.

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Psychological and Biological Response. Since entering high school, Kekoa has become depressed. He does not feel valued as a Native Hawaiian and believes society does not have much to offer him in the way of a bright future. When asked what is going on with him, he just responds by saying, "I Hawaiian so no moa [more] much for me. No make sense. I not going college so no need get good grades. Mo bettah I get one job and help my 'ohana [family]." Although Kekoa has always been overweight, he has gained a significant amount of excess weight since starting high school and is now obese, which has markedly decreased his physical functioning.

Resulting Health Inequities. Kekoa has taken up cigarette smoking and drinking on a daily basis, his grades have dropped, and he is frequently absent from school. He was recently diagnosed with type 2 diabetes. However, his retinal exam showed early signs of eye disease, suggesting that he has had diabetes for some time. Coupled with his smoking and drinking, he is at risk for other diabetes-related complications, such as cardiovascular and kidney disease.

For NHPI children in the U.S., racism has both direct and indirect effects, experienced both in immediate health outcomes and through shaping the social determinants of health. Many believe the compulsory acculturation process due to U.S. occupation of Hawaii has had direct adverse effects on the health of Native Hawaiians through increased chronic stress, allostatic load, historical/cultural trauma, and impoverished, damaged environments. These effects may be directly implicated in the higher suicide attempt rates for Native Hawaiian youth, compared to youth of other ethnic groups in Hawai'i (12.9% vs. 9.6%).

Eliminating Health Inequities. The resilience and fortitude of Native Hawaiians have allowed them to withstand many adversities and remain steadfast in their cultural beliefs, prac-

tices and aspirations. These cultural practices and beliefs are being revived to uplift Native Hawaiian youth and their families. For example, Hawaiian language immersion schools and cultural-based public charter schools in Hawai'i (open to students of all races and ethnicities) are building a stronger Hawaiian identity and providing the educational milieu necessary to improve the social and self-image of Native Hawaiian youth. Many substance abuse interventions involve reconnecting Native Hawaiian youth to land- and sea-based ac-

[Native Hawaiian] cultural practices and beliefs are being revived to uplift Native Hawaiian youth and their families.

tivities, such as Kalo farming, aquaculture and canoeing, as the venue for building the personal, cultural and social assets and supports needed to overcome their addiction. Cultural-based programs such as these offer the promise of addressing the social determinants of Native Hawaiian health inequities. On a larger scale, there are a multitude of Native Hawaiian efforts to increase self-governance.

Ultimately, addressing the effects of racism and U.S. occupation on Native Hawaiian children requires deconstructing the genealogy of the "sick" islander child, whether from attention deficit disorder, anxiety, depression, obesity or diabetes. The deconstruction of the "sick" child can provide a historical context to shift the discourse away from one of "blame the victim" to one of restoring the agency of resistance, persistence and reclamation among NHPI children and families.

Seung-Hui's Story

On April 16, 2007, Seung-Hui Cho, a 23-year-old Korean college senior, killed 32 people and wounded

many others in what has been known as the "Virginia Tech massacre" before committing suicide. The national coverage labeled Seung-Hui as primarily responsible for his rampage and for not seeking help sooner. Blame was placed on this mentally ill Korean immigrant student instead of examining and addressing the root causes and solutions to youth violence among our growing diverse populations.

Exposure to Racial Discrimination. A closer examination of the Seung-Hui Cho's personal history and mental health trajectory suggests that the chain of events leading to the shooting rampage and suicide started in childhood. Racism, closely connected with xenophobia, played a large part in his immigrant experiences, which included social alienation, generational and cultural gaps, bullying and inadequate services. Seung-Hui came to the U.S. from Korea when he was 8 years old. His father worked as a presser at a dry cleaner to help pay for his children's education. Seung-Hui was labeled as a shy boy with an accent who did not speak much. His classmates in junior high and high school made fun of him and occasionally called out to him "go back to China." He was also bullied by affluent Korean youth through Korean church groups. At home, he was shy and not talkative, and often misunderstood by his immigrant parents due to their traditional Korean expectations of his American academic and social life.

Psychological Response. Lack of adequate, culturally competent mental health services also played a role in the chain of events. In 8th grade, he was diagnosed with selective-mutism, a symptom of schizophrenia. He often refused or avoided taking medication when it was prescribed. Throughout his youth, his family sought help for him through Korean churches, but avoided mental health services. In college, he was labeled "question-mark kid" by classmates. Seung-Hui's mental condition progressively worsened over the years, without adequate care or support, and

led to increasing social alienation and humiliation at school and at home. He underwent basic psychiatric assessments in college, but continued to fall through the cracks of the school and mental health systems. His mental health condition was not fully diagnosed before he committed suicide.

Resulting Health Inequities. Although the level of violence and tragedy in Seung-Hui's case is unprecedented, it would be a mistake to view his mental illness as an isolated case. The lack of awareness and understanding by family members, schools and health care providers about the experiences of Seung-Hui and other Korean and Asian immigrant youth with mild and severe mental health challenges pose major barriers to ensuring the provision of needed support and care.

The leading causes of death among Asian-American youth are unintentional injuries, suicide and homicide, but little is known about their root causes in Asian communities, such as the potential roles of racism and youth violence, and the impact of violent death at an early age on the neighborhood, behavioral and mental health of Asian families, and communities across America.

Eliminating Health Inequities. Seung-Hui's story points to the importance of ensuring that Asian immigrant youth with mild and severe mental health conditions are fully supported at home, school, in the communities and by service providers. In Korean communities, for example, school teachers and service providers need to ensure they are culturally sensitive and engage family members, friends and churches who play central roles to care for Korean youth in everyday life. Reducing racism and youth violence across Asian American communities also requires more data and research, prevention programs, community engagement and advocacy.

Currently, few or no data exist about racism, youth violence and mental health among Asian-American children and youth. More data are needed to identify the causes of these

issues, their interconnections, and to develop strategies for prevention. Data collection should be culturally appropriate and ensure disaggregation of Asian ethnic subgroups.

Prevention strategies must be aimed at addressing root causes, such as racial discrimination and the culture of violence in American schools and communities, while also building on community and cultural strengths, educating Asian immigrant youth and their parents to access and navigate American social and mental health services in their neighborhoods and schools, and fostering youth resilience.

It is essential to place our efforts in historical context.

Asian-American youth programs that build a sense of belonging and self-esteem can facilitate the prevention of violence, reduce risk factors and strengthen protective factors in the community. Such youth programs can mobilize families and communities, conduct research projects, implement prevention programs and lead advocacy efforts. In addition, cultural competency training is critical for all service providers and should include respect and understanding about Asian mental health beliefs and practices, particularly about “face”; the importance of culturally appropriate mental health services to ensure accurate diagnosis and treatment; the importance of ensuring family member involvement in all aspects of mental healthcare; and the provision of social support and health education for family caregivers.

Finally, partnerships of broad community collaborations across Asian youth, family members, schools, mental health providers, advocates and law enforcement in undoing racism and strengthening youth violence prevention initiatives, and working together in caring and advocating for Asian youth with behavioral and mental health conditions across our nation are more critical than ever in preventing

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youth violence and building healthy families and safe communities for Asian youth.

Conclusion

AA and NHPI children and youth are impacted by a wide spectrum of interconnected social and health inequities, including those that seriously threaten their quality of life and life itself. Understanding and addressing these inequities requires that we look beyond the surface and confront difficult social issues that are embedded in history and current realities. We need to disaggregate our data and ethnic community experiences to seek a richer understanding of the cultural contexts and gaps facing different ethnic communities.

There is an urgent need for further exploration of social, physical and mental health inequities. The theoretical model proposed by Sanders-Phillips and her colleagues shows promise as a framework for understanding and addressing the role of racism. Further work to build an evidence base will be needed to confirm the relevance of this framework among AA and NHPI communities. While empirical studies may help us understand the direct role of racism as a determinant of health, it is crucial that we also examine the indirect, invisible role racism plays in shaping other social determinants. In this regard, it is essential to place our efforts in historical context and explore the role that racism has played in colonial devastation and displacement of indigenous people as well as xenophobia and anti-immigrant discrimination, and their effects in shaping contem-

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porary institutions and policies. This exploration can be effective only if we deconstruct narratives of victim-blaming and "sick" children, and work to

restore agency in resisting oppression and building community health.

In this context, it is essential to acknowledge the role that family, culture and community can play in fostering health equity in developing

strategies at the microsystem and macrosystem levels. There are rich opportunities to learn from existing cultural and community-based programs to discover and build upon promising practices. □

Resources

Brown, D.E., Gotshalk, L.A., Katzmarzyk, P.T. & Allen, L. (2011). "Measures of Adiposity in Two Cohorts of Hawaiian School Children." *Annals of Human Biology*, Mar 14. [Epub ahead of print]

Centers for Disease Control and Prevention. (2011). "Deaths: Preliminary Data for 2009." *National Vital Statistics Reports*, 59(4). Atlanta, GA: Centers for Disease Control and Prevention National Center for Health Statistics Division of National Vital Statistics.

Glanz, K., Maskarinec, G. & Carlin, L. (2005). "Ethnicity, Sense of Coherence, and Tobacco Use among Adolescents." *Annals of Behavioral Medicine*, 29(3), 192-199.

Huang, L. N. & Ida, D. J. (2004). *Promoting Positive Development and Preventing Youth Violence and High-Risk Behaviors in Asian American/Pacific Islander Communities: A Social Ecological Perspective*. Washington, DC: Georgetown University Center for Child and Human Development and National Asian American/Pacific Islander Mental Health Association.

Juang, L.P. & Alvarez, A.A. (2010) "Discrimination and Adjustment among Chinese American Adolescents: Family Conflict and Family Cohesion as Vulnerability and Protective Factors." *Am J Public Health*, 100(12), 2403-2409.

Kaholokula, J.K., Nacapoy, A.H. & Dang, K. (2009). "Social Justice as a Public Health Imperative for Kanaka Maoli." *AlterNative* 5(2), 116-137.

Lai, M. (2008). Asian/Pacific Islander Youth Violence Prevention Center: "Community Mobilization Efforts to Reduce and Prevent Violence." *American Journal of Preventive Medicine*, 34(3S), S48-S55.

Lee, S., Juon, H.S., Martinez, G., Hsu, C.E., Robinson, E.S., Bawa, J. & Ma, G.X. (2009). "Model Minority At Risk: Expressed Needs of Mental Health by Asian American Young Adults." *J Community Health*, 34(2), 144-152.

Native Hawaiian & Pacific Islander Alliance. (2008). *Guidance on the Classification of Native Hawaiian and Pacific Islanders*. Gardena, CA: Native Hawaiian and Pacific Islander Alliance and Asian & Pacific Islander American Health Forum.

Okamura, J. (2008). *Ethnicity and Inequality in Hawai'i*. Philadelphia, PA: Temple Univ. Press.

Pachter, L.M. & Coll, C.G. (2009) "Racism and Child Health: A Review of the Literature and Future Directions." *J Dev Behav Pediatr*. 30(3), 255-263.

Ponce, N., Tseng, W., Ong, P., Shek, Y.L., Ortiz, S. &

Gatchell, M. (2009). *The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report*. Sacramento, CA: UC AAPI Policy MRP and API Joint Legislative Caucus.

Sanders-Phillips, K., Settles-Reaves, B., Walker, D. & Brownlow, J. (2009) "Social Inequality and Racial Discrimination: Risk Factors for Health Disparities in Children of Color." *Pediatrics*, 124 (Supplement).

Sapolsky, R. (2004). "Social Status and Health in Humans and Other Animals." *Annual Review of Anthropology*, 33, 393-418.

Schempf, A.H., Mendola, P., Hamilton, B.E., Hayes, D.K. & Makuc, D.M. (2010). "Perinatal Outcomes for Asian, Native Hawaiian, and Other Pacific Islander Mothers of Single and Multiple Race/Ethnicity: California and Hawaii, 2003-2005." *Am J of Public Health*, 100(5), 877-887.

Spoehr, H. (2007). *Threads in the Human Tapestry: The Disaggregation of the API Identifier and the Importance of Having NHOPI (Native Hawaiian and Other Pacific Islander) Category in Data Collection, Analysis, and Reporting*. Honolulu, HI: Papa Ola Lokahi.

Thomas, E. (2007). "Making of a Massacre: Quiet and Disturbed, Cho Seung Hui Seethed, Then Exploded. His Odyssey." *Newsweek*. Cover Story: Special Report. April 30, 2007. U.S. Edition.

Trinh-Shevrin C., Islam, N. S. & Rey, M. J., (Eds.). (2009). *Asian American Communities and Health*. San Francisco: Jossey-Bass.

UCLA Center for Health Policy Research. *California Health Interview Survey 2001-2007*. Los Angeles, CA: UCLA Center for Health Policy Research.

Yeh, M., McCabe, K., Hough, R.L., Lau, A., Fakhry, F. & Garland, A. (2005) "Why Bother with Beliefs? Examining Relationships between Race/Ethnicity, Parental Beliefs about Causes of Child Problems, and Mental Health Service Use." *J Consult Clin Psychol*, 73(5), 800-7.

Yuen, N., Nahulu, L., Hishinuma, E. & Miyamoto, R. (2000). "Cultural Identification and Attempted Suicide in Native Hawaiian Adolescents." *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(3), 360-367.

Zane, N. W. S., Takeuchi, D. T. & Young, K. N. J. (Eds.). (1994). *Confronting Critical Health Issues of Asian and Pacific Islander Americans*. Thousand Oaks, CA: Sage Publications.

Neighborhood – The Smallest Unit of Health: A Health Center Model for Pacific Islander and Asian Health

by Jamila Jarmon

“Neighbors being Neighborly to Neighbors.” This is how Kokua Kalihi Valley Comprehensive Family Services (KKV) approaches neighborhood health in Kalihi Valley, a mostly immigrant community of 30,000 residents on the edge of urban Honolulu. KKV is a federally-qualified community health center, serving about 10,000 residents, primarily Pacific Islander and Asian-American, a year, fostering neighborly values to ensure health for all. Through the years, KKV has grown and currently operates at seven separate locations in the community, including the largest public housing complex in the State of Hawai`i. With growth, KKV retains an original grassroots vision of health and well-being developed together with the community.

KKV has humble roots, beginning in 1972 with four outreach workers operating out of a trailer, going door-to-door getting to know their neighbors: their immediate needs, their hopes, dreams and individual talents, too. The four spoke three different languages and were able to assist community members with agency resources. From their trailer-offices, workers interacted with the community. Soon, medical and dental physicians volunteered their time, broadening KKV’s community participation. Standing by its motto, KKV continues to expand, maintaining an active and ongoing conversation with the growing community that includes

Jamila Jarmon (jjarmon@hawaii.edu) is a Post-Graduate Legal Fellow with the William S. Richardson School of Law’s Health Policy Center Medical-Legal Partnership for Children Hawai`i and Kokua Kalihi Valley Comprehensive Family Services’ Lei Hipu`u o Kalihi Program.

Hawaiians, Filipinos, Samoans and Micronesians, to name a few. The traditional services associated with community health centers are present at KKV, including primary care physicians, dental, nutrition, behavioral health, elderly care, and maternal-child health services. These services help KKV to retain its identity as a traditional community health center. In addition, KKV staff speak 21 dif-

KKV embraces an expanded meaning of “health care.”

ferent languages, supporting language access and cultural competency for limited-English-proficient speakers. KKV staff diversity enables it to develop innovative programs that support neighborhood health in culturally competent ways.

Adapting a community-based health model pioneered by Dr. Jack Geiger and others on the mainland U.S., KKV understands that communities want to be active participants in developing solutions and strategies that benefit neighborhood health. KKV addresses ongoing human resource needs by hiring from the community, building lasting relationships and thinking programmatically. Hiring workers from the community allows KKV to have a continued connection with the community. The employee is able to listen and work to develop programs within the community that are sustainable. The policy also provides paying jobs to the community, yielding not only health impacts, but also economic impact. By building relationships and working on an equalized plane, KKV is able to not only recognize strength and leadership within the community, it also

builds trust as an institution in the community. This helps KKV fulfill its mission of “serving communities, families and individuals through strong relationships that foster health and harmony.”

KKV focuses on its internal capacity to continue providing services to the community. The bottom line for KKV is the neighborhood’s health and well-being; all programs that begin out of this community dialogue are designed for sustainability. As a community participant, KKV seeks to develop the internal capacity of its partners and clients so that programs can last beyond individual project funding. The neighborhood is an integral part driving programming based on need. For KKV, it is important to keep up the organization’s side of the partnership and retain continuity of the programs offered, regardless of funding challenges.

KKV embraces an expanded meaning of “health care” by having a broad view of neighborhood health. It has developed a variety of innovative neighborhood health partnerships that serve its diverse ethnic community, which includes many new Pacific-Islander and Asian-American immigrant communities. This commentary highlights four programs at KKV: Lei Hipu`u o Kalihi; Kalihi Valley Instructional Bike Exchange; Medical-Legal Partnership for Children in Hawai`i; and Ho`oulu `Aina. Focusing on culture and family, these programs are guided and led by the community.

Lei Hipu`u o Kalihi

KKV’s Lei Hipu`u o Kalihi (Lei Hipu`u) is a grantee of the Health
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Through Action Grant from the Asian & Pacific Islander American Health Forum sponsored by the W.K. Kellogg Foundation. Lei Hipu`u's purpose it to work on capacity-building in the area of early childhood health within the Kalihi Valley community. Because KKV serves various ethnic groups, Lei Hipu`u conducts focus groups with each around early childhood health issues, identifying cultural similarities and differences. These focus groups produce qualitative data that help Lei Hipu`u, as a representative of KKV, understand how the community raises their children. Many of these focus groups are assembled by the community outreach specialist for Lei Hipu`u, who is a leader in the Chuukese (Micronesian) community. Hiring from the community for this position provides Lei Hipu`u continuous opportunities to work in partnership with the community and understand neighborhood priorities. The Micronesian community is the newest and fastest growing immigrant community in Hawai`i and a large consumer of KKV services. Hiring from the community not only created the opportunity to build a relationship with a new and growing immigrant population, it built the community outreach specialists' capacity and provided economic opportunity for work previously done without pay.

Relationships are built through Lei Hipu`u, which serves as a connector in the neighborhood. Lei Hipu`u created a "Leadership Council" that comes together monthly as a cohort of Kalihi-based service providers, including social workers, librarians, school staff and officials, community leaders, doctors, lawyers and more. The relationships developed have resulted in increased trust, support and collaboration among the community of service providers. The prevailing culture of the Leadership Council remains focused on the ever-shifting needs and hopes of the communities served.

Lei Hipu`u fosters a notable community relationship with the Kuhio

Park Terrace Residents Association (KPTRA). Kuhio Park Terrace (KPT) is the largest public housing complex in the State of Hawai`i, and many residents receive services from KKV. KPTRA, in partnership with Lei Hipu`u, created monthly "talk story" meetings. "Talking story" is a custom of dialoguing about community and family issues or events. These talk stories have resulted in committees forming to address issues within the community, such as tackling fire safety with the Honolulu Fire Department and discussion of traditional health practices amongst the different cultures in housing led by residents of KPT. Lei Hipu`u builds the capacity and confidence of the KPTRA to continue a dialogue in the community in order to recognize needs of their neighbors. Lei Hipu`u contributes greatly to neighborhood health and the

Health is community.

equalization of resources to benefit all participants in the Kalihi Valley community. Lei Hipu`u's goal is for community residents to take ownership of their neighborhood's health.

Kalihi Valley Instructional Bike Exchange

The Kalihi Valley Instructional Bike Exchange (KVIBE) is a program of KKV that lives by the motto "If you build it they will come." KVIBE is a non-profit bicycle shop that began in 2005 and promotes bicycle-related activities for at-risk youth in Kalihi Valley. KVIBE stocks about 100 bikes at a time and relies on steady donations. Two neighborhood residents who previously volunteered with the program currently staff KVIBE. One had previous bicycle repair expertise and the other was a youth participant who developed skills over time. Personal relationships help to foster trust in KVIBE. This trust engages Kalihi Valley youth to come and either buy, build or repair bikes there. Those who choose to build do so with

the help of KVIBE staff and other youth who have gained skills from their time at KVIBE. This program exists because it recognizes that a bike shop is one method to affect or understand community health.

KKV acknowledges that through knowledge of building a bike, KVIBE is able to build the capacity of the Kalihi Valley youth. Not only do they redeem a bike after building it, they learn responsibility, hard work, and gain mentors to help guide them. KVIBE staff are trained to discuss healthy relationships and foster a safe environment where no gang colors are allowed, targeting youth to build a sustained neighborhood health capacity for the future of Kalihi Valley. KVIBE is a true innovation in neighborhood health, providing youth a viable alternative to learn, grow and make healthy choices from positive experiences.

Medical-Legal Partnership for Children in Hawai`i

The Medical-Legal Partnership for Children in Hawai`i (MLPC Hawai`i) is a project of the Health Law Policy Center of the William S. Richardson School of Law (University of Hawai`i at Manoa). Medical-Legal Partnerships follow a model established by Dr. Barry Zuckerman of the Boston Medical Clinic, who hired an attorney to "address the social determinants that negatively impact the health of vulnerable populations." Recognizing KKV's unique relationship with the Kalihi Valley community, the co-director of the Health Law Policy Center partnered with a pediatrician at KKV to construct a program that allowed legal interventions and advocacy to improve health care and access. This particular doctor and lawyer saw that there were instances when medical conditions could be alleviated through legal intervention, such as when a child with chronic asthma and eye infections needs a landlord to fix a leaky pipe that has caused mold to develop in his bedroom. MLPC

Hawai`i approached its partnership with KKV by engaging with the community first. To begin, the MLPC Hawai`i legal director and law student interns accompanied KKV public housing outreach workers on a door-to-door survey to introduce KKV services and to hear about public housing residents' needs, including the lack of accessible legal services. After listening to the neighborhood, MLPC Hawai`i built on the trust families have with their children's doctors and began providing direct legal services to families at KKV to address the social/legal problems that negatively impact their health. MLPC Hawai`i runs its legal clinics to coincide with the KKV Pediatric Clinics, allowing legal advocates to meet with families alongside pediatricians in the exam rooms during well-child medical visits. KKV generously provided office space to MLPC Hawai`i in their office located in the KPT Resource Center, giving MLPC Hawai`i a central and constant presence in the neighborhood to continue garnering trust.

MLPC Hawai`i also works to build the capacity of the community to advocate for themselves. Clients are taught about their legal rights, recognize the effect on health, and are empowered with the understanding that those rights are enforceable. For example, the right to have habitable housing is reinforced with law for clients because many health ailments are exacerbated or persist from uninhabitable living conditions.

Also, MLPC Hawai`i has engaged in language access advocacy on both individual and systemic levels. They enlist the help of interpreters from KKV staff to ensure open dialogue with their many limited-English-proficient clients. They even look to the community for translation services to produce legal resources and information in native languages. In addition, MLPC Hawai`i advocates provide clients with "language access rights" cards so they can enforce their state and federal right to an interpreter at state agencies, federal agencies and hospitals. Knowledge is power and can galvanize people to act; provid-

ing these resources gives the community this power and experience to effectively advocate for themselves. Working closely with the community, service providers and health professionals foster the goals of MLPC Hawai`i to value and respect collaboration in real-life settings. Taking the time to build and foster these valuable relationships also helps legal ad-

Ho`oulu Aina recognizes land as a community member.

vocates to stay in touch with the ever-shifting needs and hopes of the neighborhood. MLPC Hawai`i's partnership with KKV has contributed to building resources and advocacy opportunities for the neighborhood.

Ho`oulu `Aina

Ho`oulu `Aina is a part of KKV located on a 99-acre land preserve in Kalihi Valley to engage communities in nurturing their land. Hawaiians for generations and until today honor this area as sacred to the creation gods, and this land in the past was very fertile, providing sustenance for the people of Kalihi Valley and beyond. Ho`oulu `Aina recognizes land as a community member. In partnership with the community, Ho`oulu `Aina uses a land-based program to improve overall neighborhood health. When people come to Ho`oulu `Aina to work, they nurture the land, which in turn nurtures them: "O ka ha o ka `aina ke ola o ka po`e: the breath of the land is the life of the people."

Most of the staff at Ho`oulu `Aina live in Kalihi Valley and bring valuable relationships to enrich accessibility to this unique neighborhood experience. These opportunities are, like other KKV programs, fostered through community dialogue. For example, KKV's Nutrition Program's diabetes group has utilized this access for exercise and nutrition purposes. For a year, the nutrition program was unable to influence members of the

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Chuukese diabetes group to exercise. In a meeting, the interpreter explained that there was no word for "exercise" in Chuukese. They tried "Take a walk"—to which the participants said—"To where?" It is not in their culture to "take a walk" or "exercise" without a purpose or destination. Also, highly urban areas like Kalihi are sometimes difficult or dangerous for walking. Farming was mentioned as an option and hands shot up! This led to weekly trips to Ho`oulu `Aina, to begin clearing land so that gardens could be planted, harvested, cooked and shared with family and neighbors, for their "exercise." In addition, other programs at Ho`oulu `Aina enforce health through story-telling, native reforestation and learning the history of Kalihi Valley.

Ho`oulu `Aina recognizes the community as experts in their health and values their expertise in understanding the social forces that affect neighborhood health. During an open dialogue with the community, they discussed how difficult it was to find or afford healthy food in Kalihi Valley. In addition, the large immigrant population is unfamiliar with Western foods and their nutritional value. Ho`oulu `Aina and partners are now embarking on the "Roots Project," with the goal of building community capital by providing more education and opportunity to enjoy and prepare healthy foods as neighbors. Ho`oulu `Aina will increase food production with the neighborhood and utilize the new commercial kitchen being built at KKV's main clinic. Neighbors will have the opportunity to work the land, grow food, learn how to prepare that

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food in new ways, and then share the fruits of their labor, coming together as neighbors. Ho`oulu`Aina, in partnership with the community, is directly impacting neighborhood health through food production and consumption.

“Neighbors being Neighborly to Neighbors”

KKV is an innovative community health center because it understands that the community is a neighbor and collaborator. Direct services are grounded in the various cultural traditions of patients and residents working together to provide resources necessary for health access. KKV understands that language access goes hand-in-hand with cultural competency, creating a trusting environment. Language access and cultural competency does not stop there however; hiring from the community creates more cultural context and gives economic incentive to retain language and culture. KKV recognizes that when working with a diverse community of new immigrants, Pacific Islanders and Asian Americans, community dialogue and support create sustainable programs to serve the neighborhood. KKV is a community health center with place-based focus and a health justice mission. This neighborhood health model’s use has broad application for any institution or individual working to affect neighborhood health. Health is not only medical health; it is holistic. Health is community. Health is legal advocacy. Health is self-advocacy. Health is a bike shop. Health is reconnecting with culture and land. By being a neighbor, KKV creates programs that foster a healthy community. Institutions and individuals have the ability to be neighborly. As a neighbor, KKV is a vital part of revitalizing and sustaining the Kalihi Valley community now and for future generations. □

Resources

- Asian & Pacific Islander American Health Forum. Available from: <http://www.apiahf.org/index.php/programs/health-through-action.html>
- Cargo M., Mercer S. “The Value and Challenges of Participatory Research: Strengthening Its Practice.” *Annu. Rev. Public Health*. 2008 Jan. 3; 29:325-350.
- Hancock T. “People, Partnerships and Human Progress: Building Community Capital.” *Health Promot. Int.* 2001 Sept; 16(3): 275-80.
- Hawai`i Public Housing Authority. *Annual Report Fiscal Year 2010*. Available from: http://www.hcdch.hawaii.gov/documents/2011%20Annual%20Report_draft4.pdf.
- Ho`oulu`Aina. Available from: <http://www.hoouluaina.org/index.html/>.
- Kalihi Valley Integrated Bike Exchange. Available from: <http://k-vibe.blogspot.com/>.
- Kokua Kalihi Valley Comprehensive Family Services. Available from <http://www.kkv.net/>.
- William S. Richardson School of Law: Medical-Legal Partnership for Children in Hawai`i. Available from: <http://www.law.hawaii.edu/mlpc/>.
- National Center for Medical Legal Partnership. Available from: <http://www.medical-legalpartnership.org/>.

(HIA: Cont. from page 6)

Conclusion

Regardless of what type of project, plan or policy decision is being considered, a Health Impact Assessment may be a strategic tool for a variety of reasons. In addition to providing a health lens and health analysis, an HIA can contribute a robust participatory process and a structure for communities and other stakeholders to collabo-

rate and provide input on decisions being made. HIAs may be appropriate on a wide variety of subjects (see box on p. 6 for a partial list of topics HIAs have covered). The value of an HIA can be determined by the magnitude and likelihood of potential health impacts, the distribution of those impacts, an accurate assessment of the likelihood of achieving the process and/or outcome objectives of the HIA, and a realistic evaluation of resources, capacity and stakeholder interest. □

Completed Health Impact Assessments:

- Paid Sick Days HIA <http://www.humanimpact.org/component/jdownloads/finish/5/68>
- Long Beach HIA: <http://www.humanimpact.org/component/jdownloads/finish/8/102/0>
- More on these and other HIAs:
<http://www.humanimpact.org/past-projects>
<http://www.hiaguide.org/hias>

Information on Income Disparities and Health:

- http://www.humanimpact.org/evidencebase/category/income_inequality_affects_peoples_mortality_and_health
- <http://www.cdc.gov/omhd/default.htm>
- Laura D. Kubzansky et al., “United States: Social Inequality and the Burden of Poor Health,” in *Tackling Health Inequities through Public Health Practice: Theory to Action* 86 (Richard Hofrichter & Rajiv Bhatia, eds., 2010)
- <http://www.oecdbetterlifeindex.org/countries/united-states/>

More information on the relationship between HIA and EIA can be found at <http://www.humanimpact.org/hia#EIA>

thing.

These ideas don't have to be believed, or even conscious, for them to influence behavior. Mere familiarity with derogatory stereotypes, even without belief, can cause unwitting discrimination. No wonder that even people who consciously reject anti-black stereotypes have been found to discriminate against blacks. This is because stereotypes typically operate automatically, behind our backs. In addition, we need to multiply our models of *how* racially stigmatizing ideas cause discrimination. Pure prejudicial discrimination, as in the KKK case, offers just one model. Economists stress statistical discrimination, in which decision-makers use race as a proxy for undesirable traits such as laziness or criminal tendencies. But often stereotypes work by altering *perceptions*. For some white observers, that rambunctious black youth shooting hoops in the park looks aggressive and hostile, although if he were white, he would be perceived as harmlessly horsing around. Other times they work by making well-meaning people anxious. Nervous about appearing racist, whites may avoid blacks, or act stiffly and formally toward them. The very desire to avoid discrimination can cause it.

Racial stigmatization also harms blacks through paths other than discrimination. This is why *The Imperative of Integration* argues that the standard discrimination account of racial inequality needs to be replaced by a broader account, based on the joint effects of segregation and stigmatization. Negative effects of stigmatization not mediated by discrimination include "stereotype threat"—anxiety caused by the fear that one's behavior will confirm negative stereotypes about oneself—which depresses blacks' performance on standardized tests. In addition, stigmatizing images of blacks are not just in people's heads; they are in our culture and public discourse. TV news and police dramas disproportionately depict criminals as black and exaggerate the

extent of black-on-white crimes. Such taken-for-granted stigmatizing public images of blacks amount to a massive assault on the reputation of blacks, a harm in itself. They also generate public support for policies that have a disproportionately negative impact on blacks. White support for the death penalty jumps when whites are told that more blacks than whites are executed. White hostility to welfare is tied to the public image of the welfare recipient as a single black mother, even though most recipients are white.

Such impacts of racial stigmatization on democratic policy formation

Segregation also stigmatizes the disadvantaged.

reinforce the anti-democratic effects of spatial and role segregation. Democracy isn't only about the universal franchise. It requires a trained elite, institutional structure, and culture that is systematically responsive to the interests and voices of people from all walks of life. This requires that people from all walks of life have effective access to channels of communication to elites, and that they be able to hold them accountable for their decisions. Segregation blocks both communication and accountability. There is nothing like face-to-face confrontation to force people to listen and respond to one's complaints. Out of sight, out of mind: Segregated elites are clubby, insular, ignorant, unaccountable and irresponsible. The history of the Civil Rights Movement demonstrates how mass disruptive protests were needed to teach segregated elites, and whites at large, fundamental lessons about democracy and justice that they were incapable of learning on their own.

Racial Segregation: A Fundamental Cause of Racial Injustice

So racial segregation is a fundamental cause of racial injustice in three

ways: It blocks blacks' access to economic opportunities, it causes racial stigmatization and discrimination, and it undermines democracy. It stands to reason that racial integration would help dismantle these injustices. We can think of integration as taking place by stages. We start with formal desegregation: ending laws and policies that turned blacks into an untouchable caste by forcing them into separate and inferior public spaces. This is an essential step toward destigmatization. While stigma still exists, blacks' public standing is better now that they can no longer be forced to the back of the bus. Next comes spatial integration, in which racial groups actually share common public spaces and facilities. This enables blacks to get access to many of the public goods—notably, safe, unblighted, relatively unpolluted neighborhoods with decent schools and public services—that most whites enjoy. Studies of integration experiments involving low-income families, from Gautreaux to Moving to Opportunity, show that spatial integration yields important material and psychic benefits to formerly segregated blacks, notably better housing, lower stress and greater freedom for children to play outdoors.

The next step is formal social integration: cooperation on terms of equality in institutions such as schools, workplaces, juries and the military. This is where some of the biggest pay-offs of integration occur. Extensive interracial cooperation on equal terms expands blacks' social and cultural capital, leading to better education and job opportunities. Sustained formal social integration under moderately favorable conditions, including institutional support and cooperative interaction, also reduces prejudice, stigma and discrimination, often to the point of promoting informal social integration—interracial friendship and intimate relations.

Formal social integration also improves the responsiveness of democratic institutions to all social groups. Racially integrated police forces are less violent toward blacks and more

(Please turn to page 18)

(INTEGRATION: Continued from page 17)

responsive to community concerns than racially homogeneous ones. Integrated teaching staffs are less punitive toward black students and less likely to consign them to lower educational tracks. Integrated juries deliberate longer, take into account more evidence, make fewer factual mistakes, and are more alert to racial discrimination in the criminal justice process than all-white juries. Part of the greater intelligence of integrated juries is due to the diverse information provided by blacks, who are more likely to raise critical questions, such as the reliability of whites' eyewitness identification of blacks. Deliberation in an integrated setting also makes whites deliberate more intelligently and responsibly: They are less likely to rush to a guilty judgment, and more likely to raise and take seriously concerns about discrimination in the criminal justice process, than in all-white juries. The need to justify oneself face-to-face before diverse others motivates

people to be responsive to the interests of a wider diversity of people. In public opinion polling, too, whites express more racially conciliatory positions when they think they are talking to a black pollster.

The Imperative of Integration argues that the evidence on the positive effects of racial integration, combined with theory and evidence that these effects cannot be achieved in other ways, provide a powerful case for re-instituting racial integration as a policy goal. Integration needs to be pursued on multiple fronts, including housing

Stereotypes typically operate automatically, behind our backs.

vouchers to promote low-income black mobility into integrated middle-class neighborhoods, abolition of class-segregative zoning regulations, adoption of integrative programs by school districts, extension and aggressive enforcement of differential impact stan-

dards of illegal discrimination to state action, and deliberate selection for racially integrated juries. I also argue that voting districts should be integrated in such a way that politicians cannot be elected without running on platforms with multiracial appeal. This will correct a serious downside of majority-minority districting, which is that remaining districts tend to favor race-baiting politicians running on a politics of white racial resentment. In many parts of the U.S., race relations have relaxed enough to enable blacks, even when a minority in their district, to elect their preferred candidate in coalition with a critical mass of racially tolerant whites, Latinos, Asian Americans and Native Americans.

The Imperative of Integration also argues for alternative models of affirmative action. Right now, discussion of affirmative action is dominated by two models: diversity and compensation. The diversity model stresses the supposed connections between racial diversity and diversity of cultures and ideas. It doesn't do much to support affirmative action in industries such as construction and manufacturing, where the culture and ideas of most employees make little difference. Nor does it explain why selective schools should preferentially admit African Americans and Latinos, as opposed to foreign students. The compensatory model portrays affirmative action as making up for past discrimination. This encourages people to believe that racial inequalities are due to long-past deeds, overlooking the powerful continuing causes of racial injustice rooted in current segregation and stigmatization. It also supports public impatience with affirmative action. No wonder the Supreme Court, even while upholding affirmative action in *Grutter v. Bollinger*, expressed the view that affirmative action will no longer be needed in 25 years.

Once we understand that current racial inequality is rooted in current racial stigmatization and segregation, affirmative action can be understood differently. *De facto* segregation creates referral networks that exclude blacks from information and recom-

Further Readings

Estlund, Cynthia. *Working Together: How Workplace Bonds Strengthen a Diverse Democracy*. New York: Oxford UP, 2005.

Frankenberg, Erica & Gary Orfield, eds. *Lessons in Integration: Realizing the Promise of Racial Diversity in American Schools*. Charlottesville: Univ. of Virginia Press, 2007.

Gaertner, Samuel & John Dovidio. *Reducing Intergroup Bias: The Common Ingroup Identity Model*. Philadelphia: Psychology Press, 2000.

Kinder, Donald & Tali Mendelberg. "Cracks in American Apartheid: The Political Impact of Prejudice Among Desegregated Whites." *Journal of Politics* 57:2 (1995): 402-24.

Pettigrew, Thomas & Linda Tropp. "A Meta-Analytic Test of Intergroup Contact Theory." *Journal of Personality and Social Psychology* 90:5 (2006): 751-83.

Sanders, Lynn. "Democratic Politics and Survey Research." *Philosophy of the Social Sciences* 29.2 (1999): 248-80.

Sklansky, David Alan. "Not Your Father's Police Department: Making Sense of the New Demographics of Law Enforcement." *Journal of Criminal Law and Criminology* 96:3 (2006): 1209-43.

Sommers, Samuel. "On Racial Diversity and Group Decision Making: Identifying Multiple Effects of Racial Composition on Jury Deliberations." *Journal of Personality and Social Psychology* 90:4 (2006): 597-612.

Tilly, Charles. *Durable Inequality*. Berkeley and Los Angeles: Univ. of California Press, 1999.

Wells, Amy & Robert Crain. "Perpetuation Theory and the Long-Term Effects of School Desegregation." *Review of Educational Research* 64:4 (1994): 531-55.

mendations to job openings in firms that employ few blacks. Role segregation within firms creates stereotypes of qualified workers that mirror the identities of those who already occupy those roles. Non-stereotypical workers are therefore *perceived* to be unqualified for such roles even when they could fill them successfully, and so are excluded even when managers believe they are hiring on merit. Affirmative action within firms serves to block these and other racially exclusionary practices. This is *discrimination-blocking* affirmative action. *Integrative* affirmative action explicitly adopts racial integration as an institutional goal, in the name of promoting democratic responsiveness to the full diversity of people whom the institution is supposed to serve, overcoming racial inequalities in social and cultural capital, and breaking down racial anxieties, prejudices and stereotypes through integrated, cooperative work teams.

Any argument for restoring racial integration to a central place in the public policy agenda must address three objections. Conservatives oppose integrative policies on grounds of color-blindness. In *The Imperative of Integration*, I argue that the color-blind principle is conceptually confused, because it conflates different meanings of race and different kinds of racial discrimination. It is one thing to discriminate out of pure prejudice against a group with a different appearance or ancestry, or to treat race as a proxy for intelligence or other merits; quite another to take race-conscious steps to counteract racial discrimination and undo the continuing causes of racial-based injustice. Affirmative action, properly administered, does not compromise but rather promotes meritocratic selection. Some on the left oppose integrative policies because they fear the destruction of autonomous black institutions and cultural practices in the name of as-

similation and object to the psychic costs of integration on blacks. I argue that integration is distinct from assimilation, since its aim is not to erect white practices as the norm, but rather to *abolish* white exclusionary practices and replace them with practices inclusive of all. And, while integration is stressful, as people learn to cooperate across racial lines the psychic costs of integration decline. Finally, readers of *Poverty & Race* will be familiar with the argument that integration is an unrealistic fantasy. We know, however, that the experience of integration is self-reinforcing: people of all races who grew up in more integrated settings tend to choose more integrated settings later in life. So we should not foreclose all hope. After all, only a few years ago the idea of a black president was regarded by many Americans to be an unrealizable dream. □

Resources

Most Resources are available directly from the issuing organization, either on their website (if given) or via other contact information listed.

Materials published by PRRAC are available through our website: www.prrac.org. Prices include the shipping/handling (s/h) charge when this information is provided to PRRAC. "No price listed" items often are free.

When ordering items from PRRAC: SASE = self-addressed stamped envelope (44¢ unless otherwise indicated). Orders may not be placed by telephone or fax. Please indicate from which issue of P&R you are ordering.

Race/Racism

- *The Imperative of Integration*, by Elizabeth Anderson (246 pp., 2010), has been published by Princeton Univ. Press. [12763]
- *Angels of Mercy: White Women and the History of New York's Colored Orphan Asylum*, by William Seraile (287 pp., 2011, \$27.95), has been published by Fordham Univ. Press, 212/743-8337, justyna.zajac.oup.com [12779]
- **Greenboro, NC Massacre:** A CNN story about Greensboro's civil rights history and demography that also includes within a link to a video interview with Nelson Johnson on the Greensboro Massacre is available at <http://www.cnn.com/2011/US/06/07/greensboro.race/> [12788]
- *Finding Our Way* is a 90-min., 3-part 2011 documentary by Giovanni Attili and Leonie Sandercock on the still unresolved conflict between indigenous people in north central British Columbia and the government of Canada. Inf. at mailbox@movingimages.ca, www.movingimages.ca, <http://www.facebook.com/FINDING.OUR.WAY>. thefilm [12795]
- "Faces of Racial Profiling: A Report from Communities Across America" (81 pp., Sept. 2010) is available (no price

listed) from The Rights Working Group (a project of the Tides Center), 1120 Conn. Ave. NW, #1100, Wash., DC 20036, 202/591-3300, www.rightsworkinggroup.org [12804]

- "The Persistence of Racial and Ethnic Profiling in the United States," a 98-page, Aug. 2009 follow-up report to the UN Committee on the Elimination of Racial Discrimination, published by ACLU and The Rights Working Group, is available (no price listed) from the latter org., 1120 Conn. Ave. NW, #1100, Wash., DC 20036, 202/591-3300, www.rightsworkinggroup.org [12806]

- *The Dream Is Freedom: Pauli Murray and*

American Democratic Faith, by Sarah Azaransky (176 pp., 2011, \$55), has been published by Oxford Univ. Press, 800/451-7556. [12808]

● ***I AM A MAN: From Memphis, a Lesson in Life*** is a new (2011) 47-minute documentary on the 1968 Sanitation Workers' strike that brought Martin Luther King to Memphis, resulting in his assassination. It's available (\$20 on the web, but the producer at the Memphis Convention & Visitors Bureau might generously send it without charge); there's also a separate 2nd "Behind the Scenes" element on how the movie was made. Contact Calvin Taylor, 901/543-5306, calvin@mcvb.org [12822]

● **"Breath of Peace: Portraits of the 1961 Freedom Riders"** was a marvelous exhibit [I caught it at the SF Jewish Comm. Ctr.-CH] that toured several cities, with photos of over 4 dozen Freedom Riders (mug shot when arrested, accompanied by current photo), along with personal statements by each on why they participated, what the journey meant for them, what they now are doing. If you act quickly, it may be possible to arrange for at least a partial local stop. The photographer, Eric Etheridge, published the photos in a book of the above title (214 pp., 2008, Atlas & Co.-212/234-3100). He can be reached at eetheridge@gmail.com. Addl. inf. from the exhibit organizers, The Skirball Cultural Center (2701 N. Sepulveda Blvd., LA, CA 90049), 310/440-4615, Erin Clancey, eclancey@skirball.org [12826]

● **"Profile of the Puerto Rican Population in United States and Puerto Rico: 2008"** was a Research Seminar, held May 11, 2011 at the Center for Puerto Rican Studies at Hunter College, NYC. Inf. from 212/772-5714. [12814]

Criminal Justice

● ***Race, Crime, and Punishment: Breaking the Connection in America***, ed. Keith Lawrence (220 pp., 2011), has been published by The Aspen Institute. Includes essays by Michelle Alexander, Marc Mauer, Alice O'Connor, Phil Thompson et al. Copies available (no price given) from the Institute's Fulfillment Office, PO Box 222, 109 Houghton Ln., Queenstown, MD 21658, 410/820-5338, publications@aspeninstitute.org [12777]

● **"Mass Imprisonment: Long-Term Harm versus Short-Term Good,"** by Robert DeFina & Lance Hannon, is a 3-page article in the Summer 2011 issue of *Communities & Banking*, the magazine of the Federal Reserve Bank-Boston, available (likely free) from them at 600 Atlantic Ave., Boston, MA 02210, 617/973-3187, caroline.ellis@bos.frb.org [12785]

● **"Balancing Drug Policy"** was a forum in the Dec. 21, 2010 issue of *The Nation*. Among the contributors: Ethan Nadelman, Marc Mauer, Bruce Western, David Cole. If you can't find it on the Internet, we'll be happy to mail you a copy if you furnish a SASE. [12794]

● **"The Impact of Light Skin on Prison Time for Black Female Offenders,"** by Jill Viglione & Robert DeFina, appeared in vol. 48 (2011) of *The Social Science Journal*, pp. 250-58. [12810]

● **"Experiencing Court, Experiencing Race: Perceived Procedural Injustice Among Court Users,"** by Jamie G. Longazel, Laurin S. Parker & Ivan Y. Sun, appeared in Vol. 1, No. 2 (2011) of *Race and Justice*, pp. 202-27. [12812]

● ***Disproportionate Minority Contact***, ed. Nicole Parsons-Pollard (300 pp., 2011, \$35), dealing with the juvenile justice system, has been published by Carolina Academy Press, 70 Kent St., Durham, NC 27701, 919/489-7486. [12813]

● **"Five Myths about Americans in Prison,"** by Marc Mauer & David Cole, appeared in the June 19, 2011 *Washington Post* Outlook Section. If you can't find it on the Internet, we'll be happy to mail you a copy if you furnish a SASE. [12824]

Economic/Community Development

● **"Post-Katrina New Orleans: A Welcoming Community?"** is a special 4-page section, with lots of relevant data, in the Spring 2011 issue of *Just South Quarterly*, available (possibly free) from The Jesuit Social Research Institute of Loyola Univ., 6363 St. Charles Ave., Box 94, New Orleans, LA 70118-6143, 504/864-7746, jsri@loyno.edu,

www.loyno.edu/jsri/ [12821]

● **"Healthy Communities, Strong Regions, A Prosperous America"** is Equity Summit 2011, organized by PolicyLink (headed by former PRRAC Bd. member Angela Glover Blackwell), Nov. 8-11, 2011 in Detroit. Inf. at www.PolicyLink.org/Summit [12786]

Education

● ***Rethinking Popular Culture and Media***, eds. Elizabeth Marshall & Ozlem Sensoy (340 pp., 2011, \$18.95), has been published by Rethinking Schools, 1001 E. Keefe Ave., Milwaukee, WI 53212, 800/669-4192, RSBusiness@aol.com. Some four dozen essays, by Bob Peterson, Barbara Ehrenreich, Linda Christensen, Ellen Goodman, Wayne Au et al. www.rethinkingschools.org [12778]

● **"The Long-Term Effects of Early Childhood Education,"** by Raj Chetty & John N. Friedman, is a 2-page article in the Summer 2011 issue of *Communities & Banking*, the magazine of the Federal Reserve Bank-Boston, available (likely free) from them at 600 Atlantic Ave., Boston, MA 02210, 617/973-3187, caroline.ellis@bos.frb.org [12783]

● **"School Testing, 1,2,3: Getting It Right,"** by Karen Kurzman, is a 2-page article in the Summer 2011 issue of *Communities & Banking*, the magazine of the Federal Reserve Bank-Boston, available (likely free) from them at 600 Atlantic Ave., Boston, MA 02210, 617/973-3187,

caroline.ellis@bos.frb.org
[12784]

- **CRESST (UCLA's National Center for Research on Evaluation, Standards & Student Testing)** announces a new and expanded website (CRESST.org). Check out their just-published policy brief on using student assessments for teacher evaluations. [12787]

- **"The Other Lottery: Are Philanthropists Backing the Best Charter Schools?"** by Andrew J. Coulson, is a 23-page, June 2011 CATO Institute Policy Analysis (#677), available from them (\$6), 1000 Mass. Ave. NW, Wash., DC 20001, 800/767-1241. [12789]

- **"Our Climate Crisis Is an Education Crisis"** appears in the Spring 2011 issue of *Rethinking Schools*. Available online at www.rethinkingschools.org and from them, 1001 E. Keefe Ave., Milwaukee, WI 53212, 800/669-4192, bill@rethinkingschools.org [12797]

- **"Who's Bashing Teachers and Public Schools and What We Can Do About It,"** by Stan Karp, appears in the Spring 2011 issue of *Rethinking Schools*. Available online at www.rethinkingschools.org and from them, 1001 E. Keefe Ave., Milwaukee, WI 53212, 800/669-4192, bill@rethinkingschools.org [12798]

- **"Making Preschool More Productive: How Classroom Management Training Can Help Teachers,"** by Pamela Morris, C. Cybele Raver, Megan Millenky, Stephanie J. Jones & Chrishana M. Lloyd (13-page Exec.

Summary, Nov. 2010), is available (possibly free) from MDRC, 16 E. 34 St., NYC, NY 10016, 212/532-3200, www.mdrc.org [12800]

- **"Unless Our Children Begin to Learn Together...: The State of Education in Halifax County, NC,"** by Mark Dorosin, Elizabeth Haddix, Benita N. Jones & Christie L. Trice (68 pp., May 2011), is available (possibly free) from the UNC Center for Civil Rights, civilrights@unc.edu [12815]

- **"A Report Card on District Achievement: How Low-Income, African-American, and Latino Students Fare in California School Districts"** (2011), from Education Trust-West, is downloadable at www.edtrust.org/west/publication/a-report-card-on-district-achievement-how-low-income-african-american-and-latino.st. [12829]

- **"What Will It Take to Get Qualified, Effective Teachers in All Communities?"** was a May 29, 2011 Center for American Progress event. Among the panelists/presenters were (former PRRAC Bd. member) Linda Darling-Hammond and (PRRAC Deputy Director) Saba Bireda. Inf. from events@americanprogress.org, 202/682-1611. [12802]

Families/ Women/ Children

- **When Everything Changed: The Amazing Journey of American**

Women from 1960 to the Present, by Gail Collins (482 pp., 2009, \$15.99), was published by Back Bay Books (Little, Brown). Copiously researched, well written history by the *NY Times* writer, which includes a good deal of material on race. [12759]

- **"Getting to Scale: The Elusive Goal,"** a 28-page updated 2011 paper, highlights the Magnolia Place (Seattle) Community Initiative and how it uses Strengthening Families Protective Factors Framework to galvanize community residents, organizational partners and existing initiatives to create a local response to improve a community. Available (possibly free) from Casey Family Programs, 2001 Eighth Ave., #2700, Seattle, WA 98121, contactus@casey.org, www.casey.org [12796]

- **"Child Care Instability: Definitions, Context, and Policy Implications,"** by Gina Adams & Monica Rohacek (45 pp., Oct. 2010), is available (possibly free) from The Urban Institute, 2100 M St. NW, Wash., DC 20037-1231, 202/833-7200, pubs@urban.org [12817]

Health

- **"Can Neighborhoods Hurt Our Health?"** by Caitlin Eicher, appeared in the Spring/Summer 2011 issue of *Harvard Public Health Review* (Harvard School of Public Health, 90 Smith St., 4th fl., Boston, MA 02120, 617/832-8470). [12773]

- **HealthExpertises** has a website -- www.healthexpertises.com -- dedicated to advice, news, topics,

dictionary and forum. Further inf. from maria.williams@healthexpertises.com [12791]

- **"Place Matters National Conference,"** sponsored by the Joint Center for Political and Economic Studies, will take place **Sept. 7, 2011** in Wash., DC. Guest speakers include (PRRAC Soc. Sci. Adv. Bd. member) Dolores Acevedo-Garcia, Congresswoman Donna M. Christensen, Gail Christopher of the Kellogg Foundation, Manuel Pastor of USC and writer/activist Tim Wise. Inf. from HPI@jointcenter.org [12776]

Homelessness

- **Free Laundry & Drop-in Shower Resources:** A listing of such, with location and hours, was posted on a San Francisco neighborhood public library bulletin board -- a nice model for other cities. We can mail you a copy of the posted notice if you supply a SASE. [12792]

- **"Simply Unacceptable': Homelessness and the Human Right to Housing in the United States 2011"** (101 pp., May 2011) is available (no price listed) from The National Law Center on Homelessness & Poverty, 1411 K St. NW, #1400, Wash., DC 20005, 202/638-2535, www.nlchp.org [12805]

- **"A Systems Approach to Solving Homelessness and Other Problems"** was held June 16, 2011 at UMass-Boston. Inf. from 617/287-4824, shaleah.rather@umb.edu [12790]

Housing

- **"The Impact of Housing Vouchers on Renters' Neighborhood Satisfaction: Understanding the Perceptions and Constraints among Assisted and Unassisted Renters,"** by Lauren M. Ross, a 30-page paper presented at the March 2011 American Housing Survey Users Conference, is available from the author, Dept. Sociology, Temple Univ. Gladfelter Hall, 7th flr., 1115 W. Berks St., Phila., PA 19122, Lmross@temple.edu [12793]

- **"Housing Rights for All: Promoting and Defending Housing Rights in the United States"** (5th ed., 2011, 151 pp.) is available (no price listed) from the National Law Center on Homelessness & Poverty, 1411 K St. NW, #1400, Wash., DC 20005, 202/638-2535, info@nlchp.org, www.nlchp.org [12803]

- **"End Game: Understanding the Bitter End of Evictions,"** by Michael D. Gottesman, is a 68-page, 2007 article that appeared in (Yale) *Student Scholarship Papers* 48. Available at http://digitalcommons.law.yale.edu/student_papers/48 [12820]

Immigration

- **"The Role of Immigration in Fostering Competitiveness in the United States"** (25 pp., May 2011), is available (possibly free) from The Migration Policy Institute, 1400 16th St., #300, Wash., DC 20036, 202/266-1940, www.migrationpolicy.org [12816]

- **"Children of Immigrants: 2008 State Trends Update,"** by Karina Fortuny (7 pp., Sept. 2010), is available (possibly free) from The Urban Institute, 2100 M St. NW, Wash., DC 20037-1231, 202/833-7200, pubs@urban.org [12818]

- **"The Integration of Immigrants and Their Families in Maryland,"** by Karina Fortuny, Ajay Chaudry, Margaret Simms & Randolph Capps (68 pp., June 2010), is available (possibly free) from The Urban Institute, 2100 M St. NW, Wash., DC 20037-1231, 202/833-7200, pubs@urban.org [12819]

- ***Immigrants Raising Citizens*,** by Hirokazu Yoshikawa (208 pp., 2011, \$29.95), has been published by The Russell Sage Foundation, 112 E. 64 St., NYC, NY 10065. [12828]

- **"Immigrant Communities and Fair Housing,"** a networking/training conference, co-sponsored by HUD, PRRAC, The National Council of LaRaza and The Equal Rights Center, will be held **July 22, 2011** in DC. Inf. from 202/402-4103, gregory.h.crespo@hud.gov

International Human Rights and U.S. Civil Rights Policy

- **"A Human Rights Response to the Economic Crisis in the U.S.,"** by Radhika Balakrishnan, James Heintz & Stephanie Seguino, is an 8-page, June 2009 report from the Rutgers Center for Women's Global Leadership. Possibly free, from www.cwgl.rutgers.edu [12807]

Rural

- **"Collaboration: The Key to Building Rural Communities"** is the 23-page, 2010 Annual Report of the Housing Assistance Council, available from them (likely free) at 1025 Vermont Ave. NW, #606, Wash., DC 20005, 202/842-8600, hac@ruralhome.org [12782]

Transportation

- **"Missed Opportunity: Transit and Jobs in Metropolitan America,"** by Adie Tomer, Elizabeth Kneebone, Robert Puentes & Alan Berube (63 pp., May 2011), is available (no price listed) from The Brookings Metropolitan Program, 1775 Mass. Ave. NW, Wash., DC 20036-2188, 202/797-6000, www.brookings.edu [12801]

Job Opportunities/Fellowships/Grants

- **Relman, Dane & Colfax**, a leading civil rights law firm, is hiring a **Litigation Associate**. Ltr./resume/one legal writing sample/law school transcript/names-tel. #s of 3 refs. to careers@relmanlaw.com or mail to Taryn Scott, 1225 19th St. NW, #600, Wash., DC 20036. [12760]

- **Relman, Dane & Colfax**, a leading civil rights law firm, is hiring a **Fair Lending Compliance Associate/Counsel**. Ltr./resume/one legal writing sample/law school transcript/names-tel. #s of 3 refs. to careers@relmanlaw.com or mail to

Taryn Scott, 1225 19th St. NW, #600, Wash., DC 20036. [12761]

- **The National Housing Trust** (Wash., DC) is hiring a **Director, Federal Policy**. Ltr./resume to cnickell@nhtinc.org [12762]

- **The Washington Legal Clinic for the Homeless** is seeking a **Staff Atty.** for its Affordable Housing Initiative. Ltr./resume/writing sample/3 refs. to jobs@legalclinic.org (Housing Attorney in subject line) or mail to WLCH, 1200 U St. NW, 3rd flr., Wash., DC 20009. [12766]

- **The Mississippi Center for Justice** (Jackson, MS) is seeking applicants for an **AmericaCorps Legal Fellow** position. \$40,400. Ltr./resume/3 profl.refs./writing sample to Beth Orlansky, Miss. Ctr. for Justice, PO box 1023, Jackson, MS 39215-1023, 601/352-2269, borlansky@mscenterforjustice.org

- **The Sentencing Project** is hiring a **Research Analyst**. Ltr./resume/writing sample to Hiring Coordinator, Sentencing Project, 1705 DeSales St. NW, Wash., DC 20036, employment@sentencingproject.org

- **The American Youth Policy Forum** is hiring a **Program Associate**. Resume/ltr. with salary reqs./writing sample/complete inf. for 3 refs. ("Program Associate Search" in subject line) by July 18 to cwilson@aypf.org or fax to 202/775-9733 or mail to the Forum at 1836 Jefferson Pl. NW, Wash., DC 20036.

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