

A Model for Eliminating Disparities in Communities,

Race/Ethnic Groups, Low SES and other

Population Groups

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Efforts to eliminate population disparities are hindered by limited perspectives of community, race, and community competence, including constraints derived from epidemiologic methods, assumptions derived from liberal and Marxist philosophies, limited public health applications, and narrow interpretations of prevention and control interventions. History, culture, context and geography shape community, race and community competence and serve to integrate these phenomenon. Community competence is viewed as the aggregate expression of these underlying determinants, whether in intervention protocols, messages, or materials. Exploring epidemiologic methods and philosophical limits provides a basis for understanding the analytic errors associated with models that choose to eliminate race based on statistical insignificance. Public health applications are more relevant when they incorporate assumptions supportive of community development and relatedly support initiatives targeting capacity and infrastructure development of respective communities. Communities can be viewed on a continuum. Communities tend toward holism if they are impacted more by the underlying determinants of history, culture, context and geography. The relevance of prevention and control interventions are heightened when they consider population groups as existing along a continuum of community and the corollary that communities at the high end will require a greater focus on capacity and infrastructure. Prevention initiatives are comprehensive if they move beyond the dimension of time (e.g. the earlier the better) and also consider the consequences of history, culture, context and geography. Ideally, communities express these determinants in term of their consciousness and collective being. Indeed, the relevance of race and ethnicity in terms of public health applications are fully realized when they are assessed as communities. Comprehensive prevention is viewed as both complex and multidimensional. The model is both flexible and inclusive. Respective communities will differ in regard to the importance of one or the other determinants. The model is applicable to all population groups. The model suggests that all groups can be placed along a continuum of community which in turn informs top down strategies related to resource allocation, assessment, and design of interventions. Principles associated with use of the model include explicit assessment of heterogeneity, ethical application of diversity and inclusivity, and assumptions that are relative and dynamic. Decisions regarding resource allocation and public health applications will be better able to undermine the institutionalization of inequity and counter ineffective interventions which serve to create/maintain gaps in health status and well-being when these decisions are based on a conceptual model that is inclusive, evaluates properly the meaning of race, and prioritizes the importance of community.

Tobacco Prevention and Control:
Overview of a Model to Eliminate Population Disparities
for Communities, Race/Ethnic Groups, Low SES,
and
other Population Groups

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Paradigm for the Millennium:

Problem:

A new paradigm is needed to address the problem of population disparities because the challenges are immense. Population disparities are a phenomena of institutionalization. In essence, disparities derive from ingrained patterns of resource allocation and prioritization that contribute to modes of inequity and social injustice observed throughout society. Traditional modes of problem solving can be categorized as incremental in nature and counter the need to attack a problem boldly and comprehensively. In addition, public health agencies attack problems categorically and are limited in their ability to deal with problems that are interrelated. Disparities in the health sector are influenced by social conditions that are cross-cutting. Thus, even if everything possible was accomplished with public health applications the impact would continue to be partial if other sectors of society maintained the status quo. The methodological emphasis on models that rely on quantification defies solutions for problems that are inherently complex and require qualitative assessments. Disparities, while not confined to Communities of Color, are over determined by race/ethnic-based demographics. One consequence is that problem solving is impacted by institutionalized modes of interpreting and relating to racial phenomena. Addressing such issues require, at a minimum, a paradigm shift with regard to how race or class or community are explained and understood.

Community:

The new paradigm provides a set of assumptions that is supportive of holism and public health applications that target communities. It does not ignore the importance of economic strata or the validity of targeting strata when it is relevant, but it does not accept the current confusion which seeks to displace race with socio-economic variables based purely on statistical calculations of significance. This paradigm or model is inclusive of both race and class and provides public health

practice with a set of assumptions that incorporates complexity and heterogeneity and assess each population group according to community parameters. Indeed, community and race and community competence (i.e., derived from cultural competence but intended to better reflect the underlying complexity of communities and race/ethnic groups) are viewed as relying on the same set of underlying determinants. These determinants are history, culture, context, and geography. Race is not a genetic construct but it is social. Social is an expression of the particular history that shaped the experience and consciousness of a race. Social is an expression of the cultural values that define the beliefs and traditions of a race. Social reflects the particular context, whether characterized by responses to racism, segregation, discrimination or other conditions of economic oppression or exploitation. Social is also geography and reflects the location of a race and what may be important in regard to the physical characteristics of the living space. Communities are similarly shaped by these determinants. Indeed, the more important are the determinants the more likely the community will reflect homogenous social systems. This is not a negation of heterogeneity but does reflect that communities are shaped by commonalities that serve as unifiers of the respective socio-demographic strata (i.e., race/ethnic groups, gays and lesbians and bisexuals and transgenders, physically challenged, uninsured, poor, homeless, women, age strata) of which communities are comprised.

Race and Class:

Communities, race/ethnic groups and other population groups experiencing disparities will be best served if we approach the development of public health applications with assumptions that directly address their needs. Yet it has been difficult to rationally assess needs because there is great confusion regarding the meaning and role of race and ethnicity. The question of race has been an issue that has caused continued debate for decades, if not centuries. The debate has two primary foci: (1) the biological determinants of race and (2) the significance of race in contrast to class (or socioeconomic status) as a predictor of social phenomena. Historically, the most central debate has been a discussion that distinguishes the genetic and social or cultural underpinnings of race. In essence, race is not a genetic phenomenon; rather it is a social or cultural construct. Even though this debate loomed larger in history, it is also one that has been more easily resolved. The emphasis on genes has typically been flawed by racist assumptions which sought to prove the inferiority of African peoples because of their genetic makeup and simultaneously has been used to support modes of oppression from slavery to the institutionalization of poverty and other indicators of non-empowerment (e.g., low income, underemployment, etc.). Thus, countering the genetic basis of race has been easier because intuitively one is rejecting the racist origins of the underlying assumptions.

The debate regarding the significance of race in contrast to class (e.g., SES) is more difficult because it is easily mystified by social science and statistical analysis in which economic indicators are shown to be better or more predictive of outcomes (e.g., prevalence, morbidity, mortality). In essence, the question is not race or class but the preferred paradigm is race and class. For example, a particular analysis may demonstrate that when comparing the impact of low income or race that it is the former that is statistically significant. The traditional response is to conclude that race is not significant and to then focus on people in terms of their economic strata. What is ignored is that people who are low income do not give up their race (or skin color) and typically go home at night and live in race-based communities. In the United States these communities, in the main, are largely defined by race or patterns of segregation because of explicit or implicit social and

economic policy. Thus, the confusion regarding race or class and the choice of an either/or model facilitates approaches away from community and toward economic stratification.

These debates are not very productive as we launch the new millennium. In regard to biologic determinism, it is clear that race is a social and not a genetic construct. Yet, as we learn more about the human genome we will inevitably have to reintegrate an understanding of genetics into social thought and theory. In regard to the statistical significance of race or class, the consequences of either/or rather than both/and modeling is to develop interventions for strata of people rather than communities of people. The one approach is driven by disaggregation of the human populace and the other seeks to define people holistically and place them in the communities in which they live and/or identify. The one provides a rationale for deprioritizing race and whole communities and supports defining intervention targets in terms of economic or educational indices of poverty or low education. In essence, the either/or model by de-emphasizing approaches to whole communities is less supportive of community development or interventions that specifically target the capacity and infrastructure needs of communities.

Community Competence:

Community competence evolves from perspectives related to cultural competence or appropriateness or sensitivity. However, unlike these earlier perspectives which are inherently reductionist, community competence reflects the complexity of communities and race/ethnic groups. It is integrative because community competent intervention protocols or materials or images reflect the historical, cultural, contextual, and geographical experience of the community or race/ethnic group. The literature typically informs us what cultural competence is not. It is not translating English into Spanish or taking a white face and making it black, brown, yellow or red. The literature does not tell us sufficiently what is cultural competence. The model does not prescribe that community competence is a recipe. It is not a specific amount of history, culture, context or geography. Rather, community competent protocols resonate with these determinants and reflect them. In addition, community competent materials are informed by images that are salient and positive, and language that is appropriate and responsive to literacy levels. Community competency may also be enhanced with the use of multi-generational imagery.

Community, Race, and Community Competence:

The model is robust because it synthesizes community, race and community competence by resting them on the same underlying constructs. The model is also inclusive because it allows that distinct communities or races will be differently impacted by these constructs. For example, African Americans are very responsive to color and define themselves as black because of the historical experience of slavery and the fact that the middle passage is part of our collective unconscious. Latinos on the other hand state that for them culture is everything and are less inclined to place importance on skin color and will often debate the appropriateness of describing themselves as black. The model provides a basis or set of assumptions that allows communities and race/ethnic groups to understand respective differences. Indeed, debates and confusion regarding skin color has out lived its usefulness in the 21st Century. Similarly, understanding the relevance of blood quotients in the determination of tribal identity amongst some Native American communities is possible when viewed from the perspectives of history, culture, context and geography. In summary, the model suggests that appreciating the relative and dynamic qualities of

the underlying constructs of respective communities and race/ethnic groups is critical to achieving interactions that are community competent.

Diversity and Inclusivity:

If the synthesis of community, race, and community competence are understood, then the importance of diversity and inclusivity cannot be negated. It is difficult to imagine how community competent outcomes can be achieved without the presence of diversity and inclusivity.

Importantly, diversity and inclusivity are processes and not programs. Organizations, program developers or policy makers will often be content with formula supportive of diversity and inclusivity but stop short of substantive program development or interventions. Diversity should be viewed in terms of representation. The critical question relates to whether people are or are not at the table. Inclusivity is more substantive and relates to the role of diverse representation in decision making. The norm should be to have diversity and to include people in decision making and planning early on in the process. Ideally, diversity and inclusivity are ethical practices and their absence should be considered to be unethical.

Capacity and Infrastructure:

Capacity and infrastructure are the direct expression of public health practices whose approach is supportive of community development. However, the importance of this approach or interventions that facilitate the development of capacity and infrastructure are largely reliant on an understanding of community and a perspective that views them holistically. If the approach is to disaggregate, a severe limitation of epidemiologic methods with inherent tendencies to specify variables and contrast, compare, or control, then the vision will not encompass community but rather the stratum of which, in the aggregate, communities are comprised.

Capacity and infrastructure are concrete outcomes that are enhanced if they are also community competent. The components of capacity and infrastructure are research, programs, leaders, organizations and networks. A community or race will possess capacity and infrastructure to the degree there is research that addresses their specific needs and researchers who are representative; programs that enable services and utilize appropriate materials; leaders who are knowledgeable and serve as advocates and decision makers; organizations that represent their interests and provide relevant resources and services; and networks that provide logistical support for strategic planning, information sharing, priority setting, and policy development. Capacity and infrastructure are enhanced when other tangible resources (or outcomes) are available such as consultants, technical assistance and training programs and materials that are responsive to community needs and level of readiness to engage tobacco prevention and control initiatives. The gap in capacity and infrastructure between Communities of Color and the mainstream, for example, are the degree to which these concrete resources are present and available or are absent.

Comprehensive Prevention, Prevention and Control Applications:

Prevention and control applications can be shaped according to the expressed needs of a community. The underlying assumption of the model is that the more homogenous the community, or relatedly, the more relevant the underlying constructs of history, culture, context and geography, the more likely the community will require interventions supportive of community

development or capacity and infrastructure. The concept of prevention is broadened to be inclusive of community development applications. Comprehensive prevention reflects this breadth.

Traditionally, prevention is determined by one dimension: time. In other words, if we are successful in intervening early then we have prevented something from happening. Control strategies are viewed as occurring downstream and are intended to lessen the consequences of an event or to provide a cure. Comprehensive prevention relies on both time and geography (serves as a gateway to the community-based parameters emanating from the historical, cultural, contextual and geographical determinants of a community and/or race/ethnic group) and be more responsive to goals and objectives supportive of community development.

Comprehensive prevention strategies that target Communities of Color will necessarily have to consider issues of community development or the extent to which capacity and infrastructure are or are not present. Comprehensive prevention also allows us to distinguish between working “with” communities or working “in” communities. In other words, establishing a program on a street corner that reaches out to the homeless has merit but this ought not to be confused as community development or a holistic approach to community and related comprehensive prevention interventions.

Model Characteristics:

The model is relative, dynamic and inclusive. It is relative because the underlying components impact distinct communities or race/ethnic groups or other population groups differently. It is dynamic because the relationship of the constructs to respective groups can change over time. It is inclusive because distinct population groups can be organized according to a common set of assumptions. Thus, it is important to target people of low income because it is a profound risk factor for tobacco-use. However, the model provides that one can respond to low income persons as a particular strata, perhaps providing low literacy materials or policies that remove fees as a barrier to cessation services. It also makes clear that low income strata also need to be reached in the communities where they live and this may require a different set of interventions and be more related to the development of capacity and infrastructure of the respective community to facilitate service to low income persons in their communities.

Low income strata are viewed as a distinct group which raises the question regarding the nature of an intervention in terms of comprehensive prevention, prevention or control. The model suggests that less is needed for low income strata in terms of capacity and infrastructure because as a defined strata they do not comprise a community. Indeed, low income strata are found in all communities. Because capacity and infrastructure needs will be more limited for population strata, and although it is important to locate organizations that serve the poor, engage them in tobacco control, and include them in coalitions; they will not require the same degree of comprehensive prevention as do population groups that meet community-defined criteria.. The model allows that a multi-community or multicultural or diversity emphasis need not be viewed as a threat to the interests of any particular community or race/ethnic group or population strata. Rather, it is important to assess States or Territories with respect to heterogeneity, construct defined population groups along a continuum of community based on their relationship to the underlying

determinants, evaluate respective capacity and infrastructure needs accordingly, and assess comprehensive prevention, prevention and control applications from the strategic perspective of the ultimate goal to eliminate population disparities for each of the respective groups.

Application Guidelines

1. Plan strategically with goals that are short and long term.
2. Determine heterogeneity in state or territory and within respective race/ethnic groups and/or communities.
3. Establish baseline of disparity indicators (e.g., epidemiologic, behavior, health, capacity and infrastructure) for communities, race/ethnic groups, or other population groups.
4. Use best estimates for population groups (e.g, API) and/or disparity indicators (e.g., capacity and infrastructure) when minimal information is available or assessment protocols are not yet fully developed.
5. Surveillance and evaluation will use race/ethnicity for description and not analysis. Socio-demographic variables will be used for description as appropriate.
6. Surveillance and evaluation will use socio-demographic variables for analysis. Determinants of community and race or variables related to history, culture, context, and geography can be used for analysis when or if they are developed and available. Race/ethnicity should be used for analysis only as a last resort when more appropriate explanatory variables are not available. The significance of race should be determined by assessing potential interventions and not solely on the basis of statistical analysis.
7. Evaluate decision making processes for diversity and inclusivity.
8. Develop strategic plan (e.g., 10 years) related to heterogeneity, established interventions, materials or programs requiring development, and community development or capacity and infrastructure needs.
9. Develop guidelines for developing and/or assuring delivery of community competent interventions.
10. Assess strategic plan with regard to trust and program flexibility.
11. Implement strategic plan.
12. Assess strategic plan annually.

Suggested Activities for Health Departments:

1. Support capacity and infrastructure development.
2. Support culturally competent programs, research and data analysis.
3. Support community model of assessment and applications.
4. Support targeted initiatives.
5. Support and provide technical assistance.
6. Support and provide training.
7. Support and provide evaluation at the local level.
8. Support multi-community monitoring of State/Territory-wide operations and applications.

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