# Meeting People Where They Are: Extending Services Building Capacity in Black Communities

**Abstract**

The social and physical environments have played a fundamental role in the production and maintenance of racial health inequities in the United States. Contexts of these environments not only shape the social norms and health behaviors of individuals from an early stage in life, but also the stressors and coping resources available. Historical and current racial residential segregation has played a central role in determining the resources available to black communities residing in such neighborhoods. These challenges were discussed in detail at the inaugural Collaboration on Race, Inequality and Social Mobility in America (CRISMA) conference in March 2018. This paper features the work of health equity scholars, Dr. Riana Anderson from The University of Michigan and Dr. Keon Gilbert from Saint Louis University, at the CRISMA conference who described their efforts to extend healthcare services to marginalized racial groups, particularly African Americans while simultaneously building upon the cultural strengths of African Americans.

**Keywords:** African Americans; Social Context; Access to Care; Resiliency; Racial Socialization; Health Promotion

**Introduction**

Modern residential segregation reveals the profound effects of governmental segregation policies and laws on neighborhood environments (White & Borrell, 2011).Black Americans living in segregated neighborhoods are at greater risk of premature mortality and bear a disproportionate burden of morbidity relative to white Americans (Geronimus, Bound, Waidmann, Colen, & Steffick, 2001; Thorpe et al., 2015). These disparities are a result of the social and physical environments created by policies and practices that have fueled racial residential segregation and shaped neighborhood context throughout the United States, historically and contemporarily. Neighborhood context, including the resources available (or lack thereof) have played a fundamental role in the production of racial health inequities in the United States. Neighborhood racial and ethnic composition is a key factor in the availability of health promoting resources embedded within neighborhoods. In addition, neighborhood context shapes both the social norms and health behaviors of individuals from an early stage in life and the stressors and coping resources available to neighborhood residents.

*Racism and Place*

Institutionalized racism has played a large role in the provision of social welfare policies. During the implementation of the New Deal and the radical transformation of America's cities and suburbs, Black Americans were systematically denied low-interest home loans and subject to redlining practices used by banks. Redlining is the denial of loans by banks to certain residential areas in cities based on income and racial makeup. Banks color-coded maps of entire cities, and "redlined" neighborhoods that were predominantly minority, refusing to lend to home buyers in these neighborhoods (Oliver & Shapiro, 2006). Low-interest, federally backed housing loans instituted during the New Deal Era allowed a much larger proportion of white Americans to buy

homes by reducing the down payment to about 20% of the final price (Katznelson, 2005). By purchasing homes with federally-subsidized loans, white Americans were able to build equity through homes and generational wealth. These opportunities were not equally available to communities of color, thus fueling the racial wealth gap (Rothstein, 2017).

While a deep investigation of policies and practices related to U.S. residential segregation is beyond the scope of this paper, it is important to note that many of the policies and practices that were operative in the genesis of segregation are now illegal, yet have lasting impacts today. black Americans remain the most segregated racial group in the U.S. when compared to all other groups (Intrator, Tannen, & Massey, 2016; Logan, 2013). Segregated neighborhoods are less likely to have access to  primary care facilities, full-service grocery stores, and quality public schools and libraries (Williams & Collins, 2001). Not only are there fewer outlets for healthy, affordable food, but there is also a preponderance of fast-food restaurants as well as stores that largely sell calorie-dense products of low nutritional value. High-poverty neighborhoods are further burdened by higher levels of drug distribution and community violence, which weaken the levels of neighborhood trust and organization (Patillo-McCoy, 1999). These factors contribute to the stress that individuals in poorer communities feel on a day-to-day basis and increase their risk of poorer health outcomes (Balfour & Kaplan, 2002).

The overarching theme at the inaugural Collaboration on Race, Inequality, and Social Mobility in America (CRISMA) conference at Washington University in St. Louis was race at the forefront and its connection to health, education, and economics. However, a subtheme connecting all topics was the role of context. Numerous speakers, including the keynote speaker for the conference, Angela Glover Blackwell, the founder of PolicyLink, described the importance of race and place:

You tell me your zip code, and I know way more about you than I ought to. I know, if you happen to own a home, whether you can pull any value out of it if you want to start a business or respond to an emergency, whatever might come up. I know what the chances are that your children go to a good school. I know whether or not you will live in a natural job network, which is how people get jobs.

Glover Blackwell argued that place determines how long people will live, their quality of life, mobility, and prevalence of chronic diseases such as diabetes and hypertension. Throughout the country and within the local context of St. Louis, there are neighboring zip codes with drastically different life expectancies and stark differences in racial composition, corresponding to disparate life expectancies.

*Meeting People Where They Are*

To improve health outcomes and access to resources, decades of damage done by federal and state policies must be addressed to reverse the effects of segregation. Successful efforts would need to be bold and radical in order to have a population-level effect. While that is a necessary goal for racial equity, progressive solutions take time, political will, and innovative policies centering marginalized perspectives to have the greatest effects. As both property owners, businesses, and other stakeholders often financially benefit from segregated neighborhoods, greater incentives and consequences must be implemented to curb the impacts of segregation. However, what are marginalized communities of color to do in the interim?

Several health equity scholars including Dr. Riana Anderson at the University of Michigan and Dr. Keon Gilbert at St. Louis University spoke at CRISMA on the role of racial residential segregation as a fundamental cause of health inequity, chronic stress, and its constraints on promotive health behaviors. In addition to its deleterious impacts, Drs. Anderson

and Gilbert shared developed strategies to extend services to marginalized racial groups, particularly African Americans living in segregated areas. Drs. Anderson and Gilbert described their efforts to meet people where they are, whether through promoting health in barbershops or fostering resiliency through family socialization efforts to navigate racism.

*Promoting Black Men's Health in Barbershops*

Dr. Keon Gilbert, Associate Professor of Behavioral Science and Health Education at the St. Louis University College for Public Health and Social Justice, focuses his research on disrupting the narrow portrayal of black males in media and centering the roles of discrimination, criminalization, and segregation in health outcomes. Gilbert referred to novelist Ralph Ellison's term 'invisible man' to describe the social invisibility experienced by black boys and men. Gilbert argues that these populations deserve greater attention as their risk of chronic disease decreases their overall life expectancy when compared to white populations and black women. Furthermore, Gilbert estimates 1.5 million black men between ages 25 to 54 are missing from daily life due to mortality or incarceration and are absent from much health surveillance and research. Gilbert posits that this intersection of race and gender matter due to factors including delays seeking health care, fewer health-protective behaviors, poor stress and coping mechanisms, and lack of social support. He frames the health and well-being of black males around the systemic effects of marginalizing policies such as legalized segregation, access to social capital that could improve health, and social assets that help identify mechanisms that create risk. Social assets must be accounted for since controlling for socioeconomic status alone does not decrease health disparities for black men (Gilbert, 2018; Hudson et al., 2012;Williams, 2003).

Segregated social environments produce a variety of unique stressors that affect access to resources and social support that would otherwise be used for coping. Instead of healthier, more sustainable coping methods, people in resource-deprived areas must rely on short-term protective factors that provide immediate relief but create long-term harm such as high-caloric foods with low nutritional value. Despite its protective factors against mental health harm, unhealthy is ultimately detrimental to physical health due to its higher risk factor for chronic disease and obesity (Gilbert, 2019). Furthermore, coping mechanisms and other health behaviors are shaped by the social norms of one's community and its accessible resources. Black men who grew up and worked in predominately segregated, resource-deprived neighborhoods were more likely to be diagnosed with hypertension.  For black men ages 40 and older, cardiovascular disease is the leading cause of death (Gilbert, 2019). Furthermore, the odds of an unarmed black male being killed by the police increase when accounting for neighborhood factors, such as the rate of high school dropouts. Homicide and unintentional injuries are the leading cause of death for black men ages 15 to 35 (Ackermann, Goodman, Gilbert, Arroyo-Johnson, & Pagano, 2015; Gilbert et al., 2016). These interactions between race, environment, and leading causes of death suggest that environments affect health behaviors, social norms, and availability of community resources, consequently constraining health-promoting resources.

The Environmental Affordances Model, developed by James Jackson and colleagues, informs Gilbert's work (Jackson, Knight, & Rafferty, 2010; Mezuk et al., 2013). The model calls for researchers to consider how the social and physical environment produce a range of stressors and coping resources that can promote the use of environmentally-afforded coping mechanisms, such as smoking cigarettes or drinking alcohol. Such coping methods offer short-term benefits but can negatively affect long-term health outcomes, including the development of chronic

diseases. Acknowledging that there are limited health-promoting resources in many black

neighborhoods, Gilbert has implemented a barbershop health promotion approach over the past

ten years in order to extend health services and health education to black men in St. Louis.

Bringing services, such as blood pressure screenings, to black men in barbershops has been

shown to be an effective method of engagement as it delivers services in an environment that

black men frequent who may otherwise not have a primary care physician or regularly seek

healthcare. Gilbert not only provided health screenings to men, his team linked men to healthcare

services and provided culturally-specific health education. His team's health education efforts

included cooking demonstrations as well as the provision of health information through

pamphlets. Gilbert's work also illustrates the need to identify key settings to intervene, going

beyond typical spaces such as churches, clinics, or community centers.

*Racial Socialization to Promote Healthy Coping*

Racism is not just experienced in rare, direct, interpersonal incidents of prejudice. Scholars

theorize that it can be experienced vicariously as people learn about experiences in their social

networks, through national incidence, such as police-involved shootings, or systemically through

broader policies or institutions (Hicken, Lee, & Hing, 2018; Nuru-Jeter et al., 2009). Broader

experiences of racism reflect cultural racism, which reinforce the idea that black lives holds less

cultural and social value than whites. This experience is particularly damaging to the

development and health of black youth. Considering the negative, hegemonic stereotypes that are

present in the nation's consciousness as well as subsequent treatment of black people, how can

black families, especially children and adolescents, cope with exposure to cultural racism and

improve health outcomes.

Dr. Riana Anderson, Assistant Professor of Health Behavior and Health Education at the University of Michigan School of Public Health, developed a family-based intervention to help mitigate the negative effects of racism by emphasizing the coping process through health-protective conversations between youth and their caregivers. Anderson grounded her intervention work in the Racial Encounter Coping Appraisal and Socialization Theory (RECAST). RECAST emphasizes the process of racial socialization as a key, cultural adaptation of traditional stress and coping models. It is theorized that the socialization process can help families talk about race and promote resiliency.

Guided by the RECAST theory, Anderson has developed the Engaging, Managing and Bonding through Race (EMBRace) intervention in order to promote positive psychological and academic outcomes for black youth. The intervention acknowledges the frequent, chronic nature of contemporary cultural racism. EMBRace is a family-based intervention designed to promote frequent, competent discussion on race and racism among black youth. Other goals of the intervention include the development of positive coping processes, reduction of stress among parents, and improved family functioning. The intervention takes place over five, 90-minute sessions that occur over seven weeks. Sessions are facilitated by a therapist and include the development of parent and caregivers' capacity to help their children access the effects of racism and identify positive coping mechanisms. For example, Anderson encourages families to resist against racism by providing tools such as cultural pride and anticipation of bias. Families also engage in role-play activities to help each other walk through how they would navigate experiences of racism before, during, and after an incident. This intervention helps families to process experiences of racism and encourage healthy, active coping, which could help to mitigate the harmful effects of racial stress.

**Discussion**

Contextual factors, such as the built environment and racial wealth disparities, interfere with black people's ability to fully participate in public health and medical initiatives to improve health.  This reality suggests that co-location of services that people need is critical to improving access to the services that may positively affect health outcomes and reduce health inequities. At the core of these best practices is effective community engagement and meeting people where they are to best accomplish realistic goals. In addition to the strategies that CRISMA conference panelists shared, there are a number of approaches to improve access to care for underserved populations. For example, practitioners have recommended the co-location of services to improve access to healthcare. In this way, patients can seek healthcare while also attending to key social determinants of health such as housing, basic social needs, employment, legal assistance, and other social services. Another strategy to improve access to services in resource-deprived communities involves building the capacity of community residents to help provide services for their broader communities. For example, the American Public Health Association defines community health workers (CHWs) as "a frontline public health worker who is a trusted member of the community served."("Definition of Community Health Workers," 2019; Spencer et al., 2013). The incorporation of CHWs into interventions builds the skills of community members through training and creates a bridge between their ethnic, cultural, or geographic communities and healthcare providers to improve health outcomes for patients (Balcazar et al., 2011; Fisher et al., 2012). CHWs have demonstrated promise in improving physical health behaviors and outcomes, particularly for racial and ethnic minority communities and in those who have traditionally lacked access to adequate health care, particularly mental health (Reinschmidt & Chong, 2007; Spencer et al., 2013, 2011).

In addition to the need for authentic community engagement to achieve health equity, it is important to place race at the forefront when examining the impact of the environment on health. One of the unique contributions of both Drs. Anderson and Gilbert is that they have placed race at the forefront, emphasizing the specific contextual realities in which black people reside along with the cultural assets that black people possess. There is still a great need to develop culturally appropriate, context specific interventions to address large racial health disparities. Improving access not only includes the provision of services and health education but also fosters the natural assets and resiliency factors within the black community. Health equity scholars at the CRISMA conference, including Drs. Gilbert and Anderson, illustrate approaches that are intentional in the consideration and incorporation of race, place and community engagement, aiming to meet people where they are.

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