Advancing Public Narrative for **Health Equity** & **Social Justice**

NACCHO
National Association of County & City Health Officials

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ACKNOWLEDGEMENTS

INTRODUCTION AND OVERVIEW

Introduction

Public health practitioners contribute to health equity every day. Given the pressures they face, motivating supportive public action by constituents requires a compelling, shared story that makes social injustice more visible. Such stories are related to a strategy for shifting public narratives. Public narratives refer to the shared systems of meaning in a culture (sometimes conflicting and invisible) manifested through stories, practices, myths, systems of representation, social rules, paintings, fiction, advertisements, museum displays, performances, language, and symbols that surround us in making intelligible how society works, and the interpretation of events.

Public narratives are central to reclaim public health's social justice legacy in at least two ways. The first includes creating closer ties between public health and social movements for economic and social equality, and the second by telling its story in ways that move both constituents and colleagues. Public narratives, as a form of power (and yet invisible), influence what is politically possible and build solidarity. Used in facilitated dialogue, the curriculum explores the relevance of public narratives, how and why they shape our sense of the future, and approaches to disrupt dominant narratives (see Chapter 2). The curriculum offers guidance to reclaim and revitalize an effective public narrative, based on principles of social justice.

Through hands-on activities, examples, exercises and questions, we offer methods to facilitate collective efforts to identify, interrogate, and counter dominant public narratives and the systems that support them, in all aspects of the culture in everyday life and public health practice. This includes learning to notice and question them, by drawing attention to organized networks of power which hinder actions toward narrative change.

Goals

Advancing Public Narrative for Health Equity and Social Justice has three central goals:

▶ Demonstrate approaches to make dominant public narratives associated with the production of social *injustice* more visible and surmountable;

▶ Develop critical observational skills and sensibilities for recognizing and disrupting these narratives; and

▶ Connect learning to a transformative public health practice that can advance health equity through a social justice-based public narrative.

We want public health practitioners and their allies to become more aware of public narratives and their power, consequences, contradictions, and relationship to public health practice. We want to impart the skills to detect, question, and disrupt commonly accepted dominant public narratives, including those in public health practice. Getting there requires cultivating an inquisitive frame of mind so that practitioners will be better able to a) reclaim and collectively promote a social justice-based public narrative to advance health equity, and b) illustrate how a public narrative can make visible the suffering and inequality, often hidden from scrutiny, that inhabit core institutions and social structures.

"Once you get used to not seeing something, then slowly, it is no longer possible to see it." —Arundhati Roy

Overview

Our purpose is to expose public health practitioners to the power of public narratives to act more effectively as narrative strategists in the elimination of health inequities. Dominant public narratives reflect the interests of society's most powerful groups. They often sustain social injustice by obscuring its causes and making it appear natural and inevitable through a subconscious series of reinforcing stories. What we can do about it?

Learning to notice and question these narratives—drawing attention to organized power and its mechanisms—is a first step towards disrupting them. Below are two activities designed to investigate how taken-for-granted assumptions and familiar perceptions understood as common sense can affect the interpretation of experiences. Once newly aware, it is often difficult to un-see or forget.

Activity 1

Look at the black and white photo. What do you see? Different people see different things.

The photograph is a cow's head.

For those who do not initially see what the photograph shows, once revealed, it is difficult to unlearn what you now know. We do not become conscious or attuned to all that surrounds us, unless somehow it becomes relevant. This type of awareness can be especially useful in interpreting or noticing less visible, long-term social and cultural processes that affect our lives.

Source: Optometric Extension Program Foundation

Activity 2

Familiar habits and routine experiences can inhibit reflection of how we interpret those experiences: high school students are used to seeing maps that look like the Mercator projection below.

Source: : dikobrazik/Envado Market

Now, look at the second map, McArthur's Universal Corrective Map of the World.

Source: McArthur Maps

Dialogue/Reflection Questions

1. How do these two maps differ?

2. How difficult or easy is it for you to read the second map? Why are North America and Europe almost always *on top* when the earth is round? Who decided that north is up?

3. What might be inferred by having the Pacific rather than the Atlantic in the middle of the map?

4. How might the different maps have any implications for how North Americans and Europeans view their place in the world and how might other nations view their place in the world because of this shifted map?

The orientation of most maps arose from the interplay of chance and advances in map-making, but also because of politics. Map design represents examples of a dominant public narrative that affects our perceptions. Questioning the perspective in these maps is one small example of the work involved in scrutinizing and penetrating dominant public narratives.

Relevance of Public Narratives in Public Health

Why should public health practitioners pay attention to public narratives? Because it matters whose narratives dominate. Dominant narratives can tell a story about who is responsible for the production of health and illness, and this affects the choice of strategies which seem possible or imaginable.

For several decades, public health has been documenting racial and class disparities in health. But according to surveys, far from being evidence of injustice, many Americans view these disparities as "unfortunate, but not necessarily unjust." A public narrative featuring a self-determining individual who makes right or wrong "lifestyle choices" renders the social and political determinants of health inequity invisible, and instead blames individuals for their poor health. Similarly, public narratives

rooted in white supremacy suggest that the cultures of oppressed racial and ethnic groups are responsible for their own health outcomes.

Dominant narratives attempt to discredit and prevent a counter-narrative from gaining momentum. What narratives can public health foster with authority and legitimacy in the task of eliminating health inequity? How can practitioners translate the realities of health inequities and their causes to broader constituencies? How can narrative change become a priority? How can they intervene in the narratives that perpetuate health inequity?

Public Health Practitioners: Champions for Health Equity, Transforming Public Narratives

Many public health practitioners already engage with colleagues and allies to raise, nurture, and articulate an effective social justice public narrative that supports a common agenda to achieve health equity. Some partner with communities and ensure that voices previously missing are equal partners in the collaboration. The values espoused in public health represent a broad vision that incorporates well-being and the expression of people's full capabilities, including a deep concern for the collective health of communities.

What is required to strengthen a public narrative for social justice, which has been a central principle of public health from its birth in the 1840s? (See chapter 5 for an elaboration on social justice.) Public health practitioners across the country are making a difference. A newly formed national organization, Public Health Awakened (PHA) (https://publichealthawakened.com) is composed of public health professionals organizing for health equity and racial justice. Born in a moment when institutions of democracy are being threatened, and connecting with social movements, PHA mobilizes groups, tracks the public health impact of policy, and provides leadership training and technical assistance. The Healthy Heartlands initiative, a collaboration across seven midwestern states, gathers the strength of public health practitioners and grassroots organizers to address the social determinants of health inequities by building permanent alliances for racial and health equity.

Those engaging with social movements are discovering possibilities for transformation. Many are capable and ready to do more than treat the consequences of social injustice.

Community organizer Doran Schrantz, Director of ISAIAH (http://isaiahmn.org), asked a group of public health officials, as part of an initiative to build permanent alliances among organizers and public health practitioners, "How can public health practitioners become courageous champions for the public's health…fierce, fearless advocates for the public good?… Public health practitioners cannot be agnostic, disinterested technicians in the struggle for health equity. If they do not define their own identity, others may do it for them." Thus, realizing health equity involves courageous leadership and intentional risk-taking. It requires that its practitioners become citizen professionals—bringing their whole self and values to the work.

Public health practitioners can intervene in public narratives, including stories from constituent voices, communicating outside the framework of dominant narratives, which are inherently unstable and always contested, especially as they become disconnected from peoples' experiences. No society reproduces itself without repetition and revision of its narratives.

Dominant narratives have been successfully challenged throughout our history, as witnessed by successful social movements. They require constant vigilance, defense, and reworking to reproduce and sustain power. Their contradictions provide openings and the space for questioning. In representing and signifying health equity, public health must devise inspiring, coherent, dramatic stories that reach people's hearts and minds for audiences ready to receive them.

Some may say that this constitutes preaching to the choir. Few choirs exist and some need practice. But many advocates are already engaged in social movements and others are ready to join or build a social justice choir, create a songbook, and teach each other to harmonize.

Worldview and Public Narrative

Most people have a philosophy of life or perspective referred to as a worldview. For our purposes, a worldview is "a collection of beliefs, norms, value systems, core themes, popular wisdom and traditions that people draw upon to help them make sense of the world around them. Worldview is often linked to unexamined assumptions about human nature, identity, gender, race, class, [religion], and sexuality and family."[1] These worldviews, sometimes representing grand, linked themes often become deeply embedded in us, mostly without awareness, and sometimes serve to justify and legitimize power relations. They affect how we determine possibilities for organizing society, what can and should be changed, and how to live our lives.

Public narratives are the commonly expressed meanings throughout the culture, reflecting worldviews, which explain social and political phenomena, e.g., economic crisis, war, racism, history, and state of the ecological system. These shared bodies of related stories exist in our collective consciousness, helping to make sense of experience. They arise from historical conditions, economic structures, political institutions, and the exercise of power, not from individuals. Generally, not intentional, they shape conceptions of individual reality, e.g., influencing explanations for how the government works or why inequality exists. They may link seemingly disconnected random events that sustain a coherent worldview.

Public narratives also provide the grounding from which people make determinations about how society functions and their role in it. They have the power to shape what is feasible and desirable, even one's identity. Imprinted in the collective national consciousness through shared history, they can either constrain critical thinking or unleash imagination. We swim in them, and therefore we not typically *notice* them, unless they are made salient. Our objective is to identify, question, and disrupt dominant narratives to learn how they are communicated and, when appropriate, create and disseminate contending public narratives that reclaim public health's core social justice values.

Making these narratives visible and relevant is difficult because they take many forms: stories, systems of representation, social customs and mores, art, photography, language, images, advertisements, poetry, parables, spectacles, and films that permeate all aspects of culture. They can also be inscribed within intangible institutional practices in education, corporate discourse, and the judicial system, among others.

Sometimes when a new narrative appears and conflicts with a long and deeply held narrative, people may discredit the new narrative. Historically, some scientific discoveries—often shocking at first—can lead to a shifting narrative that changes awareness, often in unexpected ways.

▸ Prior to the discoveries of the astronomer Copernicus in the early 14th century, people saw themselves as being at the center of the universe. The Catholic Church fought the view that the earth was not the center of the universe.

▸ Seeing the earth from space for the first time led to an often-indescribable shift in consciousness. The earth appeared to some to be more finite and vulnerable; for many, it led to a sense of connectedness.

Sometimes, those within an established power structure create a narrative to rationalize their decisions, sometimes associated with the oppression of people with less power. This was the case with slavery.

▸ The institution of slavery existed mostly unquestioned for thousands of years in cultures all over the world; it was a system often seen as natural. In the United States, however, the 'self-evident' truths that all men are created equal led to opposition to slavery on moral grounds, which, in turn, demanded a rationalization for slavery for the first time: "There must be something different about those people," historian Barbara Fields notes, "You need a radical affirmation of bondage only where you have a radical affirmation of freedom."[2]

Many narrative shifts occurred that influenced struggles against oppression through social movements that ultimately mobilized populations toward social change. Yet, they all remind us of the vigilance necessary to sustain and refine narratives with each reconfiguration of power:

▸ The labor movement supported workers' right to organize, raised the standard of living, and improved working conditions. Since the 1970s, corporations fought unions at every turn, and worked to diminish their power.

▸ The Civil Rights movement won significant victories, gaining the right to vote and advancing legal equality. Yet some activists argue that its story of progress was almost too linear and incomplete, as it played out among whites who mostly failed to grasp the depths of racism and its enduring legacy in American culture.[3]

▸ Formed in 1987 as the AIDS Coalition to Unleash Power, Act UP is an international advocacy group working to impact the lives of people with AIDS and the AIDS pandemic to legislation, medical research, treatment, and policies that ultimately brings an end to the disease. ACT-UP fought successfully against stigmatization of AIDS victims, lack of access to medications, and increased public understanding of the disease.

▸ Black Lives Matter is an international activist group that campaigns against violence and systemic racism towards black people. It evolved from community outrage about police shootings of young black men. The stories they tell of people's experiences have transformed the narrative about what it means to be black in the United States. They recognize the power of narrative in shifting consciousness.

▸ The farm worker justice movement, which extends from the United Farm Workers movement, established in 1965, to today's Farmworker Justice, works to empower migrant and seasonal farmworkers to improve their living and working conditions. As the struggle continues so does the effort to sustain a narrative through story-telling.

Recovering "The Political Unconscious"
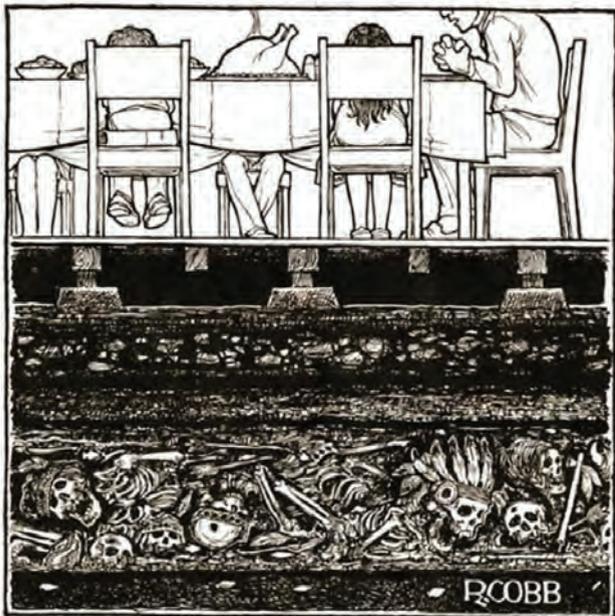
Source: Ron Cobb, artist

Sometimes we unconsciously repress feelings or memories that are painful or unpleasant. The political unconscious refers to people's individual and collective knowledge or attitudes about, for example, privilege, war, and suffering that becomes lost, repressed, or distorted.

The unwillingness to confront our history often facilitates unconscious adaptation to many dominant narratives that obscure social and political reality. Analytic skills can wither if not used regularly, especially with ever-present media conditioning. Here are a few examples of the types of questions that can lead to reflection and making connections among seemingly disparate phenomena enhancing critical awareness:

▶ Was the history of different cultures, beyond the American and European, given equal, if any, time in your school curriculum?

▶ When you think about the Founding Fathers, how often do you remember that they were a landed aristocracy of wealthy, slave-owning white men?

▶ Do you know who makes your clothing, where it is made, and what workers get paid?

▶ When you eat a meal, how often do you think about the lives of farm workers, who played a significant role in getting the food to your table?

▶ Are you aware of the struggles that led to the eight-hour work day becoming standard practice?

▶ In your workplace, how much control do employees have over their jobs? What are the non-obvious forms of workplace control?

▶ How often do you think about your race? If you are white, do you sometimes forget that you're white? If so does that mean white people are forgetful?[4]

▶ How might society be "set up" so whites do not have to think about race (if you are challenged by this question, consider the corollary of how often able-bodied individuals think about their physical mobility as opposed to people with disabilities). If you are a person of color, in what circumstances are you most likely to be aware of your race; why might that be?

Most people can answer these kinds of questions, if asked, but such questions rarely come to mind on a regular basis. Transforming narrative requires us to restore the capacity to be self-aware of context and to question taken-for-granted narratives about the world. Public health must be intentional about building spaces where these and related questions can be asked, including how they affect health. Such questions, reflected in dialogue, can lead to transformative critical thinking.

Public Narratives in Public Health

A Caveat: Transformation Through Insight and Discovery

Shifting consciousness differs significantly from learning better methods of persuasion, effective messaging, or improving communications strategies. Learning to counteract dominant narratives rarely involves logic, formulas, applying concepts or "figuring it out." Instead it entails reflection, questioning, dialogue, creative exploration, imagining, listening, and recognizing the location, interests, and history of those in power. Gaining insight through discovery is a transformative process.

Staff and leadership of the Ingham County Health Department (ICHD) integrated the practice of facilitated dialogue as a methodology for organizational change. The health department spent years engaging staff and community in dialogue on a regular basis. The subjects included racism, class oppression, and gender inequity. Someone asked Doak Bloss, the ICHD Health Equity Coordinator at the time, "What's the practice after all that work?" His answer: "The dialogue is the practice." The staff were transformed by their experience. Most asked different questions, had different assumptions about their work, and had improved their relationship with community residents. Many were not necessarily conscious that they themselves had changed. We believe that public health practitioners can become more courageous risk-takers.

Constrained by a Narrative: A Public Health Example

The Case of the Pima Indians

How do public narratives affect the way public health views its work?

The PBS documentary series *Unnatural Causes: Is Inequality Making Us Sick?* presents the story of the Pima and Tohono O'odham Indians of southeastern Arizona who, at one point, had the highest diabetes rate in the world. The National Institutes of Health, relying on a standard biomedical model, received and spent over $80 million over many years studying their genetics. They found nothing to explain the causes of this phenomenon. The search for causes within a biomedical model assumed a genetic deficit. The dominant narrative, focusing on individual behaviors, genetics, and risk factors, in this case arising out of a bio-medical model (discussed in chapter 3), led to wrong conclusions.

The scientists, locked into one way of explaining their condition, ignored the social and political context, especially the history of the Pima. Their condition had nothing to do with genetics, but instead with the disruption to their lives, livelihoods, and culture, caused by the loss of their political power. During the 20th century, the diversion of river water to upstream white settlements, mines, and ranches (later, the building of the Coolidge Dam in 1928) destroyed their agricultural economy and plunged the Pima into poverty.

Dispossessed of their land, water rights, and cultural practices, they could not farm. The federal government began providing food assistance in the 1930s, primarily commodity foods high in sugar and saturated fat. But diet alone did not cause the epidemic. The Pima, no longer farmers, living in a hot desert, with no exercise and no work, were exposed to chronic stressors of poverty and lack of a future, which increased their susceptibility to diabetes.

Dialogue/Reflection Questions

1. In what ways do our definitions of problems telegraph the solution trajectory?

2. How does the NIH definition of a condition or circumstance as a problem already predetermine or constrain the range of response, as opposed to some other entity's definition? How did the NIH definition prevent researchers from seeing other aspects of the Pima's lives (e.g., the history and context of the injustice perpetrated on the Pima over time)?

3. How does your experience with solving public health problems reinforce or contradict this pattern? For example, solutions for childhood obesity, the opioid crises, others?)

4. How might you revise the definition of the problem in the Pima case to advance a broader solution? What conclusions can we draw from the Pima Indian experience that will influence how problems are defined in your own work?

Notes

1. Sandra Hinson (2016) Worldview and the contest of ideas, Grassroots Policy Project, Berkeley, CA: 1.

2. Barbara J. Fields (March 2001) Excerpt from an edited version of a presentation given by historian Barbara J. Fields at a "School" for the Producers of the film "Race the Power of an Illusion," San Francisco.

3. Richard Delgado (1989) Storytelling for Oppositionists and Others: A Plea for Narrative 87(8) *Michigan Law Review*: 2411–2441.

4. Naima Lowe (2013) 39 Questions for White People. Retrieved at: http://www.naimalowe.net/39uestions.

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DOMINANT PUBLIC NARRATIVES

Introduction: Observing Dominant Public Narratives in Everyday Life

Dominant public narratives are deeply-rooted, widespread, stories, explanations, or cultural practices that give preference to the interests of dominant social groups, often based on race, class, and gender hierarchies. They tend to reinforce existing relations of power that generate social and economic inequality, marginalizing or silencing the voices of social groups with limited power. Their purpose is to obscure power, divide populations with common concerns, enforce compliance, and ensure that opposing visions of society's possibilities do not become reality. These narratives also tend to undermine alternative interpretations of making sense of or explaining events.

However, they constantly change, always challenged by contradictions and resistance and therefore require continuous validation. This feature, among others, provides opportunities for undermining them. Who controls these narratives? Why and how do some stories and explanations become dominant and what are the countervailing forces?

This chapter explores key features of four core dominant public narratives in American society that influence central narratives found in public health practice. These include:

1. The self-determining individual who makes right or wrong choices (individualism);

2. Racism as overt discrimination and interpersonal bias or prejudice (avoiding structural racism);

3. Equating prosperity with free, self-regulating markets; and

4. Government as inherently inefficient, corrupt and authoritarian (weakening democracy and political equality). (Other critical narratives exist, not considered here.)

We analyze these narratives to clarify the mechanisms sustaining various forms of oppression (e.g., exploitation, marginalization, powerlessness), disrupt them and support a social justice-based narrative. Critical recognition of their assumptions, social and political effects, and contradictions is a first step to avoid unconsciously participating within already predetermined frames of dominant narratives. How do we learn to become more self-conscious of them, both culturally and politically?

A Resistance Narrative

Read this brief excerpt from Communique 1 produced by Occupy Wall Street.

> Many believe we have come to Wall Street to transact…business to strike a deal. But we have not come to negotiate. We have come to confront the darkness at its source…At Wall Street we see that the basic experience has become the transaction; that life's central purpose is to convert all of existence into tradable currency…. What do we want from Wall Street? Nothing, because it has nothing to offer us.[1]

Dialogue/Reflection Questions

1. What strikes you as particularly unexpected or important in this statement?

2. How does your experience contradict the orientation laid out in this statement? How does this statement illustrate refusal of conventional politics focused on policy?

3. What conclusions can we draw about power and its placement from this Communique? What is unobvious that Occupy Wall Street want us to see?

Dominant narratives are typically the outcome of ongoing struggles, among competing interests, not necessarily named or observable. Revealing the conscious interests and networks that produce and benefit from these narratives requires a method or sensibility to *detect, question, and replace them*. How do they seep into our collective consciousness and exclude or silence voices of those with less power?

Example: *Re-experiencing a National Monument*

The first image of Mount Rushmore provides an illustration of the taken-for-granted nature of dominant narratives and the voices and values they erase. The image exemplifies one type of dominant narrative, displayed in a public monument.

Dialogue/Reflection Questions

1. This is of course a renowned monument. What does it represent?
2. What do you imagine are the themes and ideas in the brochures provided at the site of the monument?
3. How does your experience reinforce or contradict those themes?

Rarely do we find critical analysis of this famous sculpture outside of its own pre-given meaning, history, and the sensation of viewing it. Contradictions may arise when probing the reasons for its construction and the values it purports to represent and symbolize, such as freedom and democracy.

Now look at the second image.

Dialogue/Reflection Questions

1. What do the faces behind the sculpture represent?
2. What questions and contradictions does the image raise about the original image?
3. What hidden or forgotten narratives does it acknowledge or make significant?
4. What are some of the ways that we could make the hidden narratives visible?

Source: Alamy.com/Thomas Sbampato

Source: David Behrens

A critical knowledge of American history will expose other layers of meaning. For example, the above image reminds us of how the U.S. Government appropriated territory that had been illegally seized from the Lakota people. It can also prompt us to remember other groups such as women, African Americans, and workers who are not part of the founding narratives. Once recollected, this history cannot be easily forgotten or un-seen.

We now turn to an exploration of four linked themes of dominant public narratives.

The Self-Determining Individual (Individualism)

"Self-Help Self-Help!"

Individualism is a philosophy, set of ideas, symbols, and practices that reinforces the notion of the unique individual as a self-sufficient rational entity, who freely makes consumer-like choices, outside of pre-given social and political influences or the pressures of living conditions. Individuals serve as the unit of analysis to explain events that are disconnected from and obscure the social realities of racism and class oppression. Individualism supports a view of the independent individual, apart from history or political power. Its narrative may make difficult support for social rights, as part of a larger category of people—to housing, education and health care, compared with procedural rights, as guaranteed in the U.S. Constitution, e.g., the right to free speech, a speedy and public trial, peaceable assembly.

Following are examples, examining the potential force of this narrative in different circumstances.

Examples of Implications Related to The Self-Determining Individual Supported by Dominant Narratives

Example 1: *Blaming Individuals*

During the Great Recession of 2008, large banks and financial institutions, having used their extraordinary power and resources to undermine financial reform, presented the crisis as an unfortunate event, due to mistakes, human weakness, moral failings, and poor judgment by bankers handling complex financial instruments. Their narrative blamed borrowers, who were mostly targeted in communities of color and those with limited wealth, for seeking subprime mortgages, ignoring their own responsibility to reject such loans and their aggressive policy in promoting these mortgages. Financial institutions urged people in the aftermath to invest and manage their money more effectively by learning how markets work.

Dialogue/Reflection Questions

1. Why do you think the narrative of the great recession of 2008 was so dismissive of financial institution responsibility and so harsh on borrower decision making?

2. How did the advice given by financial institutions that people should learn to invest, reflect the individualism narrative? Why was blame so easily shifted to and accepted by the public?

3. In what other circumstances do we observe the individualism narrative potentially influencing public decisions, e.g., defining poverty as individual pathology?

4. What is the effect of the individualism narrative on the decision making of large financial institutions, or other large institutions? How does it encourage or excuse their assessment of their own behaviors? How might financial systems be encouraged/challenged to assess their own roles in the recession?

Example 2: *Self-Help, No Need for Investigation or Collective Action*

A local government report to the media alerted the public to a crisis in the water supply—high levels of a dangerous chemical were identified. The advice to the population included: "Use a filter on the sink if water is tainted, or drink bottled water." An investigation indicated that the source was from an industrial plant that had caused this to happen four times in the previous two years.

Dialogue/Reflection Questions

1. In what ways have you witnessed or experienced similar cases where the responsibilities of corporations or governments have been deflected to individuals?
2. If the response to this situation were to be less focused on personal action, what would it look like?
3. Why might the media explanations and suggestions be readily accepted by the public?
4. How would you describe a more critical narrative that shifts the subject of local news stories about what residents' response should or could be to these kinds of health crises?

Example 3: *Weapons of Mass Distraction*

When faced with patterns of mass killings in schools, the National Rifle Association (NRA) and the gun industry immediately divert attention to identifying mentally disturbed individuals, instead of focusing on gun control. They place attention on funds for improving mental health services, arming teachers, weaknesses in the justice system—almost anything, except proposals to control the purchase and use of firearms.

Dialogue/Reflection Questions

1. How does the individualism narrative contribute to the difficulty in explaining how the availability of guns contributes to this societal tragedy?

The Impact of Explaining Racism as Overt Discrimination or Unconscious Interpersonal Bias

Source: Kara Springer

The dominant public narratives that reinforce racism exist everywhere in society. They get expressed in beliefs, discourse, symbols, stereotypes, values and practices. These narratives constantly shift and adapt as conditions change and serve to rationalize the privileges of racism that sustain white supremacy.

This section first explores those narratives that function to obscure the realities of racism and its ubiquitous character, beyond interpersonal bias, prejudice, and discrimination. These draw attention from the deeper pervasiveness of structural racism and white domination

throughout society's institutions. The second part provides examples in routine practices and stereotypes from everyday life which result in rendering structural racism and the benefits of white supremacy invisible.

Structural racism, a core root cause of health inequity in the U.S., is a systematic social injustice, with respect to both physical and socio-economic violence that perpetuates cumulative advantage and unearned benefits for whites.[2]

Official, Comfortable Anti-Racism

Jodi Melamed, Professor of Africana Studies, describes how the U.S., in different historical periods, presents itself as a country that has successfully sought to overcome racism.[3] Relying on benign narratives of multiculturalism, contemporary "official" or acceptable anti-racism emphasizes attention to moral and psychological issues, resolved by assimilation and education. These efforts rarely challenge more difficult questions of power imbalance and accountability for material oppression associated with exclusion and exploitation. For example, unpaid slave labor, Jim Crow laws, and ongoing discrimination resulted in whites having many times the assets of African Americans. This gap will not close without concerted conscious structural transformation.

Unwillingness to Acknowledge Whiteness and White Supremacy

White people often refuse to accept racism as a white problem. Many whites and the economic interests that benefit from racialized structures drive wedges among potentially cooperating social groups, politically weakening the collective power of people of color and the potential for whites to become reliable allies in dismantling racism. Whiteness is a powerfully constructed narrative, mostly

Source: Mirrors of Privilege, a film by Meaningful Movies Project

Making Whiteness Visible

unknowingly perpetuated by whites, which "reproduces racist practices even when, and especially when, they believe that what they are doing is morally good."[4] Secured within normal racialized practices and policies in everyday life, whiteness appears common and unremarkable. Its significance lies in the benefits and privileges conferred on whites while marginalizing people of color.

Sociologist Eduardo Bonilla-Silva, discussing the necessity of a dominant racial narrative to sustain racialized societies, describes the functions it performs, well-beyond individual prejudice:

1. An accounting of the existence of racial inequality;
2. Providing basic rules on engagement in interracial interactions;
3. Furnishing the basis for actors' racial subjectivity;
4. Shaping and influencing the views of dominated actors; and
5. Claiming universality, thereby hiding the fact of racial domination—that a racial order is in place that benefits a racial group.[5]

Read the following statements aloud:

1. …Whiteness is dependent for its meaning on the process of ignoring the experience of everything outside its range of interest.[6]

2. Whiteness is "…a location of structural advantage, of race privilege…"[7]

3. "Whiteness is best understood as a form of property rights that is systematically protected by social institutions, such as law."[8]

4. Whites can be complicit in sustaining systems of racism, even if they are not racists.

5. The problem of structural racism/white supremacy cannot be resolved through personal consciousness raising.

6. Whites hinder the great potential for solidarity across racial lines by not examining the invisibility of whiteness.

Self-Reflection Questions

1. Upon hearing these statements, what stands out for you as particularly surprising or important?

2. What bothers you about the way we currently respond to such statements?

To combat these narratives, "official" (governmental, corporate) acceptable forms of anti-racism discourse explain racism mainly as interpersonal bias, prejudice or discrimination (e.g., colorblind, post-racial, diversity).

Bonilla-Silva explains where to look to avoid being *distracted* from the realities of racism:

> "Racism is the product of racial domination *projects* (e.g., colonialism, slavery, labor migration, etc.) and once this form of social organization emerged in human history, it became embedded in societies….Racism is above anything, about practices and behaviors that produce a racial structure—a network of social relations at social, political, economic, and ideological levels that shape the life chances and reproduction of systematic racial advantages…"[9]

Dialogue/Reflection Questions

1. Where in your everyday life or in public health practice do you see narratives or stories sustaining structural racism? Have you observed such narratives which also appear to oppose racism? Can you think of examples of how race has been used to establish a social consciousness that normalizes racism?

2. How might white narratives or narrow interpretations of black experience create an accepted, unexamined discourse that sustains racism? What stands in the way of a more effective challenge to this contradictory narrative?

3. Why are the social injustice of these historical racialized projects, discussed above by Bonilla-Silva, continuously invisible to many institutions? How might we bring the failure of institutions to notice such racialized events to light?

4. In what ways might standard practices in public health lead us to overlook structural racism? In your experience, what forces push us to focus primarily on remediating the consequences of inequity, instead of directly confronting the decisions that generate health inequity?

The Invisibility of Slow Violence

The long-term deeply embedded character of structural racism destroys lives over time, its violence experienced, but mostly not immediately observable as a process. Review the following passage by English Professor Rob Nixon explaining 'slow violence' and the difficulties of portraying its effects:

> "Slow violence occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attitudinal violence that is not viewed as violence at all…. A major challenge is representational: how to devise arresting stories, images, and symbols adequate to the pervasive but elusive violence of delayed effects."[10]

Dialogue/Reflection Questions

1. In what ways have you witnessed slow violence; at work, in your community, etc.?
2. What stands in the way of responding more effectively to the slow violence of racism?

Examples of Structural Racism Supported by Unnoticed Dominant Narratives

Example: *Historical Racial Categorization*

Changes in the racial categories used by U.S. Census over centuries reflect political and social decisions that influenced the construction of race and class.[11] The U.S. Census Bureau has long justified hierarchical classifications, based on notions of white domination. Until relatively recently, "non-white" was a category for racial groups who are not white, thus normalizing whiteness as the standard. The Census practice of determining categories exemplifies how a narrative becomes entrenched in a practice. Analyst Natalie S. Burke comments, "The moment you say non-white, you have made white people the norm and everyone else a deviation… or variation of white people and the characteristics associated with whiteness. …White people and whiteness were not the original norm in America… The original people on this land were and are Native Americans (who outnumbered European immigrants upon their arrival)…."[12]

A half century later, in the 2010 U.S. Census, the built-in devaluing of identity—the category "white"—remains dominant.

Source: Department of Commerce, Bureau of the Census (1960)
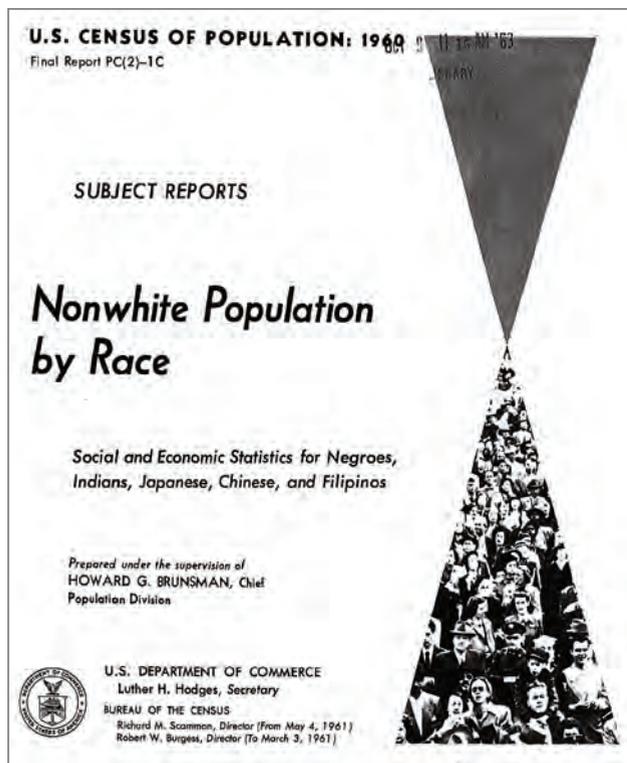
Dialogue/Reflection Questions

1. In what ways has the institutionalized practice of collecting data on racial categories resulted in the valuation of whites over others?

2. What might be the consequences of using politicized and shifting categories of race in public health practice?

3. Given the information you have read, how might the U.S. Census undercount some populations and what are the political implications of such errors?

Example: *Pervasive Stigmatization and Normalizing Stereotypes*

Institutionalized representations and stereotypes, in the media and elsewhere, have long devalued communities of color while undermining their humanity. Today attacks have become more explicit and direct. Stereotyping whole population groups as criminals, for example, facilitates rationalizing violence in law enforcement practices. Similarly, immigrants, defined as burdens who bring an "alien" culture, become useful scapegoats for dividing population groups.

Whites are often invisibly socialized, whereby they unjustifiably assume themselves, generally, to be more upstanding or moral. Some official anti-racist narratives seek to make whites comfortable in this belief—supporting the assimilation of people of color to become like whites, to be acceptable, respectable, and prove their humanity.

To the extent that these narratives become internalized in the national consciousness, they negatively affect health outcomes and lead to material insecurities over generations, creating health-destabilizing stress over time. Assimilation, recognized or not, also creates stress in those pressured to separate from their culture and identity. Patterns of stigmatization and "othering" make it more likely that those groups will be treated as disposable and less valuable, potentially making their communities more likely targets for hazardous waste, fewer government services, and higher levels of housing discrimination.

Questions

1. What examples of racialized narratives do you recognize from your own experience?

2. Discuss the implications for public health of narratives that encourage positioning African Americans and Latinos as criminal or dangerous (as threats to white dominance). For example, as a cause of economic decline by taking jobs from "real" Americans.

3. How might stigmatization facilitate law enforcement rationalizing violence?

Activity: Stereotypical Imaging

What do you see in these two images? Compare them; contrast them.
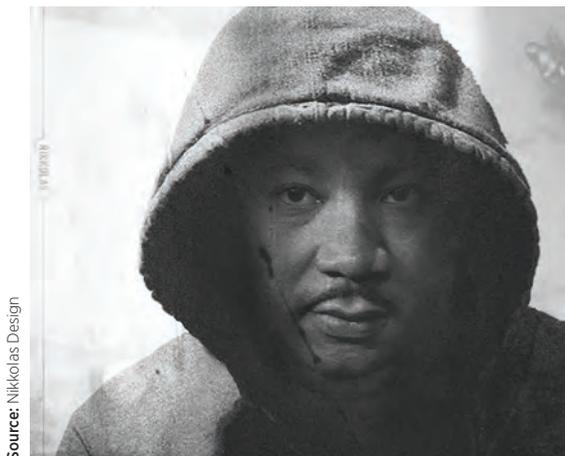
Source: Nikkolas Design

Source: Trayvon Martin Foundation, A Year in the Death of Trayvon Martin

Reflection

How might white narratives or narrow interpretations of black people's *experience* create an "official" or accepted, unexamined discourse that sustains structural racism? A distorted perception of black people's experience as primarily negative?

Dialogue/Reflection Questions

1. What dominant narratives do you notice that reflect or sustain structural racism in everyday life? What examples of racialized narratives do you recognize from your own experience?

2. In what ways does public health overlook structural racism and focus primarily on remediating the consequences of inequity?

3. Public health practitioners in the U.S. are products of the racialized environment in which they exist; as such, what ironies do you observe in the public health narrative?

4. How might public health practitioners shift common stigmas or stereotypes as they strive to shift narratives (e.g., positioning African Americans and Latinos as criminal or dangerous or as a cause of economic decline by taking jobs from "real" Americans)?

Equating Prosperity with Economic Growth, Dependent on Free, Self-Regulating Markets

Often economists and corporate CEOs use the phrase "the economy," as if it acts autonomously and has feelings and illnesses, e.g., "the economy is hurting or unhealthy." Or "We need to tame the market," as if it were an animal. This abstract notion of the economy becomes more important than human well-being in governmental and corporate policy. The language of the market described as an organic "thing" that accumulates the decisions of investors and consumers, without human intervention, is a formidable myth. It conceals the conflict and decision-making processes of powerful institutions, separating the connection between politics and economics, while avoiding responsibility for the outcomes of decisions that ultimately affect real people.[13]

Markets with Human Powers

Markets have existed for thousands of years as places of buying and selling. Today, they have been reconceived as having apparent human powers, as indispensable entities, often used to rationalize decisions that harm sectors of the population as inevitable unnamed "forces" or "market imperatives," treated as a phenomenon of nature, to limit human interference in its workings.

The concept of self-regulating markets presumes a natural, mechanical functioning of an economic system, independent of social context, especially political influence exerted by powerful interests.

Sociologist James Petras contends that the idea of 'self-regulating markets'

> "…is deceptive, because markets do not exist independent of the social relations defining what is produced and sold, how it is produced and the class configurations that shape the behavior of producers, sellers and labor. Today's market reality is defined by the views of giant multinational banks and corporations, which dominate the labor and commodity markets. To [define] markets as if they operated in a sphere above and beyond brutal class inequalities is to hide the essence of contemporary class relations."[14]

Dialogue/Reflection Questions

1. How does the claim that economic crises happen due to self-regulating market forces affect the concept of social responsibility?

2. How might the commonly taken-for-granted conception of self-regulating markets affect researching the consequences of the economic system on the public's health?

Discuss this typical headline: "X Company Fires 15,000 Workers. Spokesperson claims market forces required it." What does it imply about who is responsible? What's the unstated narrative?

Examples of Free Market Ideology Supported by Dominant Narratives

Example 1: *Making the Economy Appear to Have Human Powers*[13]

In the chart below, how are the phrases in the columns different in terms of identifying who or what is responsible for actions and their consequences? What additional examples can you think of to add to the chart?

Economic Discourse: The Avoidance of Responsibility	Clarification
Paychecks shrank	Capitalists cut wages
The economy is an ungovernable force of nature	Organized groups direct the economic system, flows of capital
Market discipline provides a necessary shock to the system	Abrupt firings; slashing pensions and health plans
The economy creates wealth	Working people create wealth
Markets are self-regulating, self-governing	Self-interested classes make decisions, press agendas
The economy is hurting	People are hurting
The market demands wage cuts	Corporations demand wage cuts

Example 2: *The Invisibility of Capitalism*

Philosopher Helena Sheehan writes:

> "[Capitalism] tends to dissipate attention to its nature as a system and its trajectory as a story…. [It] is so omnipresent as to be invisible [and] its structure…no longer accessible to immediate lived experience."[15]

Dialogue/Reflection Questions about Sheehan's Comment

1. Part of the dominant narrative of self-regulating markets is the idea that "No alternative to the capitalist structure of society exists or is even possible." How does Sheehan's comment help to explain this belief?

2. How do the narratives of individualism, avoiding structural racism, and self-regulating markets interact?

Example 3: *Privileging Economic and Quantitative Forms of Knowledge*

Each business day, the mainstream media regularly reports the Dow Jones Industrial Average, and often the Gross Domestic Product (GDP), and measures of consumer confidence, such as the consumer price index, as the main indicators of fiscal well-being in the U.S. Where are routinely presented non-economic indicators?

Source: Associated Press

Source: Shutterstock

National Public Radio has a program called "Market Place," but not a parallel one called "Work Place." Public Television once had a program called "Wall Street Week," but not a comparable program called "Week on Main Street," that might have examined the consequences for what happened on Wall Street.

Dialogue/Reflection Questions

1. Why are concepts like GDP and the DOW considered to be the main indicators of national well-being?

2. In what ways do the use of these indicators help or hinder developing and/or implementing structural changes necessary steps to eliminate inequality?

3. Can you think of social indicators that can be used to document changes in the quality of life?

Example 4: *Cost-Benefit Analysis and Risk Assessment*

The application of *cost-benefit analysis* and risk assessment to most areas of social life represents another instance where corporations often demand economic analysis to justify public policy arguments, particularly as related to public health issues. Monetizing the value of health benefits may have serious consequences for sustaining a healthy society.

The notion of measuring return on investment (ROI), expressed as a ratio, is also applied to justify policy and business decisions, sometimes inappropriately. For example, to obtain support for resources that ensure children's well-being, many advocates believe that they must demonstrate ROI to gain political support from those concerned with value for dollars spent. Using ROI as a justification for investing in children may well weaken the moral case for their intrinsic worth as human beings.

Nowadays people know the price of everything and the value of nothing.

—Oscar Wilde

RICHES, *n*: Savings of many in the hands of one.

—Eugene Debs

Dialogue/Reflection Questions

1. What are some of the ways that the benefits portion of the cost-benefit equation are described using economic measures?
2. What are some examples of social measures of benefits that might be used in a ROI calculation?
3. Have you seen examples of cost-benefit analyses that expunge the moral dimension of decisions from consideration? What are the potential consequences for people's collective health?

Example 5: *Corporate Euphemisms and Obfuscation*

Generally, euphemisms refer to inoffensive, phrases, terms, or idiomatic expressions designed to deflect attention from awkward situations. Corporate euphemisms, widely expressed in the culture, can have a significant impact in misdirecting attention from decisions associated with exploitation of workers and weakening the position of opposition, especially avoiding responsibility for actions that may harm the health of populations. As Petras explains, "the 'language' of obfuscation becomes a 'material force'—a vehicle of capitalist power, [which] disorients and disarm its anti-capitalist and working-class adversaries."[14]

Sometimes, the language used in opposition to the corporate narrative remains unintentionally inside of the categories of free market language. For example, in policy debates an assumption dominates that decisions must satisfy investors and not interfere with profitability. These assumptions support a narrative that unproven "laws of economics" outweigh harm to human or environmental health and safety.

Review the chart below.

Market/Class-Based Euphemisms

Corporate Language	Alternate Interpretation
Oil subsidies	Corporate welfare
Thousands killed in chemical plant accident	Social murder through cost-cutting on safety
Economic recovery	Recovery of profits
Privatization	Corporate takeover of public services
Austerity	Assault on living standards

Source: James Petras, "The Politics of Language and the Language of Political Regression, *Dissident Voice* (May, 2012).

Dialogue/Reflection Questions

1. When you read the phrases in the alternate interpretations column, what thoughts and/or emotions do you have?

2. How would the consistent use of alternative interpretations change the explanation of what causes economic crises?

Example 6: *Investigating Meaning, Resisting Euphemisms*

When you read the phrases in the table below, which are more familiar to you? Which phrases do you find challenging and why? What are additional examples from public health that could be added?

Euphemisms	Reinterpretation
Environmental regulation	Environmental protection
Culturally deprived neighborhood	Substandard housing
Chained migration	Family migration
Underperforming assets	Bad debt
Early retirement	Layoff
Socio-economic dynamics	Wage reduction
Food insecurity	Hunger
Welfare state	Social investment state/social protection
Upscale	Overpriced; expensive; for rich people
Poverty alleviation	Eliminate poverty and exploitation
Incentive package	Corporate welfare

Against Government: Weakening Democracy, Consolidating Power
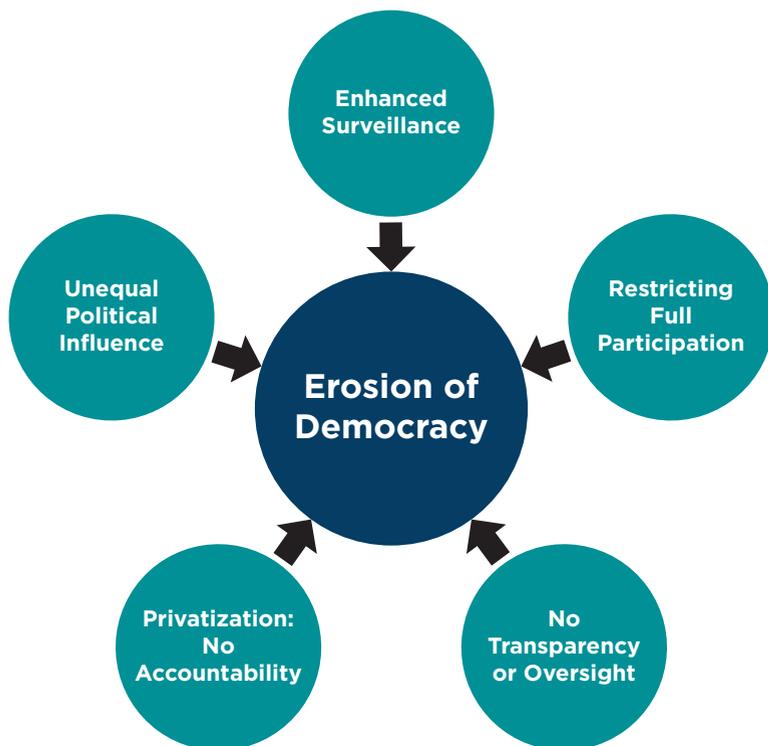
The public narrative on democracy in the U.S. has always been contentious since the founders established a system in which only white, propertied men could vote. The concept has many meanings, and it matters in determining a vision based on principles of social justice. In our view, from a public health perspective, democracy refers to a form of political equality that consists of at least three major components that are essential to sustain it: full public participation in decisions that affect living and working conditions; accountability; and transparency. Its essence centers on collective or public control of public resources. Democracy concerns the openness of the political process by which decisions are made collectively. It is not about whether government is large or small.

Democracy is necessary for good health, because the public's health depends on the ability to influence living conditions through an equitable political process. The most equitable countries have the best health status and life expectancy. Unsurprisingly, those groups with the least amount of decision-making power also tend to face the most social and environmental hazards and suffer the poorest health. Public health analyst Dan Beauchamp indicates that protecting the public health has meant "enlarging the sphere of communal provision, often at the expense of private property and sometimes…individual liberty."[16]

Weakening democracy occurs through the loss of public control for some groups to have a role in decisions that affect necessities of life. For many in the U.S., democracy is becoming more fragile. The image of circles above depicts processes through which the erosion occurs. A powerful oppositional narrative, often accepted uncritically, portrays government, explicitly and implicitly, as inherently wasteful, inefficient, a burden on the economy, unnecessarily interfering in people's lives. Yet government is not the equivalent of democracy, but one instrument for its implementation. The anti-government narrative, however, enables the weakening of public life. What public narratives facilitate that process?

Dialogue/Reflection Questions

1. How does an already-established inequitable structure of power potentially limit the advance of political equality?

Weakening Democratic Institutions

Consider the following events:

1. Limiting access to/making claims through the court system

2. Decline of an independent judiciary

3. Increased scope of gerrymandering

4. Vilification of the press

5. Attacks on administrative agencies and public servants, e.g., intelligence, environmental, public schools and teachers

6. Congress self-limiting its oversight functions of government agencies, e.g., with respect to corporate mergers, bank fraud, deregulation, environmental protection)

7. Reconfiguring the U.S. census process to ask a question about citizenship.

What do these events have in common? What impacts might they have on democracy? On our ability to address public health issues? How do contemporary public narratives fragment our understanding of the items listed above?

🔍 Example 1: *A strategy to remove politics from the market, and conflict resolution from courts and legislatures*

In the mid-1970s, bar associations, trial courts, and large foundations began to fund what were called neighborhood dispute resolution centers. Their stated purpose was to manage disputes and resolve conflicts between corporate enterprises, such as landlords and tenants, tenants among themselves, consumers and retailers, environmental polluters and communities, and so on. Trained professional mediators brought contending parties to a seemingly positive result.

Source: Monte Wolverton

The narrative to explain the need for the process suggested that overcrowded courts, police involvement in resolving minor neighborhood disputes prevented them from attending to serious crime. Parties would be able to resolve disputes quickly, privately, between individuals, so that each party reach a desired result, without courts and expensive litigation.

The unstated purpose was to minimize public conflict, avoid political debate, and limit the potential for collective response through protest, legal action, or mobilizing for a legislative agenda to change policy. Instead of people organizing against housing policy, supporting tenants' rights legislation, or initiating a class action lawsuit, any conflict—for example, with a landlord—could be resolved privately with individuals through a mediator. Instead of organizing for environmental justice against polluters, people would take their "cases" to an expert mediator in a private setting to resolve conflict.

❓ Questions

1. How do these approaches toward mediation and other forms of negotiation, such as arbitration, positively and negatively impact democracy?

2. What connections do you see between this anti-government narrative and the narrative of individualism?

Example 2: *Market Narrative vs Democracy*

This chart compares the perspective of the market narrative to that of a well-functioning democracy. Each has different goals and values.

Distinguishing Market-Based & Democratic Decisions (private vs. public)

Market	Democracy
Production decisions: whatever creates economic growth, profit	Production decisions: to meet human need
Investment decisions are private	Socially-directed investment
Social goal: no social goals or purpose	Social goal: flourishing human existence
Promotes mitigation of poor health outcomes	Promotes a public process to minimize generation of poor health outcomes
Market discipline: naturalizing whatever economic outcomes occur	Public control of economic decisions to ensure meeting needs for basic life necessities

Questions

1. What is public health's role in shaping the narrative for strong democracy?
2. How does the market narrative thwart democracy?
3. How is public health's ability to act on health equity impeded by weakening democracy?

Some Features of Dominant Narratives That Help Them Succeed

Each of the four narratives discussed in this chapter overlap through interconnected rules and practices to inhibit social transformation. While people often act in resistance to dominant narratives, these narratives evolve constantly to maintain their influence. They succeed because they:

▶ Appear as neutral and self-evident. Their power derives from acceptance, internalized as "common sense," girded by unconscious beliefs and values, e.g., about people of different races, how the economy works, and how those in poverty are responsible for their own circumstances;

▶ Undermine other systems that compete with dominant narratives;

▶ Gain support from a vast, well-resourced infrastructure built up over many decades, including mainstream media, think tanks, research centers, and trade associations;

▶ Distract attention from deep social divisions through technical, managerial discourse;

▶ Define public crises in ways that dismiss accountability;

• Marginalize the voices of some population groups (communities of color, labor, immigrants) by ignoring or stigmatizing their culture or claims;

• Indirectly position people's identities as consumers, rather than citizens—consumption becomes a substitute for democracy, collective action, and political choice; and

• Limit the scope of legitimate, acceptable political discourse and vision for what is possible to achieve.

Dialogue/Reflection Question

1. How have any of these features of dominant narrative impacted your own professional and personal experiences?

Contradictions and Limits to Dominant Public Narratives
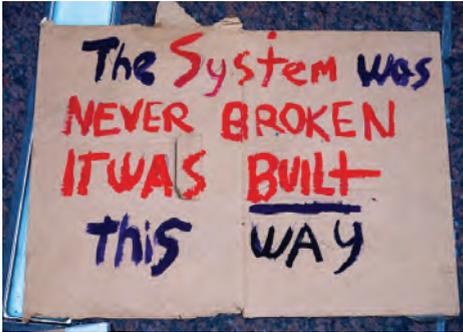
Disruption to dominant narratives may arise when their premises contain contradictory demands. This happens in times of chaos when these narratives no longer resolve the disjunction between appearance and reality, particularly in ways that cannot be hidden. Contradictions sharpen, especially as the intensity, scope, and effects of economic and social chaos receive national attention.

Consider, for example, the failure to explain adequately the way in which social and economic inequality is rising and wages stagnating at a time of low unemployment and rising stock prices. This does not seem logical according to conventional "laws of the market," disconnected as they are from the notion of political struggle. Attempts to present the common good in the language of efficiency, austerity, and profitability continue to falter.

Opportunities exist to disrupt, resist, and imagine more suitable narratives that meet fundamental human needs. This opportunity can increase when the pace of insecurity and inequality is increasing, thereby making dominant narratives such as individualism, productivity (as wages stagnate), and free markets (as a growing number of mega-corporations dominate more major segments of the economy) less relevant.

Dominant narratives associated with structural racism adapt well to change. But the newer forms of hyper-racism also produce greater solidarity and intensity of opposition, reveal racial coding, and thereby potentially mobilize broader segments of the population. Yet, without an effective counter-narrative and a vision for the future, greater authoritarian responses are equally possible when traditional institutions can no longer protect some populations from predatory interests. The dominant narratives under discussion intersect and, in some cases, parallel those in public health, to which we now turn.

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Health Equity

DOMINANT PUBLIC NARRATIVES IN PUBLIC HEALTH

Introduction: Dominant Public Narratives in Public Health Practice

Dominant narratives in public health that hinder advancing health equity have a long history, connected to broader narratives in society (see Chapter 2). Although increasing numbers of committed public health practitioners work diligently to advance health equity, recent history reveals many barriers. One is the absence of a compelling public narrative, grounded in social justice principles, which arose in the 1840s.

This absence is partially due to conventions of bureaucratic discourse; a professional culture demanding objectivity, and political pressures health practitioners face from politicians and business interests. These features enable dominant narratives to fill the void. They constrict the ability to imagine new possibilities for gaining public support in confronting root causes.[1] Public health practitioners must respond to the consequences of health inequities. Yet developing effective long-term strategies that will prevent the generation of those inequities requires a powerful public narrative that can garner public support. Fran Baum and Matthew Fisher note, "Too little attention has been paid by public health actors to the importance of ideology in their efforts to translate evidence of social determinants of health inequity into practical policy."[2]

Treating the Consequences vs. Acting on the Root Causes

Introduction

Acting on root causes of health inequity partially depends on directing resources and attention to specific social injustices underlying the health inequities, not only remediating them. This is not the fault of practitioners. It is related to the examples in Chapter 1, describing why we do not see the cow or recognize the political aspects of the world maps. Sometimes avoiding the political dimensions of health inequity is purposeful, based on fear. But accepting public health's work as inherently non-political or to avoid controversy, consciously or not, is itself a political stance.[3] The justification may result from a generally unstated belief that law, logic, and political reality demand it. Filtering controversial viewpoints is incompatible with successfully addressing root causes. Investigating the role of public narratives can bring these tensions to the surface and demonstrate the value of engaging in public conflict about health inequity so controversies do not get ignored or lost in attempts to eliminate injustice. Expressing views with a strong public narrative based on social justice principles can often build power and weaken dominant public narratives.

The Problem of Bureaucratic Discourse

Bureaucratic discourse is the collective manner and pattern used in the communication across public health operations. It has been built in a culture that focuses on things like the explanations of disease causation or the presentation of disease patterns and trends, typically minimizing historical context and political conflict. The agenda rarely includes social transformation or the question "Where do inequities come from?" Partial answers may allude to unspecified "forces," "demographic trends," and lists of "complex factors" as partial explanations for negative health outcomes—forces that are seemingly without actors and independent of time and place. The result is a narrow response to issues of social injustice in standard public health reports, press releases, performance reviews, and other communication tools.

Activity 1: Analyzing Bureaucratic Discourse

Introduction: Divergence exists between the general understanding that health inequities arise from social injustice and its application to a current practice that does not engage with the injustice—only its treatment. Such divergence constricts options to intermediate responses. The bureaucratic discourse found in many government documents, for example, fails to engage with the political realities necessary to confront health inequity. It reflects a symptom of public health's need for compelling public narratives that could support the legitimacy not only of its work on health equity, but the centrality of public health itself.

Engage all sectors
Stakeholders
Cross-cutting Access
Evidence-based Value-based
Optimize the impact
Programmatic Coordinate Leadership
New Alternative Evaluate
Optimal health
Collaboration
Systems Intervention Adapt
Skill set Partnership Policy oriented
Complex Factors Meaningful
Raise awareness
Disparities Multisectoral
Standardize

Purpose: This activity seeks to support uncovering such divergences: to notice some characteristic features of bureaucratic discourse in public health narratives that tend to obscure central causes of health inequity and divert attention.

Instructions: Review the paragraphs below from the introductory chapter of the 2013 report from the Centers for Disease Control and Prevention, *A Practitioner's Guide for Advancing Health Equity*.[4] These paragraphs may seem unproblematic upon first review. Then, with a partner, if possible, discuss what you notice about the characterization of health inequity and its causes. At the end of each paragraph, you will find a health equity perspective that critiques the report paragraph, including questions to agitate your thinking and guide you through a process to reveal unnoticed implications of the language used.

Paragraphs Excerpted from *A Practitioner's Guide for Advancing Health Equity*

P1

Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening among some population groups....Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways. Some of the factors influencing health and contributing to health disparities include the following:

▸ Root causes or social determinants of health such as poverty, lack of education, racism, discrimination, and stigma.

▸ Environment and community conditions such as how a community looks (e.g., property neglect), what residents are exposed to (e.g., advertising, violence), and what resources are available there (e.g., transportation, grocery stores).

▸ Behavioral factors such as diet, tobacco use, and engagement in physical activity.

▸ Medical services such as the availability and quality of medical services.

Narrative Critique: While the factors identified in the paragraphs certainly play a role in inequitable health outcomes, what stands out is the likely unconscious but noticeable lack of a narrative that links all the isolated "factors." Nowhere in these paragraphs (or the report) do we find an analysis of power dynamics, the interests, or the political conflicts that generate health inequities. The term racism, used once or twice, is never explained, explored, or defined. What are its processes? Furthermore, all the factors receive equal treatment. Is a root cause a factor or an injustice? Is racism a factor or an injustice?

Paragraph 1 states that disparities do not have a single cause, but who would argue that?

The statement that "They are maintained by multiple, interconnected and complex pathways" is essentially empty of content. What's not complex? The three factors listed are not discussed as more than a list of disconnected phenomena. What connects them and creates the "community conditions?" Why are there so many lacks in communities—transportation, grocery stores? Root causes are not equivalent to social determinants of health. Proposed elements appear as technical in nature. The notion of systems appears a few times. Which ones? What about them?

P2

> While health disparities can be addressed at multiple levels, this resource focuses on policy, systems, and environmental improvement strategies designed to improve the places where people live, learn, work, and play.

Narrative Critique: This paragraph does not address root causes of health inequities What causes a place (zip code) to have poor conditions? Something unfortunate? Is environmental improvement like home improvement? The political aspects receive no attention. Is improving the places the same as acting on root causes? Is the issue really about place?

P3

> Health practitioners play an important role in major health achievements through the use of laws, regulations, and environmental improvement strategies by engaging the community, identifying needs, conducting analyses, developing partnerships, as well as implementing and evaluating evidence-based interventions. These intervention approaches are briefly described below:
>
> ▸ Policy improvements may include "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."
> ▸ A voluntary school wellness policy that ensures food and beverage offerings meet certain standards.
> ▸ Systems improvements may include a "change that impacts all elements, including social norms of an organization, institution, or system."
> ▸ The integration of tobacco screening and referral protocols into a hospital system.
> ▸ Environmental improvements may include changes to the physical, social, or economic environment.
> ▸ A change to street infrastructure that enhances connectivity and promotes physical activity.

Narrative Critique: The first sentence of Paragraph 3 offers a list of general types of government action that are familiar to all facets of public health, without providing specific examples and strategies, and without an analysis of historical mechanisms that produce inequity. What are the strategies or a trajectory? Nothing specific receives a comment. What exactly will be done? Who or what mechanisms produced the health inequities in the communities? The scattered elements lack content.

P4

Such interventions have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time. However, without careful design and implementation, such interventions may inadvertently widen health inequities.

To maximize the health effects for all and reduce health inequities, it is important to consider the following:

▸ Different strategies require varying levels of individual or community effort and resources, which may affect who benefits and at what rate.

▸ Certain population groups may face barriers to or negative unintended consequences from certain strategies. Such barriers can limit the strategy's effect and worsen the disparity.

▸ Population groups experiencing health disparities have further to go to attain their full health potential, so even with equitable implementation, health effects may vary.

▸ Health equity should not only be considered when designing interventions. To help advance the goal, health equity should be considered in other aspects of public health practice (e.g., organizational capacity, partnerships, evaluation).

Narrative Critique: This fourth paragraph repeats with slightly different language what the others state. While recommending: "careful design and implementation," "efforts and resources" "organizational capacity, partnerships, and evaluation," it does not present specific analyses and strategies. Bureaucratic discourse, found in many institutions and not necessarily consciously or with intent, supports the status quo and provides little guidance for eliminating health inequity. It connects readily with dominant narratives that obscure or avoid the realities of social and political conflict.

Dialogue/Reflection Questions

1. How does current bureaucratic discourse obscure the systematic causes of social injustice?

2. Look at the language in your institution to examine what it does say and not say about causation and responsibility for social injustice. How would you rewrite documents pertaining to health inequity to reflect inequity as a cause compared with a difference in outcomes?

The Restricted Knowledge Base of Theory, Evidence

The biomedical model, with its assumptions regarding objectivity and individual differences in health outcomes, places strict disciplinary constraints on what counts as legitimate evidence and appropriate research design. Although proven successful in protecting and improving the public's health, it appears less so for addressing the sources of health inequity. It excludes too many relevant forms of knowledge and interpretative methods. As global health analyst Ted Schrecker suggests, health equity "is not a scientific issue, nor can it be resolved by scientific methods. The issue is also ethical; value judgments arise when deciding whether to make errors on the side of protecting public health or on the side of conserving state resources."[5] What other forms of knowledge might be relevant?

Analysts have pointed to the lack of a social theory to explain health inequity, which would benefit from greater integration with the social sciences, history, and other disciplines.[6] While data relying on a biomedical model can inform proximal causes, it will not foreground social and political causes. (See the Pima Indians example in Chapter 1.) In that case, privileging certain kinds of scientific knowledge unfortunately ignores other valuable information, particularly the direct experiential and historical experience of a people.

Some practitioners understandably remain skeptical about investigating social structure, political power, economic inequality, structural racism and class exploitation. They may see these concerns as incompatible with acceptable practice and evidence. Legitimate subjects for study often include only those that can be examined through the lens of seemingly value neutral, mostly quantitative measures. Yet social structures are real, even if not entirely visible or measurable within traditional paradigms.

Dialogue/Reflection Questions

1. If detachment is required in scientific evidence, what common characteristics of discussions about social determinants of health inequities work against that requirement?

2. Is detachment a benefit or barrier in discussions about social determinants of health?

3. What "evidence" is required in your work? What other evidence might be relevant but is not valued?

Example: *Explanations for Differences in Life Expectancy*

Significant differences in life expectancy (74 years in zip code 94621 and 84 years in zip code 94611, CA) in two geographically close communities can be documented but not fully explained by categories and methods within the biomedical narrative.

ZIP CODE **94621** LIFE EXPECTANCY **74**

ZIP CODE **94611** LIFE EXPECTANCY **84**

Your **ZIP CODE** shouldn't predict **how long you'll live**
www.calendow.org

Source: The California Endowment

Dialogue/Reflection Questions

1. While zip codes may predict life expectancy, what are the conditions that systematically produce these differences?

2. How can political dynamics inform zip codes and the delineation of communities? How might the stresses of racism and poverty be entrenched in geographic delineations?

3. Consider some examples from your own practice. In what ways are you able to examine long-term effects of racism or class exploitation on health inequity? In what ways is that influenced by public narratives that pre-define the legitimate scope of public health practice?

Limits of Social Determinants of Health (SDOH) as a Narrative

The SDOH narrative, an advance over traditional behavioral approaches, still lacks a direct relation to social injustice and power dynamics at the root of health inequity.[7] The five determinants depicted below (which could be extended) are themselves outcomes which result from political struggles. Notice that while the first diagram shows a link among its five elements, but the underlying cause that links all of them is missing.

Source: CDC. Healthy People 2020

Social epidemiologist Nancy Krieger, in her book *Epidemiology and the People's Health*, identifies two distinctive frameworks for eliminating health inequity. They express the importance of how a narrative that includes a power analysis might influence strategies for practice. She distinguishes between approaches that note existing policies and hierarchies versus attention to the purposeful use of power to gain domination:
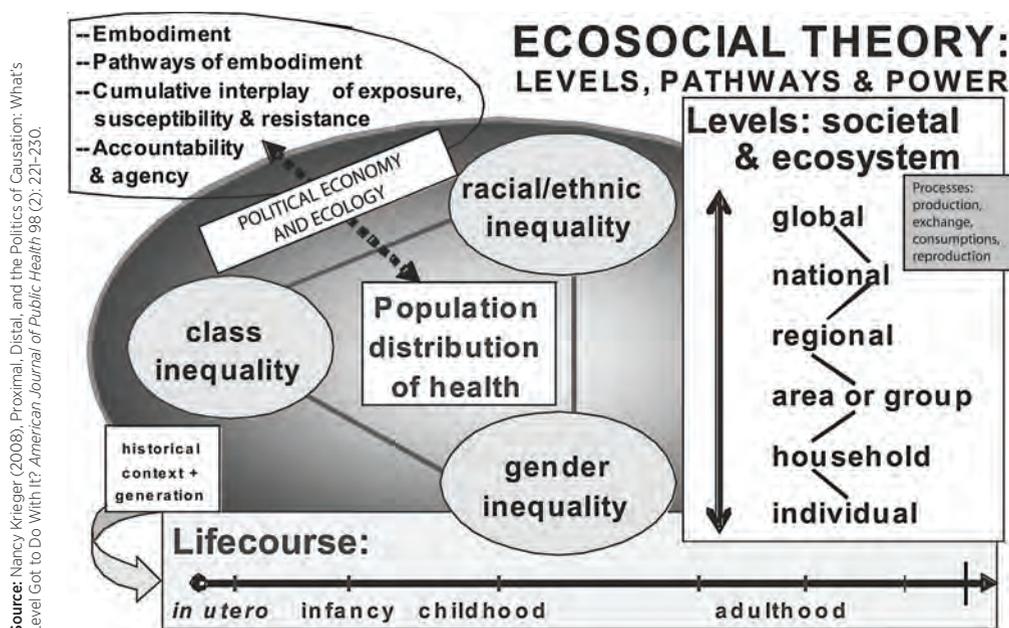
1. …*social determinants of health* [arise] from a 'social environment,' structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differentially exposed to factors that influence health—hence social determinants act as the *causes of causes.* (WHO CSDH)

versus

2. …*societal determinants of health* [are seen as] political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions; *societal determinants* thus become *the causes of causes of causes.*[8]

Sociologist Hilary Graham states, "[T]he social factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution."[9]

Dialogue/Reflection Questions

1. Why and how might the SDOH framework likely lead to support for a remedial approach to health inequity?

2. Describe an example from work in your community where patterns of decisions, governmental and non-governmental, led to poor health outcomes for a particular population.

Individualism and Health Promotion

Source: The National Cancer Institute
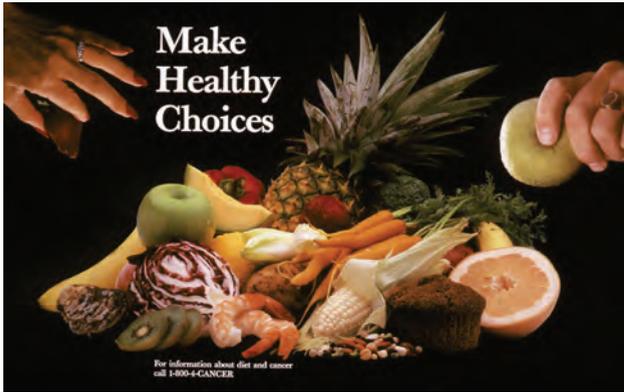
The power of *individualism* (which parallels the dominant narrative described in Chapter 2), appears most noticeably in health prevention and promotion strategies generally, and sometimes for reducing health inequities. Proponents of these strategies assign responsibility for health outcomes primarily to the individual. Health promotion models stress solutions situated in finding cures, punishment, and incentives or admonishments to change behavior (diet, exercise, lifestyle), given assumptions that health outcomes arise from ignorance, personal failure, poor choices, or genetics. But do they?

Here again, the biomedical model compares favorably with an individualism-behavioral narrative, highlighting resource deficiencies and evading power dynamics. It cannot grapple with the socio-political dimensions of health. As sociologist Lynn Weber notes, "Within this paradigm, health disparities research commonly conceives and measures social inequalities as resource differences among *individuals*… not as group dynamics."[10]

Example: *Obesity and the Individualism Narrative*

Since the 1970s, the rate of obesity in the U.S. has reached epidemic proportions. Yet the major response still emphasizes educational approaches promoting changes in diet and exercise. This decades-long crisis cannot be explained by suggesting that individuals, all at once, decided to stop exercising and to engage in poor eating habits over a particular historical period.

Source: Kim Britten, Dreamstime.com

Dialogue/Reflection Questions

1. How does the individual narrative (personal responsibility) and its emphasis on the attributes of the individual displace social and political explanations for health inequities?[11]

2. How does the individual narrative approach to obesity fail to explain the role of rising inequality, stagnant wages, ubiquitous advertising of junk food and limited access to healthy food?

3. Consider health promotion practices seen in your organization. What kind of health promotion narrative would shift attention to changing corporate and government behavior and practices instead of only individuals?

The Politics of a Question

Sylvia Tesh, environmental health politics analyst explains:

> "...individualistic ideology politicizes categories beyond the individual level. 'Will I get sick if this stuff is in the air' sounds like a value free question....'Should this stuff be in the air appears political. But the first question is as political as the second; it just hides its acquiescence to the status quo....Alan Garfinkel says, 'The individualistic question takes the structural conditions as given.'" ...As long as public discussion about toxins is in terms of individual risks, the passage of strong regulation is unlikely."[12]

Activity 2: Rethinking Health Promotion

Health promotion typically points toward the errant individual, as in the Canadian-based satirical comparison chart below that illustrates actual tips from a government agency versus the reality of what individuals cannot accomplish alone.

Purpose: To make visible the invisible using satire to highlight to highlight and expose the limitations of behavioral change and to illustrate how individual choices to achieve better health outcomes fails to confront causes.

Instructions: Review the chart. Notice the distinctions between the conventional tips on the left and the critical satirical items on the right. In dialogue with a colleague(s), discuss these two columns and ways that the points expressed resonate in your area of work. Then, develop a third that identifies possible collective action that could be taken within a social justice narrative to address possible structural changes, e.g., through democratizing decision-making, collective organizing and advocating for changing laws. The column might expand on the news item described above to include an organizing effort to expose plans to locate hazardous waste in a poor neighborhood. Review again the first column of conventional health promotion. For each item, how would you shift the narrative toward a social change approach? What tips for collective action might you suggest? If you were to add tips from your organization in the tone of the second column for each category, what would they be?

Ten Tips for Health	Ten Tips for Staying Healthy	Tips for Collective Action
Don't smoke. If you, stop. If you can't, cut down.	Don't be poor. If you are poor, try not to be poor for too long.	
Follow a balanced diet with plenty of fruits and vegetables.	Don't live in a deprived area. If you do, move.	
Keep physically active.	Don't be disabled or have a disabled child.	
Manage stress by, for example talking things through & making time to relax.	Don't work in a stressful low-paid job.	
If you drink alcohol, do so in moderation.	Don't live in damp, low quality housing or be homeless.	
Cover up in the sun, and protect children from sunburn.	Be able to afford to pay for social activities and annual holidays.	
Practice safer sex.	Don't be a lone parent.	
Take up cancer screening.	Claim all benefits to which you are entitled.	
Be safe on the roads: follow the highway code.	Be able to afford to own a car.	
Learn the First Aid ABC: airways, breathing & circulation.	Use education as an opportunity to improve your socio-economic position.	

Source: DoH (1999): Saving Lives: Our Healthier Nation. London: The Stationery Office

Source: Townsend Centre for International Poverty Research, University of Bristol

The Narrative of the Assets and Deficits Models

Review the paragraphs below and the brief critique that follows.

"Historically, approaches to the promotion of population health have been based on a deficit model…[They] tend to focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on…welfare services. These deficit models are important…but they need to be complemented by some other perspectives as they have some drawbacks. Deficit models tend to define communities and individuals in negative terms, disregarding what is positive and works well…In contrast 'assets' models tend to accentuate positive capability to identify problems and activate solutions. They focus on promoting salutogenic resources that promote the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.

Much of the evidence available to policy makers…about the most effective approaches to promoting health and to tackling health inequities is based on a deficit model and this may disproportionately lead to policies and practices which disempower the populations and communities…[which could] benefit from them. An assets approach to health and development… encourages the full participation of local communities in the health development process."[13]

A critique of the assets and deficits model narrative

While the deficits model may "define communities in negative terms," neither model looks to the causes—the production of negative conditions. The assets model functions within *the same narrative framework* as the deficits model, evading the power relations and interests that either purposefully, or as a by-product of satisfying investors, wreak havoc on the conditions necessary for healthy communities.

Researcher Lynn Freidli illustrates how the assets approach cannot "reverse the main avoidable causes of morbidity and mortality…[A]ssets-based literature is abstracted from any analysis of social injustice…" She also describes the ways in which its narrative functions as ideology to potentially achieve the following:

▸ Reinforce the view that the way in which poor people make use of welfare benefits (income and services) is morally flawed and unaffordable;

▸ Perpetuate the idea that 'a culture of poverty' produces psychological traits that trap people (and their children) in 'lives of destitution' and dependency; and

▸ Suggest that 'cycles of dependency and need' are characteristic not of the rich…but of the poor.[14]

Promoting self-esteem and coping abilities, gives the impression that psychological attributes and non-material assets (skills, wisdom) can explain differential health outcomes.

Dialogue/Reflection Questions

1. Most public health professionals understand the asset vs deficit frame and know how to apply asset frames to populations they serve. However, how does the assets strategy still link to narratives of individualism and free-market principles?

2. How does the assets model (and defining resilience as an asset) potentially distract attention from the source of inequity, and questions of political power?

3. Where do community deficits come from? Do individuals cause community deficits? What patterns have you observed regarding which communities have been subjected to health-harming conditions?

4. What is your experience and view of the assets/resilience approach in your own work? How has what you have read above shifted your insights? How can the asset approach obstruct eliminating health equity?

Racism as Overt Discrimination or Interpersonal Bias

Introduction

As indicated in Chapter 2, structural racism, in its material effects and as a strategic method of scapegoating, is typically under-examined, particularly in public health, partly because the power relations that sustain it are so thoroughly routine and deeply ingrained. As David Gillborn comments:

> "…white supremacy is not only…associated with relatively small and extreme political movements that openly mobilize on the basis of race hatred…rather, supremacy is seen to relate to the operation of forces that saturate the everyday mundane actions and policies that shape the world in the interests of white people."[15]

Framing the Relationship Between Race & Health

"Of all the forms of inequality, injustice in health is the most shocking and the most inhumane."
- Dr. Martin Luther King Jr.
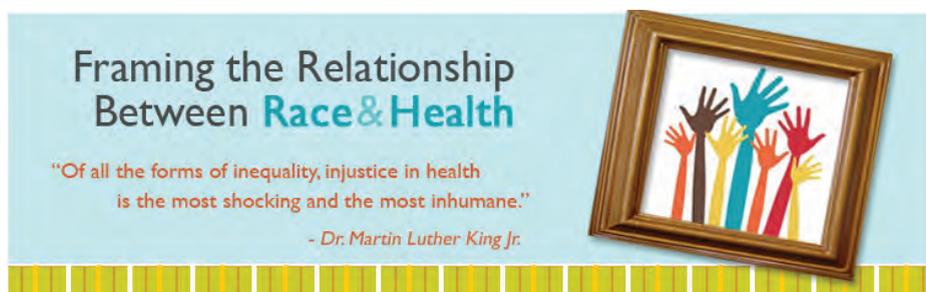
Source: Source: Access Kent, Kent County, MI; Health & Social Justice Workshops (2018)

Structural racism affects the public health response to inequity. Chandra Ford and Collins O. Airhihenbuwa explain that "the field's theoretical and methodological conventions inadequately address…[how] structural racism influences both health and the production of knowledge about populations, health, and health disparities…. Overconfidence in the objectivity of research can blind investigators to the inadvertent influence of a priori assumptions…."[16] For public health, the urgency for practitioners, as Mary Bassett states, is to "acknowledge the centrality of racism—the entrenched discriminatory practices of institutions, not only people."[17]

Example: *The Opioid Crisis*

A significant difference appears in reporting about the opioid crisis in white vs. black communities. Tessie Castillo, an advocacy and communications coordinator for the North Carolina Harm Reduction Coalition, asks why the opioid epidemic has had a more significant impact on whites. She notes three often stated responses:

1. "Whites are more likely than people of color to have access to health insurance and prescription opioids

2. "Bias among some physicians who prescribe painkillers.

3. "We still live in a largely segregated society, so a drug that becomes popular among a particular demographic stays largely limited to that demographic…"

Castillo contends that another explanation is more plausible: white privilege. She notices a number of responses by whites to their relatives, friends, or neighbors regarding opioid use:

1. "I couldn't believe my daughter was using heroin. I never thought something like this would happen to my family."

2. "We raised our children in a good family, How did this happen?"

3. "These kinds of things don't happen to us!"

In her view, an aspect of white privilege is "expecting a life free of pain. This can mean freedom from the pain of loss, discrimination, marginalization and criminalization, but also freedom from physical pain…." A number of analysts have noticed that black people in the same circumstances are characterized as addicts, rather than victims; that federal officials argue for more punitive policies toward users of color, who are defined as problematic and judged, compared to whites who are not ready to cope with the loss of work, the high cost of living, and other forms of suffering that should make us sympathetic.[18]

Dialogue/Reflection Questions

1. What do you notice about the explanations provided by Castillo? What are the assumptions?

2. How do the narratives for black people vs. white people affect our assessment of the causes and needs of each as well as our responses to each population.

3. In what ways do you see racism and white privilege operating in your institution? What narratives give rise to it or support it, if that is the case?

Example: *Flint Water Poisoning: Erasing the Origins*

The case of Flint Michigan's water crisis in 2015 illustrates how structural racism can become discernible or not through the narratives presented by both the state political system and the mass media. The dominant story in Flint presented the crisis as an effort to save city funds gone wrong. The Flint story is common and not unprecedented in other jurisdictions. It illustrates how racism, and its pervasive normality, can conceal the causes of a life-threatening public health crisis without proper context, dissipating social responsibility.[19]

FROM FLINT: Voices of a Poisoned City

DOC NYC 2016

Source: Flint, LLC, From Flint: Voices of a Poisoned City

Even when the Civil Rights Commission of Michigan issued a report, noting "the overrepresentation of people of color in decaying urban areas surrounded by greater wealth,"[20] discussion of ongoing, systemic racism in the media (e.g., red-lining, prohibitively high costs of water, environmental injustice, poor quality schools, housing and social services) still received inadequate consideration.
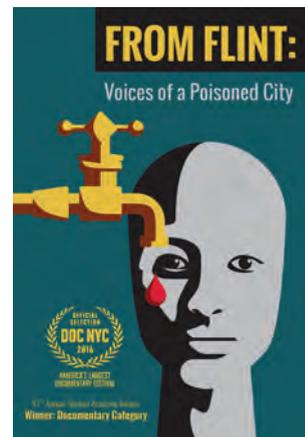
Dialogue/Reflection Questions

1. Why was it difficult to stay focused on the origin of the crisis? How might emphasis have been shifted to the root causes of racism and economic disempowerment?

2. What may have led the mass media to keep the narrative around the original decision to change the water supply and to discussions of how other communities can help distribute bottled water as opposed to deeper causes?

Unintended Racism: Examining Assumptions

Read the following passage from a document describing requirements for LHDs to fulfill public health's mission, for them to become the chief health strategist in their communities, based on changing conditions. The passage describes an expected demographic pattern over the next few years. What do you notice?

> By 2020…, the country will also be more racially and ethnically diverse, as the non-white population edges toward outnumbering the white population for the first time. And unless we tap new strategies to more effectively confront and reduce health disparities, not only will these disparities increase, they will jeopardize the overall health and well-being of our communities even more extensively….
>
> Health departments also will need to pay greater and greater attention to people of color and Latinos, Asian-Americans, and other immigrants, challenging the stereotype as "burdens to society." Demographic shifts may also be accompanied by socioeconomic changes such as a growing income gap and concurrent inequalities in health outcomes.[21]

?

Dialogue/Reflection Questions

1. What stands out for you in this segment as particularly surprising or unexpected?

2. What if anything do you notice about how they have explained the likely increase in health "disparities"?

3. How might reactions to the demographic trend described in the opening sentence vary depending on the race of the reader?

4. The paragraph suggests that not only will health disparities increase but that they will "jeopardize the overall and well-being of our communities…" Who does "our" refer to? Who does the target audience for this report appear to be?

"I have the invisible hand of the market on line two. Should I put it through?"

Source: Mark Anderson, Andertoons

The Self-Regulating Free Market in Public Health

The self-regulating free market narrative has parallels with an individualistic narrative, (see Chapter 2) and supports the belief that individuals make choices, invisibly, autonomously and rationally. Communities acting collectively by making choices to protect themselves, relying on a public democratic process, have sometimes been interpreted as interference in the free market, e.g., regulation of land-use decisions, or rent control. This notion of market laws and imperatives can undermine public health practitioners in meeting statutory requirements and using their authority, especially in serving communities with limited political power over their life conditions, e.g., those subjected to having numerous sites and sources of pollution located in their neighborhoods. As the public becomes inured to conventional market explanations,

it can become more susceptible to the belief that the market determines things like drug prices, the cost of health-care or, more broadly, that an invisible, abstracted entity makes decisions.

Questions

1. How might the idea of the market as an "actor" or "natural force" enable powerful interests to avoid scrutiny and escape public responsibility for their actions?

2. The free, self-regulating market operates all around us unnoticed; what examples can you think of where our normalization of free market narratives subordinate public health values and elevate market values?

3. What is the effect of anti-government narrative? How might free market narratives determine the future of Medicare?

"There will be a bit of a wait while we figure out a market solution to your problem."

Source: Barbara Smaller, New Yorker Collection

The Power of the Supermarket Display: Normalizing a Dominant Market Narrative in Everyday Experience

Source: Mike Mozart, flickr

Many educational campaigns against obesity are devoid of social context. The extraordinary increase in the rate of obesity since the late 1970s is not likely a result of random, individual purchasing decisions. Such a view influences health promotion efforts toward making informed purchasing choices, and ignores the role of agribusiness, supermarket chains, and advertising. Laws, available knowledge, and the economic and social position of populations play a significant role, especially those who often lack the means to realize healthier life circumstances.

Review the image of the cereal aisle in a typical supermarket. What do you notice?

Dialogue/Reflection Questions

1. What stands out to you about this product display? How might this display exemplify the expression of a public narrative? What is being "sold" beyond the sale of products?

2. How does the display support a dominant narrative that harms health? What does this type of display symbolize?

3. Unbeknownst to most consumers, these cereal products are made by four or five companies? How does that affect the meaning of choice?

Exercise

Envision yourself in a typical US grocery store. See the shelves surrounding you. Observe the strategically placed products, in the aisles and on the end caps.

▶ How is a supermarket like a theater or an exhibit? Could it be seen to have similar characteristics?

▶ What would a shelf display look like that provided knowledge about the health implications for the aisle as a whole?

▶ Would there be signs with statements about the amount of sugar, processed, high-fat ingredients? Should there be warnings about health implications from eating the products?

▶ What would a location for the sale of food look like that a) contained only healthy ingredients? b) existed in a society where people could assume that food was safe and healthy?

Now envision yourself in a grocery store designed to respond to the issues and narratives we are trying to disrupt.

▶ Imagine the walls of the supermarket displaying where food comes from, who produces it, under what conditions, and for what wages.

▶ Imagine a food system built on different assumptions and values than what we have now? What narrative themes do you imagine?

▶ Why do we accept the idea that food producers and sellers may offer for sale whatever they wish and that those who purchase must fight for ways to protect themselves? What narrative supports that acceptance? What stands in the way of responding more effectively to these structural challenges?

Weakening Democracy and Political Equality

Chapter 2 briefly described the importance of democracy and political equality to the public's health and recent threats to democratic institutions, including the constant assault on government. Sometimes the concept of government, particularly as a bureaucracy, gets confused with the public's role in a democracy and its values. Many unaccountable decision-making mechanisms lie outside the reach of traditional democratic processes or otherwise remain hidden from public scrutiny.

Health depends on having control over societal decisions and resources that affect life's conditions. Those populations with the least amount of political power over the prerequisite conditions for health tend to face the most social and environmental hazards and suffer the poorest health. How decisions are made locally and how power is used, shared, controlled and influenced have significant effects on health outcomes. Narratives that explain democracy as political equality play a critical role.

Dialogue/Reflection Questions

1. In what ways have you observed the lack of understanding of democracy, either in the community or among the health department staff?

2. How can local public health departments participate with allies in the community and other agencies to uplift a public narrative to ensure greater public participation, transparency, and accountability for decisions that promote or harm health?

3. What hinders broader dialogue about democracy in this society? How might the health department establish more venues for dialogue and debate in the community that could promote a more open, accountable process to advance health equity as a goal?

An Experiment: *A Town Hall Meeting*

Can social justice and health equity be discussed openly in your community—within the health department and across other agencies? If not, try an experiment.

Within a suitable venue, organize and promote an open meeting to the public. Subject: "Why Can't We Talk About and Promote Social Justice in Our Community Without Fear and Intimidation?"

Suggestion: Introduce as follows: Will greater discussion of social justice and health equity cause riots? Violence? Will there be a breakout of diseases? What are those who try to squelch such discussion so afraid of? Where does their power come from to control the narrative(s) that govern public health? What are we planning to do about the "spiral of silence"? Can we build solidarity and mobilize a constituency? What are our values?

Dialogue/Reflection Questions

1. What are the likely outcomes?

2. How can this type of experience build support and power for advancing a health equity narrative? What are some obstacles?

Activity: Comparing Citizen vs Expert Knowledge

Review the chart below with a peer and discuss the differences between local knowledge and professional knowledge. What knowledge might be lost when professional, scientific analysis excludes knowledge from community members who experience inequity?

Local vs. Professional Knowledge

Knowledge Production Question	Local Knowledge	Professional Knowledge
Who holds it?	Members of community—often identity groups/place specific	Members of a profession, university, industry, government agency; sometimes sophisticated NGOs
How is it acquired?	Experience; cultural tradition	Experimental; epidemiologic
What makes evidence credible?	Evidence of one's eyes, lived experience; not instrument-dependent	Highly instrumentally mediated; statistical significance; legal standard
Forums where it is tested?	Public narratives; community stories; media	Peer review; courts; media
Action orientation	Precautionary/preventive; consensus over causes not necessary	Scientific consensus over causal factors; further study in the face of uncertainty

Source: Jason Corburn (2005) Street Science: Community Knowledge and Environmental Health Justice. Cambridge, MA: MIT Press, Table 2.1: 51.

Use the chart above to think about a health equity issue you work on or are concerned about. Apply the questions in the first column to determine the extent that professional knowledge and local knowledge affect the analysis.

Example: *Mass Incarceration and Weakening the Power of Communities of Color: Expanding the Public Health Response and its Narrative*

Since at least 2005, mass incarceration has been recognized as a public health issue, but not always in its full dimensions. Mass incarceration can be described as an epidemic in itself: steeped in racist practices within the broader criminal justice system, and a form of structural violence, as the social ecology of communities of color deteriorates.

Source: iStock.com/MCCAIG

The provision of assistance by public health practitioners to those returning from prison and their families is a significant advance. However, without an appropriate explanatory narrative for its pervasiveness and continuity, ending the system will prove extremely difficult. Why? The central purpose behind mass incarceration, although shifting in scope and method, has invariably involved a deliberate practice to weaken the political power of communities of color.[22] This practice has its roots in slavery and the post-Civil War struggles to gain political power from Reconstruction, through the civil rights, Black Power, farm worker, and other social movements for racial and economic justice in the 1950s and 60s. Explaining its growth and devising strategies for its demise require a narrative detailing its integration with a racialized, exploitive economic system.[23] The dominant narrative, seeking to rectify flaws, policies, and practices in the criminal justice system, ignores the relation to racialized practices that emerge at similar

moments. It further rationalizes the system, by playing upon the public assumption that the increase simply means more people committed crimes, dismissing the characterization as social injustice.

Sociologist Loic Wacquant contends that mass incarceration (and the penal system in general) must be grasped not only in policy terms, or even to its connections with economic restructuring and punishment strategies. Instead, he suggests thinking of the penal system as a form of cultural representation and symbolic power, linked to changing economic realities. He argues for exploring symbolic power "and practical arrangements [which]…work to join the penal sanction and welfare supervision into a single apparatus for the cultural capture and behavioral control of marginal populations."[24]

Dialogue/Reflection Questions

1. What is the narrative explanation and connections among the following events that are related to mass incarceration?

‣ Elimination of the voting franchise and political voice

‣ Relocating prisoners to areas out of their zip codes to reduce their numbers in the census count of a given jurisdiction

‣ Leaving prisoners too weak and demoralized on release to engage in organized political action.

‣ Sustaining stereotypes of deviance

2. What's the missing narrative explanation between mass incarceration and:

‣ Prison labor

‣ Increasing numbers of prisons built and more privately-run prisons requiring prisoners

‣ Growing inequality, economic insecurity, and dislocation

‣ Warehousing the dispossessed, unemployed

‣ How does the prison serve as a spectacle of state authority and power? What is the spectacle meant to convey? To distract?

3. What do you notice about mass media explanations about the cause of mass incarceration?

‣ How and why does the history of mass incarceration escape the attention of the public, especially its ties to slavery, and evolving forms of racism?

‣ What conclusions can we draw from the omission of the ties between mass incarceration, the privatization of prisons and the Voting Rights Act of 1965 from the debate?

‣ If we were to change the narrative such that it encompass a transformation in public health practice, (beyond necessary service delivery to those reentering their communities) what would it look like?

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KEEP CALM AND SUBVERT THE DOMINANT PARADIGM

SUBVERTING DOMINANT PUBLIC NARRATIVES

Introduction

This chapter explores methods to recognize and subvert dominant public narratives, revealing the interests and mechanisms that sustain them, especially in everyday experience. These methods of inquiry requires enhancing perception, engaging in contextual thinking and examining why these narratives succeed or fail, with examples and activities.

Subverting dominant narratives asks us to dig deeply into long-held assumptions, in a web of meaning mostly invisible, unexpressed, and taken for granted. This is challenging but also hopeful and empowering, as we learn to become active as narrative strategists, responsive to social injustice. Obstacles arise in subverting narratives because the structures and systems of economic and political power in which they operate are not often *consciously* experienced. As expressions of power, narratives can support or contradict embedded beliefs, but rarely lead to a thorough examination of the stories that underlie the justification for these structures of power. Below is a description of some linked features of narratives, with examples, that we will examine throughout the chapter.

Features of Dominant Narratives

FEATURE	EXAMPLE
Dominant narratives absolve people and institutions of responsibility for social injustice.	Economic crisis said to be caused by markets, mistakes, unfortunate events, rather than decisions and choices made by institutions and networks of power.
Dominant narratives justify policy decisions by quantifying them with a precise cost to give the appearance of objectivity, even when the value of social goods, such as education, have value and benefit that cannot be determined by its cost as an ordinary commodity.	Cost-benefit analysis used to determine market values or prices to things including clean air, water quality, and non-renewable natural resources.
Dominant narratives use economic indicators—rather than social indicators of well-being—as main measures of value and importance, including human life.	Dow Jones Industrial Average, productivity, consumer confidence, GDP, earnings ratios.
Dominant narratives use coded racial language to feed on insecurities of the white majority; they stoke resentment and distract from threats that might otherwise unite people across racial groups, such as concentrated wealth and the destruction of the environment	Coded racial words and phrases like inner city, color-blind, states' rights, welfare queen, tough on crime, and government handout are used to denigrate public services that are needed and paid for by all, but become associated with minority groups.
Dominant narratives underwrite social divisions and drive wedges among racial groups, workers, genders, and other groups so that they do not see their common concerns.	Relies on othering, stigmatizing, categorizing, and creating competition, hierarchies, and divisions by social status
Dominant narratives position people as consumers rather than citizens; choices are defined through individual consumption rather than broad social policy, serving as a substitute for democracy	Freedom is defined as choice to buy, sell, own, have purchasing preferences, yet not as having civil rights, or making democratic decisions based on living conditions or social accountability
Dominant narratives blame people for their own condition by placing the cause of their problems on the individuals themselves, and not on systems that generate inequity	Causes of illness are due to personal irresponsibility
Dominant narratives depoliticize public conflict and issues by removing issues and conflicts from political influence and translating them into technical problems	Widespread pollution should be resolved through private negotiation among parties rather than class actions suits in the courts; pesticide company agrees to reduce toxicant in water by three parts per billion rather than end production of the product

Interrogating Dominant Public Narratives

Interrogating dominant public narratives is a method of critique to demystify power by making relevant and visible the processes, practices, and sources of social injustice. It involves exposing and disrupting dominant narratives to reclaim a script rooted within a social justice perspective, enabling the expression of those often silenced.[1]

Initial Steps to Develop for General Strategies to Subvert Dominant Narratives and Reaffirm Narratives in Support of Social Justice

▶ Strengthen organized groups of residents with common concerns that can communicate shared experiences and undermine dominant narratives, as well as building solidarity among them.

▶ Express a vision for dramatic social transformation by showing the possibility for a society without exploitation and racism, based on reciprocity and collective responsibility.

▶ Build a common agenda for advancing the *social* health of the community.

▶ Support the need for the collective health and well-being of communities over the interests of investors.

▶ Create public awareness of dominant narratives: contrast how they normalize social injustice with narratives that value human need and social and economic equality.

▶ Identify and publicize how and why the history, lives, needs, and voices of some populations get overlooked or suppressed.

▶ Name the institutions and structures of power that perpetuate social injustice and how.

▶ Expose how dominant narratives perpetuate "whiteness" as a norm or standard.

▶ Expose the illusion that power and hierarchies in society are natural and permanent.

▶ Explore the power of public narratives for advancing social justice

Skills for Engaging in Narrative Critique and Transformation

How do we engage in this work? How can people prepare themselves to question many accepted dominant public narratives by awakening public consciousness of their existence and the threat they pose?

The method involves exploring the relationship between knowledge, meaning, and power. Critical thinking is about curiosity, learning through questioning, reflection and investigating reality, rather than viewing it as given and unchangeable. Perhaps most important is recognizing the situations and perspectives of others.

Some of the skills include the following:

▶ Improving inquiry and observation that lead to questions not usually asked about political power. For example, how does structural racism explain why blacks have 2.5 times the infant mortality rate than whites? How has the decimation of labor unions led to stagnant wages?

▶ Learning how to look, listen, diagnose, and "read" ordinary events and language, etc. for political content, impact and meaning. For example:

- • How did time became a form of control and discipline in the workplace during the Industrial Revolution; a commodity for sale?

- • How does advertising invest objects with human capacities and represent a way of life, where consumption becomes a substitute for social change or even community? How and why did advertising become an art form?

- • Why are Native American tribes disrespected and insulted by naming sports teams after them, trivializing and exploiting their culture, while ignoring their oppressed history and contributions? What perpetuates it?

▶ Drawing attention to organized networks of concentrated power, e.g. the Chamber of Commerce, trade associations, the Business Roundtable, American Bankers Association, mass media, and others to continually ask, "Whose voices are the most powerful/influential? Whose voices are absent or ignored?"

▶ Demonstrating linked threads across seemingly disparate events or decisions, e.g., voter suppression, mass incarceration, privatization, gerrymandering as weakening the political power of communities of color and communities with limited resources.

▶ Identifying patterns that damage the health and well-being of populations, e.g., the slow violence of killing people over decades with toxic products, locating hazardous waste sites in communities of color, and in communities with limited resources.

▶ Noticing absences of social context, missing information and vital pieces of knowledge, others' interpretations of events that obscure realities of power, e.g., the Great Recession of 2008 was caused by bad business decisions and human weakness, rather than the financial dynamics, uncontrolled speculation, and the influence of large corporations.

▶ Learning from historical and current examples of resistance: African American spirituals and other covert forms of cultural resistance in the form of evasions, sabotage, non-compliance in everyday life, beyond either well-documented historical events or visible behavior.

Examples of Resisting Dominant Narratives
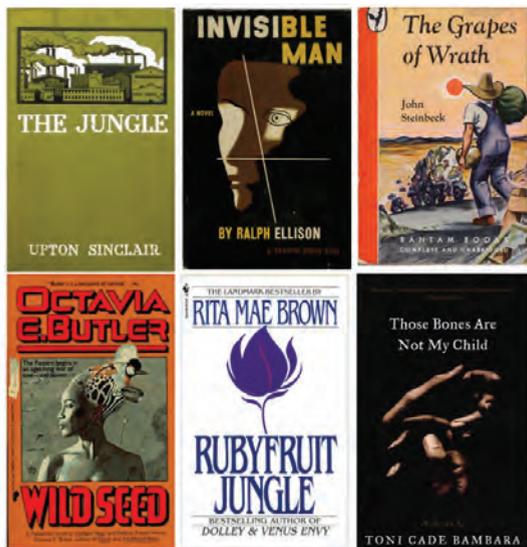
The Power of Narrative Fiction

Fiction plays a critical role in the potential for potentially embedding a social justice narrative in society through inscribing values and developing character in readers. Novels and short stories have the power to transform how people see the world and learn the stories of other cultures, as well as providing a critical window into what we cannot see in our own culture. They can represent structures of power and help us know our own history through other eyes. This ability occurs not through argument or evidence but by the way in which readers identify with characters and the values of invisible narrators as a story unfolds. Consider, for example, the influence of novels such as the *Grapes of Wrath, The Color Purple, The Handmaid's Tale, Freedom Road, Those Bones are Not My Child, The Jungle*. Narrative fiction has been a useful pedagogical tool and strategy in teaching about societies: systems of domination and subordination, historical legacies and culture.

John Bellamy Foster, in the excerpt below, provides a window into how John Steinbeck's fiction, *Grapes of Wrath*, can offer insight into invisible, opaque structures of power and class relations that may lead to critical thinking.

Example: *Fiction and Explanation: A Scene from* The Grapes of Wrath

In John Steinbeck's *The Grapes of Wrath*, an enraged Okie tenant farmer, a victim of the Dust Bowl and the Great Depression, wants to know, as he is being removed from his farm by the bank, who he can shoot. The tractor driver who comes to demolish his house says it would do no good for the farmer to shoot him, since he's just an ordinary working stiff doing his job and would be quickly replaced by another. When the farmer counters that he will then shoot the person who gave the order, the tractor driver replies that this too would be useless, since that individual is simply a bank employee.

> "Well, there's a president of the bank," continues the farmer. "There's a board of directors. I'll fill up the magazine of the rifle and go into the bank."
>
> The driver said, "Fellow was telling me the bank gets orders from the East. The orders were, 'Make the land show profit or we'll close up.'"
>
> "But where does it stop? Who can we shoot? I don't aim to starve to death before I kill the man that's starving me."
>
> "I don't know. Maybe there's nobody to shoot. Maybe the thing isn't men at all. Maybe, like you said, the property's doing it. Anyway I told you my orders."
>
> "I got to figure," the tenant said. "We all got to figure. There's some way to stop this. It's not like lightning or earthquakes. We've got a bad thing made by men, and by God that's something we can change." The tenant sat in his doorway, and the driver thundered his engine and started off….The iron guard rail bit into the house-corner, crumbled the wall, and wrenched the little house from its foundation so that it fell sideways crushed like a bug….The tractor cut a straight line on, and the air and the ground vibrated with its thunder. The tenant man stared after it, his rifle in his hand. His wife was beside him, and the quiet children behind. And all of them stared after the tractor.

The problem faced by Steinbeck's hapless tenant farmer is that there seems to be no individual or group of individuals who are ultimately responsible and accountable for the economic decisions that are harming people all over the country. …. The relation between the haves and the have-nots is clear, but the opacity of the market and the impersonality of it all nonetheless seem to constrain the possibility of active rebellion.[2]

Dialogue/Reflection Questions

1. How does Steinbeck show us something about political power without technical language?
2. How does Steinbeck's description of the farmer's situation make you feel?
3. In what ways can evoking emotion be used to either support or challenge dominant narratives?

Activity: Teaching by Seeing Context

"The Lives Behind the Labels: Teaching About the Global Sweatshop" by Bill Bigelow

Introduction: The following excerpt is part of a teaching activity seeking to develop a reflective capacity about hidden past and current history that rarely gets written and voices mostly never heard. It demonstrates an approach to revealing through discovery the invisibility of power and a method for "seeing" beyond the what is physically observable. In a lesson with his high-school class on global studies, Bill Bigelow sets a soccer ball on a stool in the middle of student desks. He asks them to write a paragraph or two describing the ball. Students were reluctant or uninspired.

Instruction: Read the excerpt from "The Lives Behind the Labels."

I began the lesson with a beat-up soccer ball. The ball sat balanced in a plastic container on a stool in the middle of the circle of student desks. "I'd like you to write a description of this soccer ball," I told my high school Global Studies class. "Feel free to get up and look at it. There is no right or wrong. Just describe the ball however you'd like."

Looks of puzzlement and annoyance greeted me. "It's just a soccer ball," someone said.

Students must have wondered what this had to do with Global Studies. "I'm not asking for an essay," I said, "just a paragraph or two."

As I'd anticipated, their accounts were straightforward—accurate if uninspired. Few students accepted the offer to examine the ball up close. A soccer ball is a soccer ball. They sat and wrote. Afterwards, a few students read their descriptions aloud. Brian's is typical:

The ball is a sphere which [sic] has white hexagons and black pentagons. The black pentagons contain red stars, sloppily outlined in silver... One of the hexagons contains a green rabbit wearing a soccer uniform with "Euro 88" written parallel to the rabbit's body. This hexagon seems to be cracking. Another hexagon has the number 32 in green standing for the number of patches that the ball contains.

But something was missing. There was a deeper social reality associated with this ball—a reality that advertising and the consumption-oriented rhythms of U.S. daily life discouraged students from considering. "Made in Pakistan" was stenciled in small print on the ball, but very few students thought that significant enough to include in their descriptions. However, these three tiny words offered the most important clue to the human lives hidden in "just a soccer ball"—a clue to the invisible Pakistanis whose hands crafted the ball sitting in the middle of the classroom.

I distributed and read aloud Bertolt Brecht's poem "A Worker Reads History" [1935] as a tool to pry behind the soccer-ball-as-thing:

Who built the seven gates of Thebes?
The books are filled with names of kings.
Was it kings who hauled the craggy blocks of stone?...
In the evening when the Chinese wall was finished
Where did the masons go? Imperial Rome
Is full of arcs of triumph. Who reared them up?...

Young Alexander conquered India.
He alone?
Caesar beat the Gauls.
Was there not even a cook in his army?...

Each page a victory.
At whose expense the victory ball?
Every ten years a great man,
Who paid the piper?

"Keeping Brecht's questions in mind," I said, after reading the poem, "I want you to re-see this soccer ball. If you like, you can write from the point of view of the ball, you can ask the ball questions, but I want you to look at it deeply. What did we miss the first time around? It›s not 'just a soccer ball.'" With not much more than these words for guidance—although students had some familiarity with working conditions in poor countries—they drew a line beneath their original descriptions and began again.

Versions one and two were night and day. With Brecht's prompting, Pakistan as the country of origin became more important.

Tim wrote in part: "Who built this soccer ball? The ball answers with Pakistan. There are no real names, just labels. Where did the real people go after it was made?" Nicole also posed questions: "If this ball could talk, what kinds of things would it be able to tell you? It would tell you about the lives of the people who made it in Pakistan... But if it could talk, would you listen?" Maisha played with its colors and the "32" stamped on the ball: "Who painted the entrapped black, the brilliant bloody red, and the shimmering silver? Was it made for the existence of a family of 32?" And Sarah imagined herself as the soccer ball worker: "I sew together these shapes of leather. I stab my finger with my needle. I feel a small pain, but nothing much, because my fingers are so calloused. Everyday I sew these soccer balls together for 5 cents, but I've never once had a chance to play soccer with my friends. I sew and sew all day long to have these balls shipped to another place where they represent fun. Here, they represent the hard work of everyday life." When students began to consider the human lives behind the ball-as-object, their writing also came alive.

Geoffrey, an aspiring actor, singer, and writer, wrote his as a conversation between himself and the ball:

"So who was he?" I asked.

"A young boy, Wacim, I think," it seemed to reply.

I got up to take a closer look. Even though the soccer ball looked old and its hexagons and other geometric patterns were cracked, the sturdy and intricate stitching still held together.

"What that child must've gone through," I said.

"His father was killed and his mother was working. Wacim died so young... It's just too hard. I can't contain these memories any longer." The soccer ball let out a cry and leaked his air out and lay there, crumpled on the stool. Like his master, lying on the floor, uncared for, and somehow overlooked and forgotten."

Students had begun to imagine the humanity inside the ball; their pieces were vivid and curious. The importance of making visible the invisible, of looking behind the masks presented by everyday consumer goods, became a central theme in my first-time effort to teach about the "global sweatshop" and child labor in poor countries.[3]

Dialogue/Reflection Questions

1. What are some examples from everyday life in the products or services we rely on where we fail to notice or consider the labor that went into their production or how they came into your hands?

2. When you think about your day-to-day work, are there processes in place that support your ability to think critically? Do you, for example, have interactions with your colleagues that lead you to think differently about your work?

Mural Art: The Political Murals of Judy Baca

Source: SPARC, Judy Baca, "Triumph of the Hands" from World World: A Vision of the World Without Fear"

The murals of Latinx artist Judy Baca reflect the lives and concerns of populations that have been historically disenfranchised, including women, the working poor, youth, and elderly and immigrant communities. Public art is a means for political transformation, particularly for representation of those with no public voice. Its great potential is to democratize artistic expression. Baca's images present history from the perspective of those who have not always been recognized—women, minorities, queer people. They create the possibility for social action that can transform communities. But her art emerges from a collective process through meetings of community residents to retell their stories and describe their experiences, as well as to participate in the making of the murals. People see themselves as part of the larger struggles. She refers to the location of the murals as "sites of public memory."

Source: Eddie Holly

Film: *Get Out!* (2017) Directed by Jordan Peele

Get Out! has been classified as a horror movie and a comedy, while it also expresses the uncertain state of American race relations. Peele is quoted as saying: "Call it what you want, but the movie is an expression of my truth, my experience, the experiences of a lot of black people and minorities. Anyone who feels like the other.…. I'd never seen my fears as an African-American man onscreen in this way." Peele's film, as described by film critic Richard Brody "uses devices and situations in order to defamiliarize them…in order to make commonplace, banal experiences burst forth like new to convey philosophically rich and politically potent ideas about the state of race relations in America." Peele "depicts the white world as seen through Chris's [the main character] eyes….Seemingly innocuous or merely peculiar things become charged with personal and political meaning."[4]

Look at this image. What if all the advertisements that surround us every day changed to reveal the underlying messages seen in this photo?

I cannot be blind to the invisible system of privilege I am a part of.

Exercises to Interrogate Dominant Public Narratives

The exercises that follow provide guidance to identify and subvert dominant narratives. These exercises are divided into three sections: 1) racism, 2) social and economic inequality, and 3) public health.

Identifying and Interrogating Dominant Narratives that Support Structural Racism

Exercise: Dog Whistle Politics: Racial Codes and the Discourse of Racism

Introduction: Racial codes are a form of strategic racism, designed to scapegoat communities of color by assigning to them blame for various social ills and deflecting attention from actual causes.[5] Racial codes, or dog whistles, avoid referring to race but are implicitly understood by the targeted audience. Just as human ears cannot hear the whistle that dogs can, these codes can be understood as implicitly supporting racist views. Coded language appears to mean one thing to the general population but has a different resonance for the particular sub-group for whom it is intended. For example, the term "inner city" is often understood by many white people to apply to (and imply that) people of color are the residents who live there with higher crime rates. Similarly, the use of the phrase "post-racial society" is understood as a dog whistle for not needing to pay attention to racism; that the civil rights movement somehow resolved racism.

Instructions: Investigating Racial Codes. Pair-up with another person and together review each term and its meaning in the chart below. Discuss your familiarity with the terms and phrases and your own interpretation and experience with them. Add examples of your own. Discuss how each term promotes or sustains racialized processes. (According Professor of African American Studies at USC Berkeley, john powell, "'racialization' connotes a process rather than a static event. It underscores the fluid and dynamic nature of race..... [These processes] may or may not be animated by conscious forces."[6])

Dog Whistle Racial Codes

Code	Meaning
It's a post-racial society. Obama was elected twice.	Structural racism doesn't exist, only individual bias. No need to discuss further.
Throwing money at poverty won't solve it.	No taxes for food stamps, housing, public welfare.
Make America Great Again.	Make America White Again.
Law & Order	Suggest tough penalites, show racial images of crime, police should have no risk.
Illegal immagrants commit crimes.	Exclude Latinos and we'll pay less taxes; keep America white.

Dialogue/Reflection Questions

1. Have you heard any of these codes in your personal or professional life?
2. Can you think of examples of this type of coded language in the field of public health?
3. How does racially coded language make it more difficult to talk about health inequities?
4. How does recognizing racial codes help us see/think differently about racism and the steps needed to dismantle and subvert racism?

COLORBLINDSUPPRESSESNARRATIVESOFOPPRESSION

For Further Reflection

The concept of "Colorblind" and its uses

The overt message is that the process or behavior under discussion is fair because it purports to not take race into account. The subgroup being addressed might be white people who resist challenges about the fairness of their actions or the institutions they represent. Or it might be addressed to whites who resent affirmative action and or policies supporting a remedy for racial discrimination. The covert message may be, "We are not going to deal with this issue, no matter how much 'they' complain." Colorblindness can serve to promote and sustain racialized processes that lead to unequal outcomes.[5] This may not be the conscious intent, but the result is failure to address racially unjust outcomes.

White people may invoke the concept, when uncomfortable acknowledging racial inequities reinforcing the idea that "The status quo is fine; bringing up race is not acceptable." Colorblindness dismisses the significance of race in situations where discrimination takes a milder form, devaluing how race shapes life experience and opportunity, and preventing a more straight forward discussion of racial issues.[5]

Exercise: Racism and the Post WWII Concept of The American Dream, Part I

Introduction: The ideal of the American Dream, presented by James Truslow Adams in his 1931 book, Epic of America, was that America was a land where life would be better and more fulfilling for everyone. This ideal, based on an assumption of "life, liberty, and happiness, stemming from the Declaration of Independence, was that fundamental social divisions could be overcome. This concept has shifted dramatically over the decades among different audiences and has been deployed for different purposes such as to support rampant consumerism and materialism. Its central meaning today fits comfortably with the capitalist logic of endless growth, wealth accumulation, and competition. Nowhere does it respond to social divisions, including racism, class exploitation, and gender discrimination. Its images and values contain profound contradictions.

Source: iStock.com/Monkeybusinessimages

Source: iStock.com/Pamspix

Instructions: View the photographs above. Describe what you see. It is typical when searching the web for images of the American Dream to find similar photos.

In groups of four, engage in dialogue about the following questions. Ask one person to take notes on key points raised in the discussion to share with the large group.

Dialogue/Reflection Questions

1. In the two pictures above, what do you notice?

2. What do the images communicate to you about the American Dream?

3. Based on your own experiences, who and/or what might be missing from these depictions?

4. What part of the American Dream were you taught to value?

5. Where are the neighbors? Who is excluded? What's missing?

Exercise: The American Dream, Part II

Read the excerpt below from Robert Jensen's essay, *The Anguish of the American Dream*, February 2011.

> Whether celebrated or condemned, the American Dream endures, though always ambiguously. We are forever describing and defining, analyzing and assessing the concept....
>
> [The history of the concept] highlights the dreams of religious freedom, political independence, racial equality, upward mobility, home ownership, and personal fulfillment that run through U.S. history, but a concept used by so many people for so many different purposes can't be easily defined. Rather than try to organize the complexity, I want to focus on what has made the American Dream possible. That much is simple: The American Dream is born of, and maintained by, domination.
>
> By this claim...I mean that whatever the specific articulation of the American Dream, it is built on domination. This is the obvious truth on the surface, the reality that most dreamers want to leave out, perhaps because it leads to a painful question: How deeply woven into the fabric of U.S. society is the domination/subordination dynamic on which this country's wealth and freedom are based?
>
> First, the *American* part: The United States of America can dream only because of one of the most extensive acts of genocide in recorded human history.... Millions of people died for the crime of being inconveniently located on land desired by Europeans who believed in their right to dominate. Second...the idea of getting one's share of the American bounty is at the core of the American Dream. That bounty did not, of course, drop out of the sky. It was ripped out of the ground and drawn from the water in a fashion that has left the continent ravaged, a dismemberment of nature that is an unavoidable consequence of a worldview that glorifies domination....
>
> The American Dream is put forward as a dream for all the world to adopt, but it clearly can't be so. Some of the people of the world have had to be sacrificed for the dream, as has the living world. Dreams based on domination are, by definition, limited.
>
> A world based on domination/subordination is a profoundly unjust world and a fundamentally unsustainable world.
>
> The American Dream is inconsistent with social justice and ecological sustainability. So, I'm against the American Dream. I don't want to rescue, redefine, or renew the American Dream. I want us all to recognize the need to transcend the domination/subordination dynamic at the heart of the American Dream. If we could manage that, the dream would fade—as dreams do—when we are awake and come into consciousness....
>
> The future—if there is to be a future—depends on us being able to give up the illusion of being special and abandon the epic story of the United States. It is tempting to end there, with those of us who critique the domination/subordination dynamic lecturing the American Dreamers about how they must change. But I think we critics have dreams to give up as well. We have our epics of resistance, our heroes who persevere against injustice in our counter-narratives. Our rejection of the idea of the American Dream is absorbed into the Dream itself, no matter how much we object. How do we live in America and not Dream?[7]

Dialogue/Reflection Questions

1. How could this analysis help us think differently about what is needed to create a just society?

2. Does Jensen's perspective challenge your own view of the American Dream idea?

Exercise: A Stock Story

The civil rights movement (and the overlapping Black Power movement) had their narratives distorted over time in many ways. The struggle was long, continuing today, lasting for decades. Victories were won at the grassroots. People put their lives on the line, all over the nation, not just in the South. Over the years, mass media, government, and schools offered official interpretations, "stock stories," simplifying and limiting descriptions of the realities, especially ignoring efforts by state and federal agencies to undermine the movement and minimizing local struggles.

Law professor Richard Delgado, in an excerpt from a law review article, suggests how dominant groups communicate their "stock" stories that perpetuate racism and white privilege, supportiing a shared reality. He notes, "In the area of racial reform, the majority story would go something like this":

> Early in our history there was slavery, which was a terrible thing. Blacks were brought to this country from Africa in chains and made to work in the fields. Some were viciously mistreated, which was, of course, an unforgivable wrong; others were treated kindly. Slavery ended with the Civil War, although many blacks remained poor, uneducated, and outside the cultural mainstream. As the country's racial sensitivity to blacks' plight increased, the vestiges of slavery were gradually eliminated by federal statutes and case law. Today, blacks have many civil rights and are protected from discrimination in such areas as housing, public education, employment, and voting. The gap between blacks and whites is steadily closing, although it may take some time for it to close completely. At the same time, it is important not to go too far in providing special benefits for blacks. Doing so induces dependency and welfare mentality. It can also cause a backlash among innocent white victims of reverse discrimination. Most Americans are fair-minded individuals who harbor little racial prejudice. The few who do can be punished when they act on those beliefs.[8]

Dialogue/Reflection Questions

1. In Delgado's example, what parts of the story resonate with you?

2. Which parts ring hollow and why?

3. Can you think of any stock stories within public health that are used to explain health inequities?

Identifying and Subverting Narratives that Support Social and Economic Inequality

Exercise: The Minimum Wage Narrative

Introduction: Debates about the minimum wage exemplify previous discussions about stock stories, coded language and other mechanisms that reinforce dominant narratives. The exercise below is designed to engage you in exploring the narrative features of three hypothetical news stories presenting the case for and against raising the minimum wage. It examines distinctive features of a dominant narrative, including two distinct narratives from the labor perspective and consideration of their potential effect.

Instructions: Review the following stories, derived from synthesizing language found in three news articles about whether to raise the minimum wage. Story #1 represents the case typically put forward from a business perspective. Stories #2 and #3 are two different views of the case put forward by workers and their representatives.

Source: Ricardo Levins Morales

STORY 1: THE CASE AGAINST RAISING THE MINIMUM WAGE REPRESENTS THE TYPICAL RANGE OF POINTS MADE IN OPPOSING A MINIMUM WAGE INCREASE.

Markets should decide. Former Governor Jeb Bush has said that ideally each state's minimum wage would be decided by the "private sector." Gov. Scott Walker and Sen. Rand Paul have said much the same thing; Mr. Paul could have been speaking for this position [that markets establish reliable prices] when he said the "minimum wage is only harmful when it's above the market wage."

Businesses will be hurt. Conservative economists have said a higher minimum wage would make it impossible for American companies to compete with low-paying foreign rivals.

Robots will replace workers. Senator Marco Rubio has argued: "I don't want to deny someone $10.10. I'm worried about the people whose wages are going to go down to zero because you've made them more expensive than a machine."

Firings, Layoffs and Reduced Hiring. If the minimum wage rises to $15 per hour, businesses will either fire many workers because they cannot afford to pay, refuse to hire new workers, or simply move their businesses to other states or overseas where wage requirements don't apply.

Dialogue/Reflection Questions

1. What fears does the narrative play upon?

2. How does it reflect the interests of business?

3. What assumptions about the labor market are in the narrative?

STORY 2: CONVENTIONAL CASE FOR SUPPORTING THE MINIMUM WAGE INCREASE

A number of states have already adopted minimum wage levels of $10–$15. At the federal level, the wage has been raised 23 times, so this is not new. Since the minimum wage has not been increased since 2007, it is time for another increase.

Raising the wage is "a matter of economic justice." Nothing is accomplished without labor. The increases reflect the realities of inflation, which have reduced the value of the wage. The minimum wage today is not enough to support a family.

Increases worker bargaining power. Low-wage workers seldom have bargaining power to achieve increases on their own. An adequate federal minimum wage effectively substitutes for that lack.

Increasing the minimum wage reduces poverty, income inequality, and welfare spending. Poverty would decline for 4.6 million people. Fewer people would require public assistance.

Raising the minimum wage would lead to a healthier population and prevent premature death. The Minnesota Department of Health documents how income directly correlates with better health and economic stability. A study examining the health benefits of a local living wage ordinance from the San Francisco Department of Health demonstrated that health significantly improves across all diseases.

Dialogue/Reflection Questions

1. In what ways is this story different from the first story?
2. In what ways is the story similar with respect to being within the frame of the first?
3. What are the underlying assumptions?
4. Would the stated case for raising the minimum wage resonate with the general public? Why or why not?

STORY 3: FRAMING WORKING PEOPLE AS HUMAN BEINGS VS. CAPITAL OR COSTS.

People in their capacity as workers, should not be treated as disposable. The U.S. working class, has always struggled to obtain a living wage. They have been fought by business interests more concerned with earnings ratios and satisfying investor/stockholder demands than the fundamental life needs and health requirements of people who earn a wage.

People, in their role as workers, are not costs like any other; they actively produce wealth through their labor. Wage-earners are not commodities, and should not be treated as another cost, like building materials or machinery. Workers are human beings with fundamental needs and deserve to live, feed their families, and support their health and well-being.

Workers are not the "problem." The problem is the system that privileges profit over people. This happens when when increased vast profits can be made by shifting jobs or a supply chain to locations anywhere in the world. Business interests have done everything possible to weaken labor's power to bargain collectively, destroy their unions, and generally cheapen the value of labor. These business interests often have unions called trade associations.

"Markets" don't make decisions. Organized networks of people do. So-called "market imperatives" and phrases like "market realities" are euphemisms used by powerful corporations, which do not accept responsibility for devaluing people's lives in the name of endless economic growth, especially when inequality is at an all-time high.

Dialogue/Reflection Questions

1. How is this story similar to Story 2? How is it different?

2. What new dimensions does Story 3 add?

3. Why is the public often inclined or *ready to accept* the business perspective? What dominant narratives support its perspective?

Exercise: Why Do Newspapers Have A Business Section but No Labor Section?

Materials Needed: Selected articles (chosen by facilitator, hypothetical or (2) pre-given in this exercise: Three Handouts, one for the questions; the blank template for constructing a labor section for each participant; and sample articles from the business section of *The New York Times* and *The Washington Post* or local newspapers.

Introduction: Labor often appears to be a "factor," a cost of production, or a "problem" for business as reported in mainstream media. If true, such dehumanization may likely have implications for health and well-being. The exercise below examines how a narrative works within a practice: in this case the production of a business section of a newspaper, not only in the story content, but also in what is absent. For example, why no comparable labor section?

PART I

Instructions: Review selected articles from a recent business section of a newspaper in your jurisdiction and/or *The New York Times, The Washington Post*, or a series of papers from around the country.

Source: University of Washington, Labor Yearbook, 1930 (July 25)

Dialogue/Reflection Questions

1. What patterns/themes do you notice in the content of the business section? What types of stories appear most often?

2. What values and interests are reflected?

3. How is labor portrayed or perceived generally in the business section? In the newspaper articles that you are reviewing?

4. How are the needs and conditions of work portrayed for people who earn a wage?

5. What conventions in business reporting do you notice that support the dominant narrative? (Illustrate with sample headlines if available).

6. What types of stories do you think are missing in this section of the paper, e.g., corporate decision that affect the health of specific population groups?

7. Is there an assumption that the term working class refers to white working class?

The Daily Herald

LABOR

Sample Headline

Headline About Labor

Different News Headline Here

PART II

Instructions: Imagine if there *were* a labor section in newspapers. Set up a blank template (see below) to create a labor section. What types of articles or categories might be included? What types of headlines would we see? What effect would a routinely presented labor section have on people's consciousness about the lives of wage earners?

Potential Categories:

profiles of workers
health and safety issues
pay rates
health plans
sick and maternity leave
labor strike news
conflicts with management
working conditions
job markets
overall well-being of working people
union busting
capital strike news (disinvestment, moving jobs overseas)
racial and gender wage inequality

Exercise: Explanations for Poverty: The Narrative of Cause

Introduction: Poverty is mostly viewed through an individual lens, blaming people for their own condition, refusing to support assistance to those made poor. At best, poverty alleviation is the suggested response. However necessary, it does nothing to stop the constant production of poverty, or affect the rate of poverty. The role of structures of power, the effects of concentrated wealth, the likelihood of exploitation, and the threat of poverty as a means to weaken labor rarely receive public attention in the mass media explanations for poverty.

It is not uncommon to see the following:

I'M AFRAID YOUR SON HAS 'POVERTY'

@CARTOONRALPH

Source: Cartoon Ralph

> "The poverty rate falls with the state of the economy and is largely beyond our control. Solutions to the problem are elusive." (https://opportunityagenda.org/explore/resources-publications/shifting-narrative-poverty)

Dialogue/Reflection Questions

1. When you think about poverty, do you think that it can be eliminated by programs and services? Why or why not?

2. Does your answer change if you consider how different groups of people are made poor?

3. Do you see similarities in narratives about the causes of poverty and the causes of health inequities? If so, what are they?

4. How does the cartoon above critique the individualist and behavioral narrative of traditional health promotion?

5. How do the dominant narratives about poverty blame groups of people for their own condition?

Recognizing & Interrogating Dominant Narratives in Public Health

Exercise: Avoiding Underlying Causes

Introduction: This exercise explores a common description of health "disparity" and what needs to be done to address it. It engages participants in identifying distinctive features of dominant narratives in public health, and contrasts them with a social justice narrative to see if these themes reflect particular interests and values. It examines how the realities of health inequity are sometimes obscured within a bureaucratic style of writing that, consciously or not, avoids political content, root causes of health inequity, and even core features of the subject at hand.

Instructions: Read the following paragraph 1 from a 2011 issue of *Monthly Mortality and Morbidity Weekly* (MMWR), which describes requirements for reducing health disparities.

> "Differences in health based on race, ethnicity, or economics can be reduced, but will require public awareness and understanding of which groups are most vulnerable, which disparities are most correctable through available interventions, and whether disparities are being resolved over time. These problems must be addressed with intervention strategies related to both health and social programs, and more broadly, access to economic, educational, employment, and housing opportunities."[10]

Dialogue/Reflection Questions

1. What assumptions underlie this statement?

2. What actions are suggested or implied by this statement?

3. What is left unsaid or ignored?

4. What questions would you ask the author?

Now read another paragraph below about the subject.

> Significant differences in health outcomes among people of color and those underpaid or forced to live in poverty result from a legacy of structural racism and class oppression. Eliminating the differences will require exploration of how inequities occur through inequitable power structures that make people vulnerable. It will also require efforts to confront the legacy of social injustice with strategies related both to transforming political power and the ongoing pattern of decisions that generate poor living and working conditions.

Dialogue/Reflection Questions

1. What is different about the approach in paragraph 2?

2. In what ways does paragraph 2 clarify or not what may be missing in paragraph 1 from the point of view of a health equity agenda?

3. What sorts of actions are suggested by this second statement?

For Further Reflection

The first paragraph does not account for injustices including racism, and class oppression. It elides accountability for health inequity by suggesting that disparities can be corrected through mitigation, without social change as a possibility. In context, its approach may not be intentionally practiced to avoid controversy. It may simply be an unconscious statement of an unwillingness to notice that the stated differences are an injustice, not random, and why it matters.

The revised paragraph attempts to state the concerns about health inequity more explicitly. Neither paragraph is necessarily factually correct or incorrect. Notice how the first one avoids the reality of injustice and objectifies it, draining meaning from the subject it is supposedly discussing.

Exercise: Unfortunate Outcome or Inequity?

Introduction: The language used to characterize and explain inequitable health outcomes is often affected by implicit assumptions or beliefs that people hold but of which they are unaware. Such language can sustain stereotypes.

Instructions: Review each pair of sentences below. How would you characterize the distinction in each pair? Why might the distinction be important for creating awareness about the causes of health inequity?

Pair 1: Native Americans have the highest mortality rates in the United States.	REVISION: Dispossessed by the government of their land and culture, Native Americans have the highest mortality rates in the United States.
Pair 2: Low income people have the highest level of coronary artery disease in the United States.	REVISION: People underpaid and forced into poverty as a result of banking policies, real estate developers gentrifying neighborhoods, and corporations weakening the power of labor movements, among others, have the highest level of coronary artery disease in the United States.
Pair 3: Factors such as our race, ethnicity, or socioeconomic status should not play a role in our health.	REVISION: Social injustices including racism or class exploitation, e.g., social exclusion and marginalization, should be confronted directly, so that they do not influence health outcomes.
Pair 4: For too many, prospects for good health are limited by where people live, how much money they make, or discrimination they face.	REVISION: Decisions by landowners and large corporations, increasingly centralizing political and financial power wielded by a few, limit prospects for good health and well-being for many groups.

Dialogue/Reflection Questions

1. What is the difference between the first and second statement in each pair?

2. What does each convey about the population under discussion?

3. What public health actions, programs, or policies do the statements in the revision suggest are necessary to achieve health equity?

4. What are other examples from public health that might be similar?

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RECLAIMING A PUBLIC NARRATIVE FOR SOCIAL JUSTICE AND HEALTH EQUITY

Introduction: Rationale for Public Narrative Change Through Social Justice

Countering dominant public narratives only takes us so far. The next stage is to identify specific core values, beliefs and components of a socially just society, and then strengthening and sharing an effective narrative for health equity and social justice. This will involve a long-term collective effort, and the power to shape it arises from a democratic process. Guidance can be found within recent projects in several organizations,[1] along with literature overlapping numerous fields, including cultural studies, critical race theory, critical pedagogy, and studies of social movements, among others. We draw upon that work, but also have much to learn from many narratives that already exist and emerge, if not widely known, from oppressed, excluded, marginalized populations across the country, dispossessed and exploited by corporate interests and public policies that sustain a racialized inequitable society.

A first task is presenting a vision and a trajectory for advancing social justice that can mobilize a population to capture the imagination for a more just society.[2,3] Literary critic Fredric Jameson reminds us, "It is easier to imagine the end of the world than to imagine the end of capitalism."[4] Reimagining society from a health equity perspective must challenge numerous rules, conventions, and traditions, which make reorganizing public health practice within a social justice narrative seem daunting. A second task includes accepting that the reality of public conflict draws attention to inequitable uses of political power and its consequences for health.

This chapter provides suggestions and reflections to stimulate dialogue. It includes a) a definition of social justice (see Unit 5); b) elements and actions to advance a social justice narrative; c) examples of these elements in past and present social justice movements; d) an example from contemporary public health practice; and e) activities distinguishing questions and concepts used in every day practice. The last part includes guidance in envisioning a story of public health that emphasizes health equity as a core mission.

Defining Social Justice for the Present

The modern narrative for social justice arose, with various meanings, during the latter part of the Industrial Revolution in the late 1840s. This is also the period when it becomes central to public health.[5] Historically at least two features define it from that period. First, it refers to equity, both in the control over working and living conditions and the uses of public resources. This includes the elimination of social injustice: the negative, pervasive effects of privilege, power, hierarchy, domination and exploitation. Racism, class, and gender oppression are basic categories in which inequality manifests as a primary instance of social injustice.

Inequality tends to undermine the second feature of social justice—democracy—the path to political equality. A fully formed democracy always depends on the willingness of large numbers of people to participate in social movements. These movements are aimed at collective empowerment of *whole classes of people,* e.g., women, people of color, workers, youth, the aged, immigrants, the LGBTQ community. They support the social relations and a narrative necessary to expand their collective power.

A thriving democracy requires more than formal processes, including voting. Instead, it depends on people's full collective engagement in all core institutions that shape their lives, such as family, schools, local government and businesses. A central goal is greater popular control over basic social decisions about production, distribution and use of public resources, education, expression of identity, and so on. Its roots derive from the value of inclusion rather than exclusion. Democracy is only possible if equality, participation, accountability and mutual respect are embedded in society's institutions.

In addition to these two features, social justice supports ensuring the ability of oppressed groups to express their identity, culture, and language, affirming differences among them and choosing to participate in any community without restrictions.[6] Realizing these goals requires not merely redressing or ameliorating inequity but creating a society that does not produce social and economic inequality.

Suggested Elements for Advancing an Effective Public Narrative for Social Justice

A public narrative based on social justice principles clearly expresses its values; it is not code for something else. For example, current anti-government rhetoric serves as a false representation which is actually fostering opposition to democracy, even if segments of the population remain unaware of the consequences. The fervent and uncritical belief in free markets is also a means of distracting attention from those responsible for decisions that generate health inequity. What does a social justice narrative require to embed itself successfully in society? Here are some elements to consider:

12 Elements for advancing social justice through narrative

▸ Provides a vision for a socially just society that is desirable, clear, and possible.

▸ Makes social injustice visible;

▸ Encourages incorporating the specific *language, beliefs, values,* and cultural representations of social justice, equality, and democracy as a normal feature of political objectives and practices;

▸ Directs *attention to the root causes of health inequity*, distinguishing between action emphasizing mitigation vs. confronting social injustice through social change;

▸ Demonstrates that oppression and inequality are *produced*, not random or the result of inevitable unnamed "forces";

▸ Acknowledges and reinforces the voices and stories of those who experience social injustice, and illustrates how they represent the shared experience of all people;

▸ Ensures that those in dominant groups become aware of their own privilege and power, and racial, economic and gender location;

▸ Emphasizes *social and political indicators* of health and well-being, such as measures of quality and distribution of safe and affordable housing, quality of education by neighborhood, levels of public investment by neighborhood, and participation in public decisions;

▸ Provides effective *explanations* for economic, social and political injustice—the context to produce health and illness;

▸ Builds *permanent alliances* with community organizers and residents;

▸ Exposes and dramatizes social injustice so that it is recognized as a public or common concern, and experienced as shared, rather than as individual and isolated problems; and

▸ Engages in political education to increase the knowledge base, skills, and activities required to establish effective opposition to social injustice and the conditions that sustain it.

Social justice movements represent examples of how people collectively provide public expression about the nature of social injustice and a vision for a future, based on social and economic equality. They do so through a series of narratives that include the history of injustice and its causes and a trajectory for social change—a compelling story.

Activity: Exploring Successful Examples of Public Narratives in Social Movements

Instructions: Consider any or all the following examples of social movements of the last 100 years noted below (civil rights, farmworkers, Black Lives Matter, ACT-UP! (Aids Coalition to Unleash Power), environmental justice, immigrant rights, labor). Discuss features and strategies with respect to public narrative in whatever cultural form, e.g., demonstrations, music, street theater, fiction, protest language or satire, that made them successful and their relation to the elements described above. How do these elements apply to the movements noted?

Explore the similarities and differences that made them successful as examples of social justice narratives in the use of language, image, representation, and strategy. Consider the features of these movements with respect to public narratives in whatever cultural form, e.g., demonstrations, music, street theater, fiction, protest, satire. How do the following movements apply or fail to apply to the 12 elements presented above or others not mentioned?

Source: Granger. Sit-in, Greensboro, NC (1960)

CIVIL RIGHTS MOVEMENT: CIVIL DISOBEDIENCE AS A PRACTICE

The civil rights movement, beginning in the 1930s and ending in the 1970s, created a narrative that defined social injustice beyond legal rights to include fundamental economic, social and political change.[7] Many of the gains are being retracted. One important result was the improvement in health outcomes that paralleled the increase in political power.

Reflection: Which of the 12 elements above do you see in the civil rights movement? For example, did it provide a path for social justice that made social injustice visible?

Source: iStock.com/Paul Moody

BLACK LIVES MATTER

Black Lives Matter (BLM) began with an emphasis on police brutality, but quickly expanded its agenda. According to journalist *Taylor Tringali* "Black Lives Matter has opened the conversation about injustices faced by black people and has garnered support and momentum in changing the long- standing narrative about blackness in America."[8] The movement is reshaping conventional narratives, formed by queer group of blacks, whites and women—through coalition building. Shannelle Matthews, Director of Communications for the Black Lives Matter Global Network, says "Building narrative is equally as important as building people power."[8]

BLM's goal to resist traditional historical narratives simultaneously praised those movements which acted respectfully yet sometimes remained docile, while condemning and seeking to silence those with more militant tactics and broad agendas. It attempts to shift

shift the narrative by being independent of charismatic leadership and not beholden to political parties. Focusing on strengthening communities, it seeks to lead the struggle to social and cultural change beyond public policy.

Reflection: Which of the 12 elements do you see in BLM? Did it refuse dominant narratives that stereotyped people of color? Reinforce the voices of those unheard or silenced?

Source: Designed by the Silence=Death Project for ACT-UP!

ACT-UP! AIDS AND THE LGBT MOVEMENT: HEALTH AND CULTURAL IDENTITY

Since 1969, the movement for gay, bi-sexual, lesbian, and trans-gender rights exemplified a powerful series of strategies that combined many forms of public narrative. They included potent symbols and imagery, guerrilla theater, civil disobedience, and direct action. They aimed at numerous targets, in many locations throughout the culture, they refused to allow others to label or stigmatize them, and forced recognition of their identities, e.g. "We're queer, we're here. Get used to it." Their approach reached into people's consciousness, beyond demands for policy changes and resources.

Effectively formed in 1987 at the Lesbian and Gay Community Services Center in New York City, ACT-UP is an international direct-action advocacy group working to have an impact on the lives of people with AIDS and the AIDs pandemic to produce legislation, medical research and treatment and policies that ultimately result in ending the disease by mitigating loss of health and lives.

Reflection: Which of the 12 elements do you see in the struggles for LGBTQ rights? How did it rely on questions of equality, representation and democracy?

Source: Ricardo Levins Morales

ENVIRONMENTAL JUSTICE: "WE SPEAK FOR OURSELVES"

Since 1982, this movement has drawn attention to environmental racism, for many years ignored by the mainstream environmental movement. Before its emergence, few thought much about the consistent disproportionate siting of most hazardous waste in communities of color and poor communities. Through street protests, and relying on street theatre and civil disobedience, the movement had successes influencing public policy to protect communities. Organized regionally, they exposed racialized land use practices and inserted themselves into decisions from which they were formerly excluded to increase their influence.

Their narrative expressed how deliberate decisions threatened their health and cultures and excluded their voice. Their slogan: "We speak for ourselves." Most critically, the environmental justice narrative challenged concepts of the official knowledge about siting waste and pollution, and about who benefits politically and monetarily. Members of the movement often conducted "toxic tours" of neighborhoods and identified creative, visual methods for expressing the long-term violence inflicted upon their communities. They also successfully challenged dominant narratives of progress, growth, development, and the inevitability of decisions imposed on them. In gaining support, a narrative of inclusion and solidarity established trust and integrity within the movement.

Reflection: Which of the 12 elements do you see in the environmental justice movement? How did they expose and dramatize social injustice?

OCCUPY WALL STREET: EXPOSING THE BIG PICTURE

Source: iStock.com/Starflamedia

Introduction: Since the post WWII era, particularly the Cold War, critique of capitalism as a social system has been a subject off limits in the mainstream media, school texts, and public debate. Capitalism, when it is described, is sometimes presented as the greatest social and economic system ever invented. As a system based on inequality and endless growth, its mechanisms of power rarely receive serious analysis on a regular basis. In late 2011, Occupy Wall Street, a laboratory of participatory democracy, was formed to challenge growing inequality of wealth. In the months that followed, the mainstream media significantly increased discussions and dialogue about inequality, even though Occupy did not succeed as a movement.

Instructions: Read the excerpt below from Communique 1, produced by representatives from the Occupy movement.

Communique 1

> We were born into a world of ghosts and illusions that have haunted our minds our entire lives. These shades seem more alive to us than reality, and...are more actual...We grew up in this world of screens...and surreal imagery.
>
> We have no clear idea how life should really feel....
>
> We have come to Wall Street as refugees from this native dreamland, seeking asylum in the actual. That is what we seek to occupy. We seek to rediscover and reclaim the world.
>
> Many believe we have come to Wall Street to transact some kind of business...to strike a deal. But we have not come to negotiate. We have come to confront the darkness at its source, here...
>
> At Wall Street we see that the basic quantum of experience has become the transaction; that life's central purpose is to convert all of existence into tradable currency....
>
> Wall Street tells us as it has always told us, that there is a plan and that it is our duty to follow that plan. We have come here to doubt and to dispute that plan.
>
> What do we want from Wall Street? Nothing. We wouldn't be here if Wall Street fed off itself; we are here because it is feeding off everyone.... We have come here to assert our real selves and lives; to build genuine relationships with each other; and to remind ourselves that another path is possible.[9]

Dialogue/Reflection Questions

1. What do you notice about the language used in this excerpt, compared with other forms of reporting or analysis about increasing inequality?

2. As the communique purposely excludes factual or numerical information, how might that shape the perception of the story built?

3. What narrative does the statement project about the system of capitalism?

4. In what ways does the Occupy language spur or stifle our imagination?

5. What characteristic does it capture from the list of 12 elements?

Follow up: Occupy, for the brief time that it existed, shifted the narrative toward inequality and Wall Street and away from the narrow policy perspective represented by the New York/Washington, D.C. financial axis. Their narrative discussed a way of life, rather than individual policy issues. Contrast the style, focus, and demands, compared to the traditional methods of single-issue interest groups seeking limited policy change.

What other social movements (labor, immigrant justice, farmworker justice, black women's equality) relied on the elements described? How?

Activity: The Economic Bill of Rights

Review the image and the Economic Bill of Rights, presented by President Franklin Roosevelt

in his January 1944 State of the Union address, the first and only such effort by an American president. He offered a substantive concept of material social rights, supporting useful and well-paying work, a good education, a decent home, and not only a right to medical care but *to good health* and well-being.
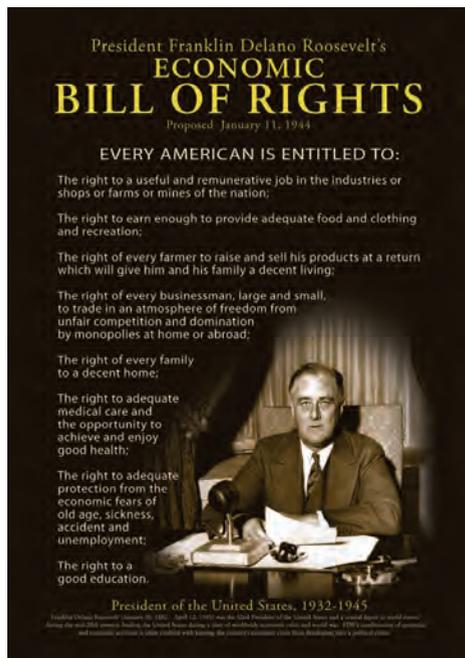
Source: Syracuse Cultural Workers

▸ The right to a useful and remunerative job in the industries or shops or farms or mines of the nation;

▸ The right to earn enough to provide adequate food and clothing and recreation;

▸ The right of every farmer to raise and sell his products at a return which will give him and family a decent living;

▸ The right of every businessman...to trade in an atmosphere of freedom from unfair competition and domination by monopolies at home or abroad;

▸ The right of every family to a decent home;

▸ The right to adequate medical care and the opportunity to achieve and enjoy good health

▸ The right to adequate protection from the economic fears of old age, sickness, accident and unemployment;

▸ The right to a good education.

Introduction: In the full address, before listing the economic rights above, President Roosevelt said: "The one supreme objective for the future, which we discussed for each Nation individually, and for all the United Nations, can be summed up in one word: Security. And that means not only physical security which provides safety from attacks by aggressors. It means also economic security, social security, moral security.... Freedom from fear is eternally linked with freedom from want...This Republic had its beginning, and grew to its present strength, under the protection of certain inalienable political rights—among them the right of free speech, free press, free worship, trial by jury, freedom from unreasonable searches and seizures. They were our rights to life and liberty.

"As our Nation has grown in size and stature, however—as our industrial economy expanded—these political rights proved inadequate to assure us equality in the pursuit of happiness. We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence."

Dialogue/Reflection Questions

1. The emphasis on substantive, economic rights was a major shift in narrative for the United States. In what ways have counter-narratives pushed against this view, then and today?

2. What stands in the way of our building these values as an integral part of the role of government?

3. The dominant narrative regarding free, self-regulating markets eventually overwhelms Roosevelt's narrative? What could have been done to normalize its ideas and implement them?

Public Health: Changing the Story

Example: *Narrative in Community Organizing*

THE ALAMEDA COUNTY STORY: CONFRONTING THE COMMUNITY HEALTH IMPACTS OF HOME FORECLOSURE AND DISPOSSESSION

REBUILDING NEIGHBORHOODS, RESTORING HEALTH
A report on the impact of foreclosures on public health

FORECLOSURE IS A HEALTH ISSUE

PRODUCED BY A PARTNERSHIP BETWEEN
Causa Justa :: Just Cause &
Alameda County Public Health Department

Source: Alameda County Public Health Department

The Alameda County Public Health Department (ACPHD) in Oakland, CA and Causa Justa::Just Cause (CJJC), a multi-racial grassroots organization, produced an extraordinary report in 2011—the first—on the health impacts of foreclosures. The result led to a narrative shift about the legitimate scope of health department work and where it needed to focus its resources, e.g., on banking practices. This narrative, embedded in the process of conducting the study, was itself an organizing effort that "amplified the voices of residents negatively impacted by foreclosures.... CJJC brought people power, campaign knowledge, and a deep understanding of housing issues. [In addition] ACPHD benefitted by having a framework that includes analysis of the role of power in driving social and health inequities."[10]

Foreclosure created overwhelming stress, disruption of peoples' lives, and disintegrated communities, leading to homelessness, loss of income, and emotional and material well-being. Documenting and exposing these practices as a health crisis for the affected community changed thinking to emphasize causes, and engaged community residents to consider challenging banking practices, rather than only delivering services. The department further demonstrated the health implications of developers' plans to displace and dispossess large numbers of people. They aided tenants facing water-shutoffs in a foreclosed building, and working with the city manager, sought to hold landlords and banks accountable for their actions. Subsequently, the department declared a health emergency related to the lack of water, supported code enforcement, a Tenant Protection Ordinance, and legislation to allow utility companies to place liens on properties for delinquent bills. An emerging narrative drew attention to identifying social responsibility for events such as mass foreclosure, the power of those who made decisions, and how the outcomes were not unexpected unfortunate events.

Reflection Questions

1. How did the process of conducting the study, apart from its findings, potentially change the narrative on the legitimate scope of public health practice?

2. In what ways did the process of conducting research through a community organizing effort dramatize that these home foreclosures constituted an injustice and not simply an unfortunate set of circumstances?

Public Health Activities: Questions and Concepts

Introduction

The following activities are meant to assist public health practitioners in detecting the underlying assumptions, beliefs, and values that are rarely considered in narratives that influence public health practice. These narratives are embedded in the kinds of questions asked or not asked, and the concepts that guide public health practice. In reviewing them, consider the absence or presence of language that draws attention to long-term effects of negative experiences and the "slow violence" that often remains invisible as described in previous chapters.

In reviewing each activity, consider how they relate or connect to the Elements for Advancing Social Justice Through Narrative in Practice, described earlier.

Activity: Changing the Questions

Purpose: To identify the kinds of questions that reflect a social justice narrative and how they differ from conventional questions.

Instructions: Review each pair of questions in the table.

Conventional	Health Equity Perspective
What interventions can address health disparities?	What generates health inequity in the first place?
What social programs and services are necessary to address health inequity?	What types of social change is necessary to confront health inequity?
How can individuals protect themselves against health problems?	What kind of public collective action is necessary to confront health inequity across identifiable populations?
How can we promote healthy behavior?	How can we democratize land use policies through greater public participation to ensure healthy living conditions?
How do we treat the consequences of health inequity?	How do we act on root causes of inequality to meet human need?
How can we create more resilient communities?	How can public health protect communities from disinvestment, redlining, predatory lending, serving as targets for hazardous waste?
What are the ways public health can adapt innovative practices to changing times?	What are the ways public health with their allies to organize for social change directed to meeting human need for health and well-being?

Dialogue/Reflection Questions

1. What general characteristics do you observe among the conventional questions, as opposed to those in the health equity perspective?

2. How might changing the questions affect your approach to public health practice?

3. Why are questions in column 2 rarely asked or if asked, investigated? What do you believe prevents public health professionals from asking the questions in column 2: what might you do to avoid those barriers?

4. What inhibits public health's capacity to recognize and act on the production of health inequities?

5. Reflect on common interventions in your work. What additional sets of questions would you suggest to address the focus of the work from a health equity narrative?

Activity: Rethinking Public Health Concepts

Instructions: Review each term in the left-hand column and compare with a term suggested from a health equity frame in the right column, to see if and how the former may constrict critical thinking about health inequity.

Conventional	Health Equity Lens
Vulnerable population	Populations oppressed or under threat
Risk factors	Social responsibility for risk
Factors	Underlying causes
Social determinants of health	Social determinants of health inequity
Intervention	Social change
Risky behavior	Dangerous conditions
Social Problem	Social Injustice

Dialogue/Reflection Questions

1. What core narrative(s) differentiate the conventional from the health equity concepts?

2. How might each term in the pair differently influence public health practice or strategy in confronting health inequity?

3. What are the narrative implications of viewing injustice as a "factor," for example racism, gender oppression, etc.? How does recognition of the concept itself work to subvert the dominant narrative?

4. What additional common public health language that is used in your work could you rethink?

Follow-Up: Consider the way in which the concept of "factors" can lead to a fragmented analysis, whereby we are asked to examine lists of things (housing, education, employment), one at a time. This approach can limit noticing the connections among them and the threads that link them. Why is racism an injustice and not a factor?

Activity: Social Murder: Making the Invisible Visible

Definition: To maximize the accumulation of profit while socializing the associated risks and costs, including death, illness and dispossession.

Consequence: Social murder typically occurs through slow violence: Delayed destruction of lives and communities over time, unnoticed, with no accountability because it is unseen.

Examples:

▸ Climate Change Denial

▸ Siting Toxic Waste in Communities of ColorPromotion of Tobacco Use

▸ Poisoning Flint Water Supply

▸ Exploiting Resources of Politically Weaker Nations

▸ Defective Product Design

▸ Home Foreclosure Through Predatory Lending Practices in Communities of Color

Introduction: The lyrics of Woody Guthrie's Pretty Boy Floyd song read: *Some will rob you with a six-gun/And some with a fountain pen.* The importance of that idea is reflected in various ways. One concerns the reality that crimes are committed differently by people of varying social status. Another is that negative effects of writing or approving economic and social policy can have the same effect, less visibly, on communities. With the stroke of a pen, laws are enacted that create "economic instability, unemployment, poverty, inequality, dangerous products, and infectious and chronic disease."[11] Unfortunately, many people die, experience serious injury or health crises because of decisions mostly unseen—this is sometimes referred to as "slow violence" or "structural violence."

Instructions: Read the quotation below, written by Frederick Engels in 1845, about society's decisions that lead to early death.

> "When one individual inflicts bodily injury upon another, such injury that death results, we call that deed manslaughter; when the assailant knew in advance that the injury would be fatal, we call this deed murder. But when society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death, one which is quite as much a death by violence as that by the sword or the bullet; when it deprives thousands of the necessaries of life, places them under conditions in which they *cannot live*—forces them...to remain in such conditions until that death ensues which is the inevitable consequence—knows that these thousands of victims must perish, and yet permits these conditions to remain, its deed is murder just as surely as the deed of the single individual..."

— Frederick Engels, *The Condition of the Working Class in England*, Panther Press, (1845 [1967]): 126.

Questions

1. After reading Engels' quotation, what stands out as particularly surprising or important?

2. Are you able to identify a term that would describe this collective phenomenon presented by Engels? Why or why not? Based on your experience with diverse audiences, how might the phrase "social murder" be helpful or problematic confronting this feature of our society?

3. How might the concept of social responsibility relate to the phenomenon of social murder? Would this shared vocabulary advance or impede the dialogue? How does your experience reinforce or contradict the use of terms such as "social murder" or the other phrases in the box above when addressing common public health practices, e.g., environmental health, tobacco control?

Envisioning A Story of Public Health

Introduction

To advance an inspiring, compelling story for public health, incorporating principles of social justice, it is necessary to redirect energy and resources that can build popular support for eliminating health inequity. As noted in the first chapter, public health practice today does not routinely articulate a compelling public narrative that could advance health equity. Indeed, the public has difficulty explaining the mission of public health. In many ways, the discipline emphasizes the management of crises, such as disease outbreaks, natural disasters, and the critical service provision and preventive

programs to treat disease and illness. Although that work is fundamental and necessary to public health, it cannot resolve health inequity; nor create widespread support and inspiration.[12]

Telling the story of public health effectively is a process with implications for the elimination of health inequity. In some unavoidable ways the story requires a narrative that can both upend and unsettle taken-for-granted worldviews. The story would connect to identifiable realities and people's experiences that stimulate provocative questioning, with the goal of disrupting dominant narratives in ways difficult to resist. There is no single story; all stories evolve, incorporating new meanings as conditions change.

Activity

Instructions: Review the elements for an effective public narrative for social justice on page 75. Build on your own experiences, knowledge, and stories from history and present reflections to devise a new or potentially emerging story for public health that can inspire or mobilize a constituency. Consider the kinds of stories that will a) enable public health practitioners to gain courage in speaking out on health inequity and overcoming fear and intimidation; b) promote a social change agenda, and c) gain political support.

Some will develop the story; some will listen to what others develop and analyze the story, posing critical questions.

Consider who would be telling the story—the point of view, the purpose, and who it is for, how it differs from what you can identify as a conventional story. Further consider: what are the conditions for a social justice-based narrative to arise?

The following guidance, regarding possible subjects to cover and questions to consider, are only suggestions. Many stories, features to include, and logic of presentation are possible.

Before beginning, consider the following quotation from Elizabeth Fee:

"When the history of public health is seen as a history of how populations experience health and illness, how social, economic, and political systems structure the possibilities for healthy or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and as social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life. Hardly surprisingly, these questions direct attention to issues of power, ideology, social control, and popular resistance."[13]
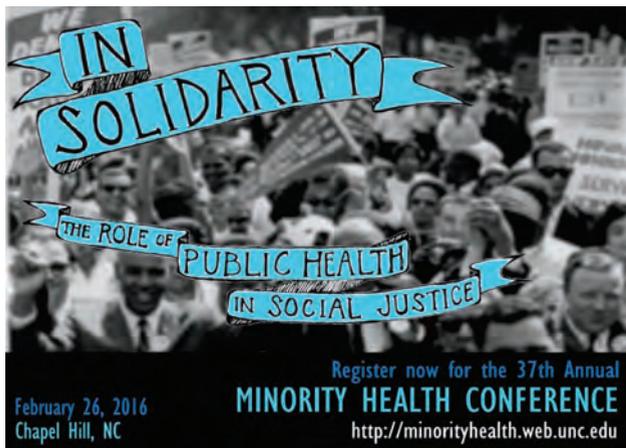
Suggested components of a story for public health through a health equity perspective:

▸ Remembering and synthesizing public health history: The role of public health in social transformation since 1848

▸ Articulating values and principles of social justice: Inspiring and mobilizing relevant populations

▸ Challenging dominant public narratives

▸ Highlighting root causes and their mechanisms: Racism, class, and gender inequity

▸ Presenting public health practitioners as champion citizen professionals—more than scientists as technicians

▸ Identifying compelling images, symbols

▸ Making common cause for common concerns with the populations served by public health and related social movements

▸ Residents subjected to inequity tell their own stories

▸ Emphasizing public health practice as a social enterprise, a collective process for producing health equity

▸ Publicly identifying the interests that generate health inequity: Providing effective explanations for why things are as they are

▸ Naming the story characters: Heroes, antagonists/villains, structures and institutions

▸ Imagining possibility: vision of the future with a trajectory and theory of social change

▸ Strategies for moving a health equity agenda

▸ Identifying the urgency for action to eliminate health inequity

▸ Presenting the story as unfinished and evolving

▸ Identifying cultural spaces, venues, and sites for telling the story

Review the suggested components of a story for public health, and possibly add your own. Within your group or externally with colleagues, thinking about your own experience and community, consider the following sets of questions about embodying a social-justice based story for public health as a representative from your community.

Questions

1. What are ten things that should be promoted about the realities of health inequity associated with its root causes and what generates it?

2. Based on your answer to question 1, what vision would you like to see expressed that defines what needs to be done to establish the conditions for producing healthy communities?

3. What story would you want to be able tell about how public health is taking leadership to confront the root causes of health inequity?

4. What current stories, language, representations, or imagery in public health need to be countered? Provide example of stories that would replace them.

5. In your story of public health, how could the health professionals (as experts, scientists) become citizen professionals—bringing their whole selves to the job as social change agents, working with residents as co-investigators?

6. How would the narrative change for explaining the role of public health to the workforce?

7. Thinking about having all barriers removed to doing what is necessary to achieve health equity (political, social), what would freedom to engage in the necessary practice look like?

Concluding Dialogue/Reflection Questions

1. What historical data and knowledge tell us about public health and its accomplishments that could be articulated as a revitalized story?

2. In creating this story, with what assumptions might you begin?

3. What gratifies you about the way we currently build the story of our profession? What stands in the way of more effective narrative about public health?

4. Who have been and who are public health's allies in your jurisdiction? What potential allies exist? Why do these relationships occur and how could they be expanded?

5. If we were to respond more effectively, in building the reputation of public health through public narrative, what would it look like? What aspects of the dominant narrative do we need to disrupt?

Reflect again on the "Changing the Questions" exercise.

6. What might be left out that would be beneficial in reframing the public health story? What should we give special emphasis? What should be eliminated or diminished?

7. What linked themes or threads are needed to produce an effective and comprehensive narrative that can embed a critical awareness of the connection between health inequities and social injustice, such as racism, social exclusion, and marginalization

Notes

1. See, for example, The Narrative Initiative, retrieved at https://www.narrativeinitiative.org; The Race-Class Narrative Project, retrieved at http://www.demos.org/publication/race-class-narrative-national-dial-survey-report; The Grassroots Policy Project, retrieved at http://grassrootspolicy.org; The Center for Story-Based Strategy, retrieved at https://www.storybasedstrategy.org; Public Health Awakened, retrieved at:https://publichealthawakened.com.

2. See, for example, Nancy Krieger and Anne-Emanuelle Birn (November 1998) A vision of social justice as the foundation of public health: Commemorating 150 years of the spirit of 1848, *American Journal of Public Health*, 88(11): 1603–1605.

3. Eric Olin Wright (2010) *Envisioning Real Utopias.* New York: Verso.

4. Fredric Jameson (2003) Future city, *New Left Review* 21: 65.

5. Amy L. Fairchild, David Rosner, James Colgrove, Ronald Bayer, Linda P. Fried (January 2010) The exodus from public health: what history can tell us about the future, *American Journal of Public Health*, Vol. 100(1): 54–63.

6. Iris Marion Young (1990) *Justice and the Politics of Difference*, Princeton, NJ: Princeton University Press.

7. See Public Broadcasting Service (1987, 1990) *Eyes on the Prize*, Parts I and II. A documentary on the Civil Rights movement produced by Henry Hampton for Blackside, Inc. on the Civil Rights Movement; Deborah Menkart, Alana D. Murray, and Jenice L. View, Eds (2018) *Putting the Movement Back into Civil Rights Teaching*, published by Teaching for Change and Poverty & Race Research Action Center.

8. Taylor Tringali (February 24, 2017) How the Black Lives Matter movement is using stories and science to drive change. *Frank*. Retrieved at: http://frank.jou.ufl.edu/2017/02/16286

9.   Occupy Wall Street (December 2001) *Tidal: occupy theory, occupy strategy: Communique1.*

10. Kathi Schaff, et al (2013) Tackling foreclosure and improving health through local partnerships, community organizing, and policy change, *NACCHO Exchange* vol. 13(1).

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FACILITATED DIALOGUE:
A Brief Guide for Replacing Dominant Narratives with Actionable Equity and Social Justice Narratives

RENEE BRANCH CANADY AND MARIJATA DANIEL-ECHOLS

Introduction

Public health has its foundation in pursuing social justice, yet it is not impervious to the influence of dominant narratives. If the field is to return to identifying and confronting root causes of inequity (for example racism, gender, and economic oppression), its practitioners must be prepared disrupt these narratives. Narratives requires reinforcement because they are malleable. We can act collectively to transform them. How do we do that?

Ingham County public health professionals, working with their colleagues and their communities over decades developed and refined approaches to dialogue that can be applied to reclaim social justice narratives and pursue equitable health outcomes for individuals and communities.[1] The intentional practice of facilitated dialogue is a methodology for action and change. When done well, it provides participants an opportunity to question what they think they know and, as a community, develop alternative interpretations, shared understanding, raise the voices of those who have been excluded, and promote a social justice-based public narrative. This chapter presents an overview for engaging in effective facilitated dialogue.

What Is Facilitated Dialogue?

Facilitated dialogue is a multi-faceted process that integrates the techniques of facilitation with the principles of dialogue to advance action across difficult topics.

How often have you heard the question "When are we going to stop talking about this and start doing something?!" In our years of facilitating workshops on health equity and social justice, it always amazes us how often this question will arise. The tension in this statement assumes that "talking" and "doing" are mutually exclusive. In our experience, working with public health professionals around the sensitive issues of equity and justice, nothing can be more stifling of action than silence.

This push to "stop talking" has also revealed itself in another slightly counter-intuitive way. A participant in our workshop who was a white woman shared her experience of camping with several couples who all had prior relationships. As they all sat around the campfire, a few began to discuss issues of race in this nation. The conversation began to swell, and the passion, frustration, and perhaps even anger was audible to everyone. Suddenly, one of the women, who was not a part of the discussion, stood and walked to the area of the discussion and shouted, "This conversation has to stop!" The inability or refusal to engage each other effectively around challenging and difficult topics is a barrier to advancing change. Therein lies the critical distinction – dialogue is different from conversation, producing a deeper level of understanding, interpretation, and application. Dialogue is a methodology to advance change.

Four Major Features of Facilitated Dialogue

Combining facilitation and dialogue produces a new approach from how they operate independently. Firstly, facilitation and dialogue independently are often described by the goal of neutrality. Facilitated dialogue as a methodology is not neutral; the facilitator sets the context but does not feed the content. With facilitated dialogue, the facilitator is a partner in building the content which will guide shared conclusions.

Secondly, even more than not being neutral, facilitated dialogue for health equity has a standpoint: in this case, a clear, social justice point of view. Thus, facilitated dialogue requires strong facilitation skills, knowledge of the mechanisms of systemic oppression, and the motivation to work in community to create solutions to inequality.

Third, facilitated dialogue does not seek consensus as is a common goal of facilitation. We would submit that in consensus neither party gets what they want but they reconcile and settle for less. Facilitated dialogue moves people to build shared meaning and likely new solutions that would not have been created independently.

Lastly, dialogue is an exchange of ideas without judgment. However, in facilitated dialogue we seek transparency of judgement rather than removal of judgement. Judgements have an impact on the exchange, whether spoken or unspoken, and inviting this dynamic into the exchange brings authenticity, supports the participation of everyone, and advances action. In the context of developing effective strategies to promote social justice, we engage in action-oriented activities.

Facilitated dialogue integrates the best of these three techniques and skillfully adapts them to fulfill a vitally important need. Facilitated dialogue is adaptable to the participating players and contexts and offers guiderails for keeping the discourse moving forward.

How Do You Do Facilitated Dialogue?

Guidelines for Dialogue

Establishing guidelines is an essential part of creating a context within which dialogue can happen. Oftentimes facilitators set 'ground rules' for how people will interact during a workshop or meeting. While the facilitated dialogue guidelines below do serve the purpose of establishing how people should conduct themselves, they are also foundational, functional strategies that can be used to identify and challenge dominant narrative. The guidelines for facilitated dialogue include:

▶ *It is OK to disagree.* Our opinions are informed by our lived, varied experiences. It is to be expected that disagreements come up during dialogue. If there is no disagreement we are not thinking keenly.

▶ *Make space for discomfort.* Given that during dialogue there will be disagreements, we must increase comfort with discomfort – both our own and the discomfort of others.

▶ *Practice self-focus.* Each of us can only speak from our own experiences and understandings. In dialogue you must tell your own story. Using I statements brings authenticity to your narrative and can compel others to listen deeply.

▶ *Practice both/and thinking.* Within dominant narratives we are socialized to use either/or thinking. That paradigm makes it easy to make individuals and groups that are different from us the 'other.' It limits our ability to disrupt dominant narrative and construct social justice narratives.

▶ *Try on.* Similar to both/and thinking, this guideline encourages people to be open to considering alternative ideas. Acting intentionally to introduce convincing social justice narratives will sometimes involve promoting unpopular, ignored, devalued, and new ideas.

▶ *Notice intent and impact.* Everyone has had the experience of having what they planned on doing (helping a neighbor carry grocery bags inside) and what happens (dropping a bag and breaking all the eggs). Regardless of the intention, the eggs are still broken, and we must help clean up the mess, compensate our neighbor for the cost of the eggs, or go to the store and buy another dozen eggs. Similarly, when in dialogue we must hold ourselves accountable to what happens, how people really live, and name who dominant narratives oppress.

A familiar practice among facilitators after laying out the guidelines for interaction is to ask the group for additional rules that they want to include. While this is a reasonable strategy to gain their support, in the social justice facilitated dialogue context this can be a challenge. Several additions that participants typically want to add can undermine a genuine, open, and frank focus. Three examples of common, but challenging additions to the guidelines are:

▶ Assume positive intent;

▶ Be respectful; and

▶ Treat people the way you want to be treated (golden rule).

So what is the problem of assuming positive intent? Recall, that one of the guidelines for dialogue is notice intent and impact. Assuming positive intent is sometimes code for do not hold me accountable for the results of my actions or impact of my words. Yet accountability is essential to a social justice narrative.

One of the guidelines highlights the need to acknowledge each other's experiences, so what is wrong with being respectful as a guideline? A powerful aspect of dominant narratives that oppress is their resistance to challenge. They are accepted as unquestioningly true or inevitable. Unfortunately, "be respectful" is sometimes used by those with privilege to silence or further marginalize other groups. It can be code for do not question or challenge conventional ideas.

The golden rule – what can possibly be wrong with treating other people how you want to be treated? On its face, this sentiment is generous. It speaks to the goal of treating people well. In a social justice context, we must challenge the thinking that how you as an individual want to be treated is how others also want to be treated. Built into this rule is the assumption that your view of the world is valued the same way by others – it might not.

Dialogue Prompts

Setting the context that can support dialogue does not guarantee that it will happen. Participants will sometimes need help broaching a sensitive topic or deciding how to share their thinking with others. Dialogue prompts are another important facilitator tool for catalyzing discussion. Prompts are most useful when they support participants in thinking keenly and listening deeply. Three examples are prompts that acknowledge the lived experience of participants; introduce effective language structures for seeing oppression and privilege; and those that lead to practical analysis and application of health equity concepts to their lives.

The Lived Experience of the Participants. This type of prompt helps participants reflect upon the multiple aspects of their cultural identity. Doing so lays a foundation for relationship-building and the sharing of sensitive life experiences as the dialogue evolves.

New Language Structures for Seeing Oppression and Privilege. One aspect of noticing dominant narrative is knowing its vocabulary. As explained in Chapter 2 of this book, dominant narrative uses coded language or systems of representation to obscure oppression. In a facilitated dialogue process, the facilitator and participants decipher those codes and social justice terminology. For example, in a facilitated dialogue, participants name unearned privilege and acknowledge its impact on social and economic status.

Practical Analysis and Application of Concepts to Real Life Scenarios. As a part of the facilitated dialogue experience, participants need to be able to practice not only noticing and challenging dominant narratives but creating actionable social justice public health narratives. One way to provide that practice is through the analysis of case studies, drawn from participants' work experiences. Facilitators guide participants through a process of identifying the types of oppression evident in the scenario, its potential impact on individual and/or community health, and brainstorming action steps to address the roots of inequality at play.

Conclusion

Ironically, the increasing attention to health inequity, has threatened the establishment of a meaningful exchange about population health. The dialogue of population health has often been misinterpreted and misapplied; the vocabulary of public health has been usurped as terms like health disparities and health equity are used synonymously and applied incorrectly. Similarly, the concept of social determinants of health was introduced into the discourse as the space where inequity occurs. We would submit that this use is also erroneous, in that social determinants of health lie midstream at best and often distract us from moving to the more difficult considerations of root causes.

As we challenge the field to transform its thinking back to the causes of the causes, it is not sufficient to think only about the conditions in which we live, grow, age, work, play, and pray. Rather we must also press to include the explanations for the blatant differences in those conditions; e.g., the reason why inadequate housing is patterned and predictable and the burden experienced by predominantly by communities of color. We must tackle the social determinants of health *inequities* to effectively situate our work in the social determinants of health. The patterns of the worst experiences tracking predictably with communities of color, begs us to explicitly address to true root causes, the actual sources including structural racism, class exploitation, gender inequity, and other forms of oppression.

Dialogue is as much about having the questions as it is about having the answers, and in many cases, it may be exclusively about the questions and trusting that the exchange, if authentic, will give birth to the answers and their conclusions. Dialogue is about engaging the head and the heart; the cognitive and the affective; what we know and what we feel. The willingness to risk discomfort best positions you for effective and meaningful dialogue which is needed as we seek to uncover the invisible, unspoken statements of narrative.

Notes

1.   The following groups and individuals were critical to the development of this methodology, Ingham County Health Department (ICHD; Michigan) and its community partners and Doak Bloss, BA, retired Health Equity and Social Justice Coordinator (ICHD) and former Senior Project Coordinator for MPHI.

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