Distribution Agreement

In presenting this thesis as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis. I retain all ownership rights to the copyright of the thesis. I also retain the right to use in future works (such as articles or books) all or part of this thesis.

____

Nancy K. Stephens Date

EXAMINING MPH STUDENT KNOWLEDGE AND AWARENESS OF RACISM:
IMPLICATIONS FOR THE PUBLIC HEALTH CURRICULUM

BY
Nancy K. Stephens, M.S.W.
Degree to be awarded: M.P.H.
Executive MPH

Iris Smith, PhD — Date
Committee Chair

Juan Leon, PhD — Date
Committee Member

Laura Gaydos, PhD — Date
Associate Chair for Academic Affairs, Executive MPH Program

EXAMINING MPH STUDENT KNOWLEDGE AND AWARENESS OF RACISM:
IMPLICATIONS FOR THE PUBLIC HEALTH CURRICULUM

BY

Nancy K. Stephens
M.P.H., Emory University 2016
M.S.W., Howard University, 2002
B.A., Howard University, 1990

Thesis Committee Chair: Iris Smith, PhD

An abstract of
A Thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements of the degree of
Master of Public Health in the Executive MPH program
2016

Abstract

EXAMINING MPH STUDENT KNOWLEDGE AND AWARENESS OF RACISM:
IMPLICATIONS FOR THE PUBLIC HEALTH CURRICULUM

BY
Nancy K. Stephens, M.S.W.

Problem/Background: The public health community has questioned the role of public health in addressing racism. Various public health stakeholders have supported the idea that racism is a public health issue and some academic literature has furthered this idea with calls for the inclusion of eliminating racism content within the public health curriculum. If racism is and should be considered a public health issue, how, if at all, is it represented in the public health education/curriculum and is there currently any knowledge and awareness of racism as it pertains to public health among MPH students?

Methods: Data was collected via an online survey containing both quantitative and open-ended questions. The study's target population consisted of second-year (18 or more credits hours completed) graduate students from the Rollins School of Public Health's Master of Public Health (MPH) program. The survey measured whether respondents had experiences in their classroom/coursework versus outside of their MPH program that raised their awareness and knowledge of racism's impact on health as well as whether or not they considered their MPH program's racism content to be appropriate.

Results: Students overwhelmingly indicated being knowledgeable about racism related topics and concepts. In addition, students felt prepared to work as practitioners to eliminate race based health disparities and address specific issues like how racism can impact access to health among people of color. Nonetheless, students most often attributed their knowledge to sources outside of their MPH program. A majority felt that their MPH program should offer more opportunities to discuss racism's role, relationship and impact on health disparities and that this content should be included on a "mandatory" and "required" basis versus via voluntary or extra-curricular activities.

Summary: This study suggests several specific areas where increased attention and incorporation of racism related content is warranted among schools of public health and their governing national organizations as well as for the entire public health community.

EXAMINING MPH STUDENT KNOWLEDGE AND AWARENESS OF RACISM: IMPLICATIONS FOR THE PUBLIC HEALTH CURRICULUM

BY

Nancy K. Stephens
M.P.H., Emory University 2016
M.S.W., Howard University, 2002
B.A., Howard University, 1990

Thesis Committee Chair: Iris Smith, PhD

A Thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements of the degree of
Master of Public Health in the Executive MPH program
2016

ACKNOWLEDGMENTS

My Thesis Committee

I would like to thank Dr. Juan Leon for his input and editing; I appreciate your time and efforts. A special thank you to Dr. Iris Smith, my thesis committee chairperson for her guidance, responsiveness and encouragement; you played an invaluable role and I can't thank you enough.

Rollins School of Public Health

Sincerest gratitude to the staff of the EMPH program (e.g., Moose, Leah, Karen, and Dr. Gaydos) as well as Rollins staff (e.g., Kara Robinson) who assisted with my study recruitment and Emory staff (Mr. Miguel Martinez, with the Office of Investigation Research) for supplying important data. I would also like to extend a special appreciation to the students of the Rollins School of Public Health who participated in my study by taking the time to complete the study survey. Your comments were thoughtful and thought provoking; there wouldn't have been a study without you. Thank you so much!

My Family

Finally, thank you to my family, especially my mother Annie and my brother Harry, for their continued love and support. I would like to extend a posthumous thank you to my Aunt Marie Barnes for always caring and keeping up with how school was going, even at the age of 101. Aunt Marie, I am sorry that I wasn't able to tell you in person that I'd finally finished but I know that you are smiling in heaven. And lastly, a special posthumous thank you to my Dad, Harry S. Stephens, PhD, whose love, strength and wisdom continue, even in his absence, to inform my life; I missed you regularly during my thesis process and will continue to miss you daily.

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION 1
Background/Problem Statement 2
Purpose Statement 5
Significance Statement 6
Research Question(s) 7
Research Question 1 7
Research Question 2 7
Theoretical Framework 8
Definition of Terms 10
CHAPTER 2 - REVIEW OF THE LITERATURE 12
Introduction 12
Current Knowledge: Racism, Health Disparities, and Public Health 12
History of Health Disparity in Public Health 12
Health Disparities, Racism and Public Health: Is Racism a Public Health Issue? 16
What is Racism? 17
Racism Curriculum in Public Health 19
Core and Interdisciplinary Competencies 19
Focus on Community Service Based Learning 22
Cultural Competency vs. Racism Curriculum 24
Assessing Racism Curriculum in Public Health: Needs and Thesis Goals 27
CHAPTER 3 – METHODOLOGY 30
Introduction 30
Population and Sample 30
Research Design and Recruitment 31
Research Design 31
Recruitment 32
Study Instrument 33
Data Analysis 35
CHAPTER 4 – RESULTS 36
Introduction 36

Demographics 36
Racism Education in Public Health Curriculum 38
Characteristics of Knowledge 40
Prepared as Practitioners 45
Addressing Access in Public Health Curriculum 46
Appropriate Racism Content 47
Assessing Community Service 54
CHAPTER 5 – DISCUSSION 58
Introduction 58
Summary of Study 58
Problem 58
Results 59
Limitations 64
Implications 65
Recommendations 66
Open dialogue 66
Partnering 67
Curriculum 68
Diversity 68
Practicum/Community Service 69
Guiding Principles and Policy Changes/Updates 69
Future Research 70
Advocacy 70
Conclusion 70
REFERENCES 72
APPENDICES 78
Appendix A – IRB Approval Letter 79
Appendix B – Recruitment Email – Sent September 23, 2016 80
Appendix C – Recruitment Email – Sent October 12, 2016 81
Appendix D – Recruitment Flyer 82
Appendix E – Survey Instrument (Including Informed Consent Letter) 83

LIST OF TABLES

Table 1.1 – Social Ecological Framework 8
Table 1.2 – The Social Ecological Framework's Implications to the Study 10
Table 1.3 – Definition of Terms 10
Table 2.1 – Reports and Resolutions Regarding Racial Health Disparities 15
Table 2.2 – Jones' Three Levels of Racism 18
Table 2.3 – ASPPH's Diversity & Culture Competency 24
Table 4.1 – Demographic Characteristics of Respondents 37
Table 4.2 – Familiarity with Racism Related Concepts 39
Table 4.3 – Venues of Exposure to Racism Related Content 41
Table 4.4 – Venues of Exposure to Racism Content 44
Table 4.5 – Racism Related Content "Sufficient" 48
Table 4.6 – Racism Related Content "Need More" 50
Table 4.7 – Racism Related Content "Need More" – Global Health Perspective 53
Table 4.8 – Practicum Placement Descriptions 57

LIST OF FIGURES

Figure 2.1 – The Impact of Racism on Health 18
Figure 2.2 – Association of Schools of Public Health Core Competency Model 21
Figure 4.1 – Comfort Discussing Issues of Racism 39
Figure 4.2 – Prepared as Public Health Practitioners 45
Figure 4.3 – Addressing Access to Health Care and Public Health Services 46
Figure 4.4 – Racism Content in Education/Curriculum 47
Figure 4.5 – Community Service Related Practicum Placements 55
Figure 4.6 – Worked with Community Members 55

CHAPTER 1 - INTRODUCTION

Herein lie buried many things which if read with patience may show the strange meaning of being black here at the dawning of the Twentieth Century. This meaning is not without interest to you . . . for the problem of the Twentieth Century is the problem of the color line . . . the relation of the darker to the lighter races of men in Asia and Africa, in America and the islands of the sea.

W.E.B. Du Bois,
The Souls of Black Folk (1903)
as cited in Thomas (2001)

There is currently an abundance of discussion regarding racism in the United States with conversations and debates only intensifying in recent months and years. These discussions have been precipitated by the recent shootings of Black men from Trayvon Martin in 2012 (CNN, 2016) to Alton Sterling and Philando Castile this past July, (Blay, 2016) as well as the racially motivated murders of church parishioners in Charleston, South Carolina in 2015 (Randolph, 2015) and subsequent debate of the relevance and utilization of the confederate flag (Ravitz, 2015). The 2016 presidential campaign has only served to exacerbate these tensions with talk of building a wall to block Mexican immigration (Shabad, 2016) and the tracking and mass deportation of Muslims (ibid) in addition to the physical violence and attacks on people of color attending certain campaign rallies (Del Real, 2016).

With talk and tensions related to racism rising, the public health community has been slow to acknowledge or respond (García & Sharif, 2015) to recent racial tensions or the awareness borne out in public health research that there is a connection between racism and health disparities. Related to these recent events and rising racial tensions, Garcia and Sharif (2015) note that “what is glaringly absent is a public health perspective in response to these events.” However, there have been a few public health stakeholders that have been more vocal recently in supporting the idea that racism is a public health issue (Frenk, 2014; García & Sharif, 2015) and some academic literature has furthered this idea with calls for the inclusion of eliminating racism content within the public health curriculum (Frenk, 2014; García & Sharif,

2015; Harvard Public Health Editorial Review Board, 2015) . Therefore, if racism is and should be considered a public health issue, how, if at all, is it represented in the public health education and curriculum and is there currently any knowledge and awareness of racism as it pertains to public health among MPH students?

This study will measure these questions by examining the knowledge and experiences of MPH students to determine the ways in which content on racism exists within their academic programs, i.e., curriculm content, internships, extra-curricular activties, etc. Results from this study may provide generalizable results that can inform the public health community, and specifically masters level public health programs, with information that either confirms or denies the need for more inclusion of eliminating racism content in public health education and curriculum and illuminate potential best methods for achieving this goal.

Background/Problem Statement

America has struggled with racial harmony and to fulfill the ambition of a "melting pot" society (Cubias, 2009) since the Pilgrims first met American Indians at Plymouth Rock. From the beginning, racial divisions have flourished and were exhibited in institutions such as slavery, internment camps and reservations. America has attempted - from the Civil War to the Civil Rights movement – to remedy our divisions and ironically, has come to realize that the very concept of race is a construct without genetic basis (California Newsreel, 2003). Nonetheless, the concept of "race" is deeply entrenched and divisions based on race are still reflected in our society (Shoichet, 2015). This is true for almost every aspect of life governed by institutional and systemic structures from education to criminal justice. Despite good health being a basic necessity for sustaining all human life, the American healthcare system has not been immune to inequality in outcomes either.

Healthy People 2020, our nation's guide to health promotion and disease prevention, includes among its four "overarching goals," the need to " achieve health equity, eliminate disparities, and improve the health of all groups" (Department of Health and Human Services, 2010). Yet, this idea is in contrast to the statistics related to race based health disparities. According to a report by the Kaiser Family Foundation (KFF), it is estimated that "30% of direct medical costs for Blacks, Hispanics, and Asian Americans are excess costs due to health inequities" (Kaiser Family Foundation, 2012). In addition, in 2009 it was reported that "eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion and reduced indirect costs associated with illness and premature death by approximately $1 trillion during 2003-2006" (Centers for Disease Control and Prevention, 2013).

There is a plethora of published material acknowledging the reality and impact of race based health disparity and inequity though few discuss the role of racism in creating and maintaining disparity. García and Sharif (2015) say that avoiding the "explicit acknowledgement" of the "connection to racism" serves to "undermine or disguise the impact of racism on racialized health disparities" and "enables the perpetuation of these inequities." Nonetheless, there is research and public health stakeholder recognition of the contributory role of racism in health inequity and disparity (Feagin & Bennefield, 2014; Frenk, 2014; Jones, 2001, 2003; Krieger, 2015). A recent Harvard Public Health Review editorial stated that "racism is a public health problem that contributes to higher levels of stress, greater exposure to risk factors, reduced access to medical and social services, and ultimately to excess levels of disease, disability and death" (Frenk, 2014). García and Sharif (2015) also "argue that addressing racism is central to eliminating racialized health disparities." Another study identifies "racism as a

pathogen with biological consequences" the effects of which are "reflected in long-standing health disparities" (Thomas, 2001). There is even research pointing to the impact that perceived and anticipated discrimination can have in producing "stressors" that negatively impact both physical and mental health (Williams & Mohammed, 2009).

Knowledge that racism is a contributory factor in health disparity makes it among the public health community's purview. While slow to acknowledge this, in recent years, both public health researchers and stakeholders are making this assertion more and more. García and Sharif (2015) point out that "racism is a social determinant of health that perpetuates and exacerbates the very trends our field works to reverse." In accepting the connection between racism and health disparities, it is also incumbent on those in the public health community to employ efforts to resolve the issue or more specifically, to eliminate racism. García and Sharif (2015) "strategize a reformed public health agenda that recognizes the connection between structural racism and racialized disparities in health."

Not only is there recent acknowledgement that racism is a public health issue, there is also debate regarding the advantage and appropriateness of considering the concept of racism versus cultural competency (Bull & Miller, 2008; Kumagai & Lypson, 2009; Taboada, 2011) in addressing health disparities. It is suggested that efforts centered on racism, because of the concept's social justice premise, are intrinsically beneficial to providing more effective approaches to addressing race based health disparities (Kumagai & Lypson, 2009) than cultural competency alone.

To the extent that addressing racism is a public health issue and can reduce and/or eliminate health disparities based on race; it becomes essential to incorporate eliminating racism education and curriculum geared toward training and preparing the public health workforce. This

work, incorporated into graduate level public health programs, can serve to produce leaders in the field of public health that are equipped to reduce and potentially eliminate the impact of racism on health disparities and outcomes. This perspective is supported by most public health stakeholders, such as Taboada, who states that "to effectively eliminate racial/ethnic health disparities in public health practice, all students need a strong foundation in understanding the concept of racism and how racism operates daily…students must have a vocabulary for talking about race and racism and an understanding of how these systems affect health outcomes" (2011). Bull and Miller also suggest that "designing curricula that integrate knowledge and experiences with vulnerable populations is critical to prepare graduates to assume a leadership role in the reduction of health disparities" (2008).

Purpose Statement

Important public health researchers and stakeholders are now recognizing both the connection between racism and health disparities and are calling on the field of public health to implement eliminating racism curriculum into public health education. Nonetheless, there is little research or suggestion regarding the specific models and methods best for incorporating eliminating racism curriculum into public health academic programs. Further, there is even less understanding of the knowledge and awareness of eliminating racism related competencies that currently exist among graduate level public health students or the student "characteristics" (Booske, Robert, & Rohan, 2011) or demographics (e.g., ethnicity, educational background, etc.) that may contribute to their knowledge and awareness.

Frenk (2014) suggests that the public health community "must recruit, retain and educate students to be leaders in addressing the health challenges posed by racism and all forms of exclusion." Similarly but with some additional detail, García et al., (2015) "advocates for the

integration of race-conscious curricula in public health programs based on the social justice principals and history of public health" and indicates that "these curricula can include models, theories, and methodologies that explicitly recognize racial injustice as a threat to health." While both Frenk (2014) and Garcia et al., (2015) assert – to varying degree – that eliminating racism curriculum should be implemented in public health education, neither provide specific models, approaches or a discussion of current skills exhibited among public health students. Also absent is a discussion or perspective on the current curriculum efforts. This study will consider the knowledge, awareness and "characteristics of awareness" that may or may not already exist among masters level public health students related to reducing health disparities impacted by racism.

Significance Statement

America may or may not be a harmonious melting pot but it is nonetheless a very diverse society. For many years it has been predicted that by the year 2050, the majority of Americans will be people of color (Kaiser Family Foundation, 2012); however, more recent statistics published by the Kaiser Family Foundation (2016) indicate that by as early as 2045, over half of the population will be people of color with Hispanics accounting for the largest increase in population. In order to control the spiraling costs to the nation's economy and the health care system – not to mention the overall physical and mental health and well-being of the soon to be majority of American citizens – efforts to reduce costs associated with race based health disparities will be imperative.

Further, because race based health disparities can be seen in most morbidity and mortality indicators (Williams & Mohammed, 2009), they therefore represent a considerable problem for the society as a whole and the public health community specifically. Numerous public health

agencies and organizations – public, private, and non-profit – regularly put forth efforts including research, policy, and practice change, to reduce and/or eliminate health disparities. Yet, the incorporation of eliminating racism work into the public health curriculum can provide another significant avenue for addressing race-based health disparities and therefore improve the well-being and outcomes for not just people of color but for society as a whole. García et al., corroborates this by suggesting that "such an approach to training frames public health as inherently antiracist work, which has broad implications for the future public health workforce, both within and beyond academia" (2015).

Research Question(s)

This study is about the role of public health education/curriculum in addressing racism in order to reduce and/or eliminate race based health disparities. A measure of this issue is to examine the knowledge, awareness, and experiences of Masters of Public Health (MPH) students to determine the ways in which content on racism currently exists or does not exist within their academic programs, i.e., curriculum content, internships, extra-curricular activities, etc. The study will use an online survey containing both quantitative and qualitative questions to answer the following questions:

Research Question 1*:* If racism is and should be considered a public health issue, how, if at all, is it represented in the public health curriculum and education?

Hypothesis: Racism content is represented in the public health curriculum and education.

Null Hypothesis: Racism content is not represented in the public health curriculum and education.

Research Question 2*:* Is there currently any knowledge and awareness of racism as it pertains to public health among MPH students?

Hypothesis: There is currently knowledge and awareness of racism as it pertains to public health among MPH students.

Null Hypothesis: There is currently no knowledge and awareness of racism as it pertains to public health among MPH students.

Theoretical Framework

Behavioral theories are often used in developing and implementing health promotion because they can assist in understanding the dynamics and conditions needed to effect human health related behavior change (DiClemente, Salazar, & Crosby, 2013). As stated by DiClemente, et.al, in his book *Health Behavior Theory in Public Health*, "theory helps us to develop an organized, systematic, and efficient approach to investigating health behaviors" (2013).

The Social Ecological Theory (SEF) (Department of Health and Human Services, 2008) of behavior change was used in developing this thesis and is a multilevel model that considers the impact of interpersonal, intrapersonal, organizational, community and societal influences on an individual's life and behavior. Each level of the SEF model is defined below in Table 1.1.

Table 1.1 – Social Ecological Framework	
SEF Level	**Framework**
Intrapersonal	The individual person's impact on their own life
Interpersonal	The impact of a person's closet relationships, i.e., family, close friends, etc.
Organizational	Groups formed around one goal or mission whose activities can impact a person or community.
Community	The entities in a person's environment where they participate to either provide or receive assistance, services, and/or support.
Societal	Includes broad reaching policy or political influences like legislation that are enacted at the local, state or federal level.

The SEF's interconnected, multi-level approach is appropriate to this study because it is in congruence with the study's multi-faceted implications. Also, use of the SEF model helps to

illustrate a tenant of this study which is that in order for an individual to adopt healthy behaviors often depends on whether there are supports or barriers in their environment. For example, the Affordable Care Act, a policy implemented at the societal level, is intended to provide a mechanism for improved health care for all people – including people of color – by making health insurance more accessible and affordable (Department of Health and Human Services, 2015) . However, having health insurance alone isn't enough. Once a person has health insurance, they must also have the means to access health care. Access to health care can mean many things including both personal income to pay necessary deductibles and copayments (on an individual level) as well as having the availability of appropriate (i.e., to ones physical condition and geographic location) and reliable transportation. Both of these issues disproportionately (as compared to other ethnicities in the general population) present challenges for people of color. For people of color, there are often several barriers to accessing health care that can create and exacerbate health disparities. These can range from a lack of personal financial means resulting from a lack of suitable employment opportunities or low wages to inappropriate transportation, which includes not having a personal vehicle or not living in a community where public transportation to appropriate medical facilities is feasible (i.e., proximately or cost prohibitive).

Through the use of education, health communication and promotion, the SEF targets a particular population with interventions that are specifically designed to create behavior change at the corresponding SEF level. While this study's target population is graduate students in a master's level public health program, there are additional implications to other groups. Table 1.2 is a breakdown of relevant SEF levels and how they correspond to the objectives and potential implications of this study.

Table 1.2 – The Social Ecological Framework's Implications to the Study	
SEF Level	**Study Objective/Potential Implications**
Intrapersonal/ Interpersonal	Improved physical and mental health and well-being for individuals and communities of color.
Organizational/ Community	1. Among academia in schools of public health – This study may increase attention and discussion of the issue of racism within the community of schools of public health. Also, this study may help identify the extent to which public health practitioners recognize and are prepared to work with the issues that impact health disparities induced by racism. This includes greater focus on their contact with communities during their practicum experience as well as whether they have had content related to understanding the barriers to health care among people of color. 2. Among communities of color – Changes in policy and practice among public health organizations and agencies that work with communities of color resulting in more social supports and resources such as improved built communities, employment opportunities, economic development, etc.
Societal	Improvements in racial tension and well-being among all citizens from a reduction or elimination in the impact of both personal and institutional discrimination and prejudice. This can result from a public health workforce that is well-trained and prepared to develop and implement policies, practice, research and education that promotes the elimination of racism and its impact on the public.

Definition of Terms

Some terms used in this thesis may have ambiguous meaning. These terms are listed in Table 1.3 along with definitions that describe the term's meaning as it applies to this study.

Table 1.3 – Definition of Terms	
Term	**Definition**
Racism	"A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that: ▪ Unfairly disadvantages some individuals and communities ▪ Unfairly advantages other individuals and communities ▪ Saps the strength of the whole society through the waste of human resources" (Jones, 2003).
Health disparity	"Refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group" (Kaiser Family Foundation, 2012).
Health equity	"The attainment of the highest level of health for all people" (Department of Health and Human Services, 2010).
Cultural Competency	"a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Centers for Disease Control and Prevention, 2014).

Table 1.3 – Definition of Terms	
White Privilege	A concept often considered "native to U.S." society/culture, it refers to "the collection of benefits that White people receive in a racially structured society in which they are at the top of the racial hierarchy," where "white skin confers on those who live in it an extensive array of unearned privileges not available to people of color" (Cole, 2016).
Institutional/Institutionalized Racism	"The differential access to the goods, services, and opportunities of society by race. It is structural, having been codified in our institutions of custom, practice, and law so there need not be an identifiable perpetrator" (Jones, 2001).
Social Justice	"The view that everyone deserves equal economic, political and social rights and opportunities" involves providing "access and opportunity for everyone, particularly those in greatest need" (National Association of Social Workers, 2016).
People/Person(s) of Color	People who are considered non-White (i.e., not of European decent) based on skin-color and/or nationality. Includes American Indian or Alaskan Native, Asian/Pacific Islander, Black or African-American, Hispanic (non-White).
White/Caucasian People	People who are of European decent (non-Hispanic).

CHAPTER 2 - REVIEW OF THE LITERATURE

Introduction

This study is intended to examine whether knowledge exists among master's level public health students of the impact of racism on health outcomes and to what extent this knowledge is influenced by their MPH academic program. There are several relevant topics associated with this study including the history of public health's efforts regarding race based health disparities, the use of terminology like cultural competency versus racism, the use of community service learning as a method of addressing health disparity as well as whether and how well racism's impact on health disparity has been incorporated into the public health curriculum. This chapter will discuss these topics as they are represented in the literature and then conclude with a discussion of how this study will add to and inform the knowledge base.

Current Knowledge: Racism, Health Disparities, and Public Health

History of Health Disparity in Public Health

It is easier to understand the current state of health disparities and the impact of racism on health outcomes in the United States (US) when you first consider the issue from an historical perspective. According to Feagin and Bennefield (2014), it is important to have this understanding of America's history of racism and oppression in order to "deal justly with continuing racial disparities in health and health care." Any reliable history lessons about the earliest days of America society should include the acts of oppression and discrimination directed at people of color. Racism and oppression in the US is pervasive due to "centuries of genocide, 336 years of slavery and legal segregation" where for "over 20 generations, Whites have inherited socioeconomic resources from ancestors who benefitted unjustly from slavery, segregation, and other racial oppression" (ibid).

Late 19th and Early 20th Century

Negative assumptions and assertions about the impact of race on health outcomes were once rooted in the concept of "biological inferiority" and existed in science, research and medical practice as far back as the nineteenth century" (White, 2011). According to White (2011) concepts like "biological determinism" – the claim that "behavioral norms and biological differences are a consequence of inherited inborn distinctions" – fueled insidious beliefs such as "craniometry, (skull measurements correlate to brain size, intelligence, and personality traits" as well as "eugenics, (the study of improving the population by controlling hereditary qualities, i.e., race, through reproduction and migration)." According to White (2011) these ideas were promoted as early as 1896 by researcher Frederick L. Hoffman, in his book *Race Traits and Tendencies of the American Negro,* where he suggested that Blacks were inherently inferior. Hoffman suggested that higher rates of mortality among Black people (as compared to White people) were due to their "inferior vital capacity" as opposed to "conditions of life" and as a consequence, they represented a "hindrance to the economic progress of the White race" (ibid).

The author, scholar, social and civil rights activist and co-founder of the National Association for the Advancement of Colored People, W.E.B. Du Bois, was instrumental in refuting the claims made by Hoffman and discrediting his research (White, 2011). Du Bois was responsible for authoring two publications informative to the discussion of health equity (ibid). Du Bois' publications, *The Philadelphia Negro* (1899), which "was the first social-science study sampling Blacks" and *The Health and Physique of the Negro American* (1906) are "considered early harbingers of public health – and more specifically, social epidemiology – research" (White, 2011). Du Bois' work is considered significant because it provided "systemic empirical

investigation" of the impact of "societal" factors and disavowed the idea of biological inferiority (ibid).

During this time period and similar to Du Bois, Booker T. Washington, author, educator and founder of the Tuskegee Institute, spoke against the "poor health status of Black Americans as an obstacle of economic growth" (Thomas, 2001). Washington founded events like "Health Improvement Week" later known as "National Negro Health Week," which was targeted to mobilize Black Americans around improving their health status (ibid).

In America, in the early 20th century, public health intervention was targeted for and directed mainly to White people, while in comparison, the public health issues of Black people were considered to be "problems of and for *their* communities" (Thomas, 2001). Not only were the health issues of people of color dismissed or ignored, Bassett (2015) discusses the "medical experimentation" and "progress that has been made" by medicine and public health "at the expense of certain communities" and points to such incidents as the "infamous Tuskegee syphilis study" (ibid), which failed to obtain proper informed consent or provide details of the study to the study's African American male participants in Tuskegee, Alabama (Centers for Disease Control and Prevention, 2016).

Late 20th and Early 21st Century

Health inequality remained a continuing problem toward the end of the 20th century as evidenced by the Rev. Dr. Martin Luther King's famous quote made during his speech before the 1966 Medical Committee for Human Rights, that 'of all the forms of inequality, injustice in health care is the most shocking and inhuman' (Giscombe & Hamilton, 2013).

In recent years, (late 20th and early 21st centuries), pervasive race based health disparities continue to perplex and efforts to tackle them have been undertaken by notable "national and

international" (Jones, 2003) public health organizations like the Institute of Medicine (IOM) and the World Health Organization (WHO). Table 2.1 is a chronological, non-exhaustive list of some of the notable reports and resolutions from the late 1900's and early 2000's that have impacted the discussion of race based health disparities.

Table 2.1 – Reports and Resolutions Regarding Racial Health Disparities (not an exhaustive list)			
Year	**Organization/Event**	**Title**	**Significance to Racial Health Disparities**
1998	Institute of Medicine (IOM)	Future of Public Health	• "Pointed to flaws in the system for educating public health practitioners" *(Walker, 1989).* • "Social justice underpinnings" *(Taboada, 2011).*
1998	Department of Health and Human Services	Initiative to Eliminate Racial and Ethnic Health Disparities by the Year 2010	Made "first articulated commitment to ridding the nation of 'racial' and ethnic health disparities." This goal later "formalized in Healthy People 2010" *(Jones, 2003).*
1999	Institute of Medicine (IOM)	The Unequal Burden of Cancer: An Assessment of NIH Research and Programs for Ethnic Minorities and the Medically Underserved	"A conceptual shift away from the emphasis on fundamental biological differences among 'racial' groups to an appreciation of the range of cultural and behavioral attitudes, beliefs, lifestyle patterns, diet, environmental living conditions, and other factors that may affect cancer risk" *(Thomas, 2001).*
2001	American Public Health Association (APHA)	Research and Intervention on Racism as a Fundamental Cause of Ethnic Disparities in Health	"Resolution adopted as public policy and among documents focused on the impact of racism on health".*(Jones, 2003)*
2001	3rd World Conference Against Racism, Racial Discrimination, Xenophobia, and Related Intolerance	Declaration & Programme of Action	Conference convened by the United Nations and resulting document includes content on the impact racism on health. *(Jones, 2003)*
2002	Institute of Medicine (IOM)	Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care	• "Reviewed hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes" and that disparities existed "despite matching for socioeconomic and insurance status" *(Ansell & McDonald, 2015)*. • Noted that "racial disparities exist in health care and that provider bias, stereotyping, and prejudice are contributing factors" *(Nelson, Prasad, & Hackman, 2015).*
2013	Dept. of Health and Human Services, Agency for Healthcare Research and Quality	National Healthcare Quality and Disparities Report (NHDR)	"Showed that disparities for Americans are not improving and some are becoming worse" *(Nelson et al., 2015)*

Prompted by the recent police shootings of Black men and resulting protests as well as other racially charged events, there have been several recent articles (Bassett, 2015; Frenk, 2014; García & Sharif, 2015; Krieger, 2015) written by public health stakeholders and researchers discussing public health' s role in addressing these tensions. Interestingly, this is not new territory for public health. In fact, in 1998, the American Public Health Association (APHA) issued a statement regarding the "disproportionate impact of police violence on people of color" (García & Sharif, 2015) yet, 18 years later, the US and the public health community is still confronting similar issues.

Health Disparities, Racism and Public Health: Is Racism a Public Health Issue?

The idea that "race has a biological or genetic basis" is no longer an acceptable premise among credible researchers and public health practitioners (LaVeist, 2000). In spite of the rejection of a "biological predisposition" public health's attention to and recognition of the role and impact of racism on health status, outcomes and disparities has been somewhat slow to evolve (Bassett, 2015; García & Sharif, 2015). Bassett (2015) notes that a specific search of health disparity related articles published over the last decade in the *New England Journal of Medicine* returned only 14 articles containing the word "racism" out of 300. However, in recent years there has been greater research and acceptance of the impact of racism on health and public health's need to consider racism a "public health problem" (Frenk, 2014; García & Sharif, 2015; Harvard Public Health Editorial Review Board, 2015; Thomas, 2001; Williams & Mohammed, 2009, 2013).

There is also little doubt or debate regarding the fact that race based health disparities remain prevalent and pervasive; research reveals this reality (Booske et al., 2011; Thomas, 2001; Williams & Mohammed, 2009). Williams and Mohammed (2009) write that of the leading

causes of death, including heart disease, cancer, stoke, etc., “African Americans have higher death rates than Whites” and that “African Americans and American Indians have higher age-specific death rates as compared to Whites” (2009).

While research and attention may be increasing, recognizing and framing the discussion of the impact of racism on health often ignores the role of White privilege, power, and supremacy that structures American life. Feagin et al., (2014) in their discussion of “systemic racism” object to the term ‘racial disparities’ and refer to it as “euphemistic or white-concealing, vague white-framed language” that avoids the role of “white perpetrators” in creating and maintaining disparities. Feagin et al., (2014) also note that this denial occurs even in the literature where “little attention” is given to “powerful, mostly White decisionmakers whose racial framing and racialized actions have created, shaped, or maintained these health inequalities.”

What is Racism?

In order to adequately discus the role of racism in health outcomes and subsequently in public health education, it is important to have a clear understanding of the definition of racism and how it exists in society. Jones (2003) proposes the following definition of racism:

> *A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that*
> - *Unfairly disadvantages some individuals and communities*
> - *Unfairly advantages other individuals and communities*
> - *Saps the strength of the whole society through the waste of human resources*

Jones (2001, 2003) suggests three levels of racism – institutionalized, personally mediated, and internalized – that can be used to generate “hypothesis about the basis of race-associated differences in health outcomes, as well as for designing interventions to eliminate those differences.” Table 2.2 provides definitions of Jones’ three levels of racism.

Table 2.2 – Jones' Three Levels of Racism	
Levels of Racism	**Definition**
Institutionalized	Differential access to the goods, services, and opportunities of society by race.
Personally Mediated	Prejudice and discrimination where prejudice is differential assumptions about the abilities, motives, and intents of others by race.
Internalized	Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.

(Jones, 2001)

Defining racism and gaining an understanding of how it "operates" (ibid) in society can inform the public health community's theories and "hypotheses" (ibid) toward a better understanding of the "basis of race-associated differences in health outcomes, as well as for designing interventions to eliminate those differences" (ibid). See Figure 2.1 for a diagram illustrating Jones' theory of the impact of racism on health.

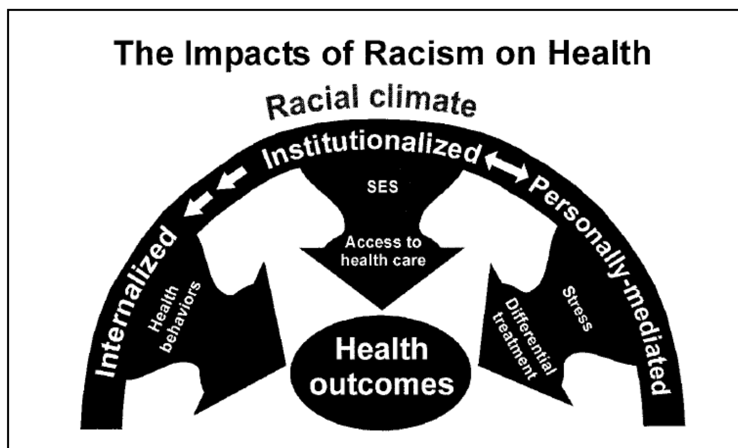


Figure 2.1 – The Impact of Racism on Health (Jones, 2001)

Jones (2003) also considers the impact of racism on all people by noting that it "undermines realization of the full potential of our whole society because of the waste of human resources." The negative impact of racism on societal well-being and not just people of color is

also recognized by other researchers. Feagin and Bennefield (2014) specifically discuss the public health problems presented by “systemic White racism and its negative effects on minds and bodies in all racial groups.” According to Lee et al., (2015), while “racism and prejudice negatively affect the health of those targeted,” there is research showing increases in the “stress hormone cortisol” among White people that exhibit “high levels of racial prejudice” when they are in contact with people of color but no similar response around other White people. In addition, “maladaptive cardiovascular responses that were indicative of physiological threat” were also reported among White people while interacting with Black people (Lee et al., 2015).

Racism Curriculum in Public Health

Efforts toward mitigating and eliminating the negative impact of racism on the public’s health must include how well, if at all, these issues are incorporated into training the public health workforce. In other words, how well does public health education incorporate knowledge and skill building around how racism impacts health status, outcomes, and disparities? The Council on Education in Public Health (CEPH) is the organization that provides accreditation to schools and programs of public health (Council on Education for Public Health, 2016). The CEPH advises, via a related technical assistance paper, that “curriculum can be a powerful method of demonstrating efforts to achieve racial and ethnic diversity” (Council on Education for Public Health, 2005).

Core and Interdisciplinary Competencies

There was recognition of a “need for change in educational practices across the health professions” in both the “literature and all 4 seminal Institute of Medicine reports published during the past 9 years” (Calhoun, Ramiah, Weist, & Shortell, 2008). These changes, which included a greater focus on “competency-based education” (ibid), were acknowledged by the

CEPH. However, similar to the impact of racism on health, core competencies were slow to catch on in public health education and as recently as the 2002 CEPH publication *Accreditation Standards for Graduate Schools of Public Health*, there was only a mention of the “concept of competencies” (Calhoun et al., 2008) while there were “no references made to the terms competency or competency-based education” (ibid).

However, in 2004, the Association of Schools and Programs of Public Health (ASPPH), which provides support to accredited schools and programs of public health in the form of promotion and representation (Association of Schools & Programs of Public Health, 2016), was assisted by the Centers for Disease Control and Prevention (CDC) in development of a “Core Competency Model Development Project” (Calhoun et al., 2008; Taboada, 2011) for MPH programs. MPH programs are typically structured around five core disciplines including biostatistics, epidemiology, environmental health science, health policy and management, and social and behavioral sciences (Calhoun et al., 2008). By 2006 (ibid), the ASPPH completed work establishing a core competency model for the MPH degree that included the incorporation of seven “cross cutting” (Taboada, 2011) competencies that can and should be applied to and reflected in each of the five core disciplines as illustrated in Figure 2.2.

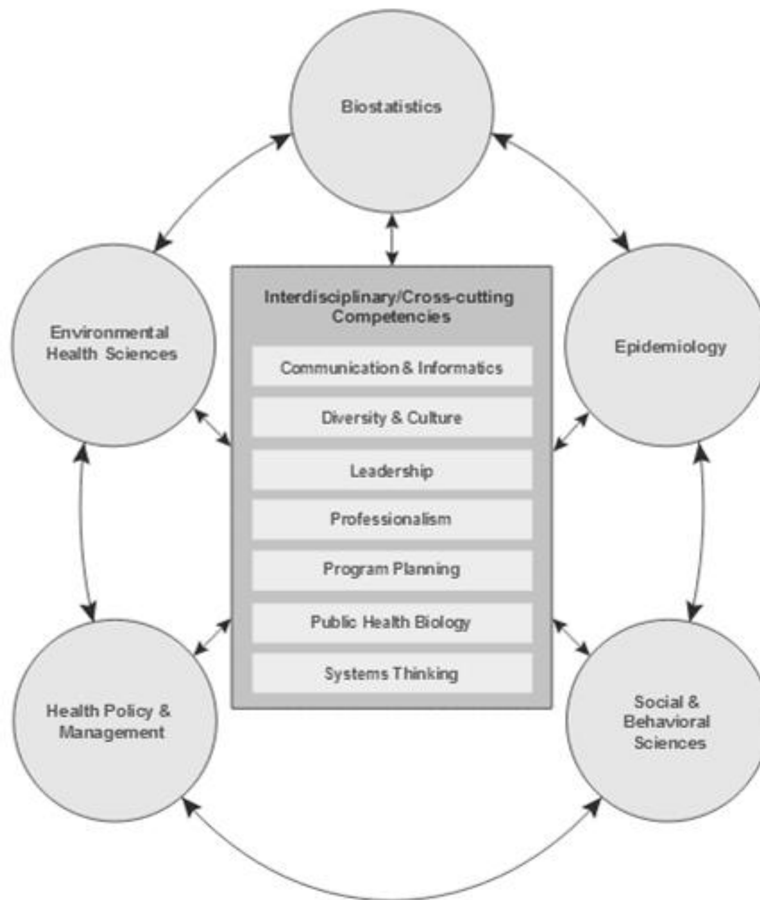


Figure 2.2 – Association of Schools of Public Health Core Competency Model (Calhoun et al., 2008)

One of the seven core competencies is "diversity and culture" (ASPPH, 2016a; Taboada, 2011), which instructs that MPH students should have the "ability to interact with both diverse individuals and communities to produce or impact an intended public health outcome" (ibid). Yet, public health's ability to impart knowledge and skill to students around "diversity and culture" might come into question by some when considering whether these basic tenants are fully incorporated into public health education. For example, public health stakeholders have noted the need for diversity in student bodies and faculty within schools of public health in order to meet the needs of an increasingly racially/ethnically diverse population (Association of Schools of Public Health, 2006; Council on Education for Public Health, 2005; Mitchell &

Lassiter, 2006). However, according to the ASPPH (2016b), the number of "underrepresented minority" student applicants to public health schools and programs in 2015 was at "nearly 30%" (ASPPH, 2016b). This implies that at least 70%, an overwhelming majority, of applicants to public health schools were White/Caucasian. In spite of public health stakeholder guidance and suggestions encouraging diversity and greater understanding of race based health disparities, the reality is that these numbers don't represent any improvement over the 67% of White/Caucasian students quoted by Taboada (2011) as the total number of White/Caucasian students attending schools of public health in 2009. This demonstrates that when certain ideals like the inclusion of "diversity and culture" are merely suggestions versus requirements or mandates that create universal practice change, outcomes related to these measures are not likely to be achieved.

Focus on Community Service Based Learning

Much of the literature points to public health's use of community-based service or community service-learning activities to incorporate "diversity and culture" into masters level public health education and curriculum (Anderson, Royster, Bailey, & Reed, 2011; Council on Education for Public Health, 2005; Taboada, 2011). The CEPH defines community-based service learning as activities "offered as organized programs in collaboration with ethnically diverse communities in the geographic area of the school or program" (Council on Education for Public Health, 2005). The CEPH (ibid) further suggests that community service can provide "rich opportunities" and "first-hand experience" working with "culturally diverse groups and individuals from varied backgrounds." In addition, community service learning is said to provide knowledge of "underserved populations" and disparate health outcomes in ways that cannot be achieved with typical classroom and coursework assignments (ibid). Taboada (2011) explains that the CEPH considers community service based learning as a "hands-on pedagogical model

that integrates research, service, and teaching to help students learn about and develop skills to mitigate racial/ethnic health disparities." Anderson et al. (2011) further assert that community service can provide "didactic learning in real-life scenarios; lead to strong community-campus partnerships that benefit community, student, and faculty; and help in developing and implementing solutions to social problems" (ibid). However, Taboada (2011) discusses limitations to this approach based on first-hand experience working as a "Latina" graduate student in a community setting. Taboada (ibid) suggests that the community model fails to "adequately educate students on the intersection of racism and health outcomes." Taboada further states that though the model attempts to "expose students to racial/ethnic health disparities" (ibid) via their engagement "with community members, it does not ensure long-term sustainable changes or benefits for the host community" (ibid). In addition, Taboada asserts that the model itself contributes to racism by exposing the host community to "Eurocentric power and privilege" dynamics associated with having "White middle-class students engage with low income clients and communities of color" (2011). In actuality, from a socioeconomic and caste perspective, this "power and privilege" (ibid) dynamic could play out among community members and graduate students of any ethnicity. Not only does Taboada (ibid) suggest that students need to have a "vocabulary" about racism but also a solid knowledge of how systemic and institutional racism impacts the day-to-day lives – and ultimately the health status and outcomes – of people of color.

The community-based service model is widely recognized as an important approach "well-suited" for public health students because it can provide "hands on learning" that can expose students to increased understanding of health disparities (Anderson et al., 2011). Nonetheless, Bassett (2015) points out considerations in implementing community-service

learning including that public health should “explicitly discuss how we engage with communities of color to build trust” as well as consider the assets that already exist in “high-risk communities.” Basset suggests that public health practitioners should take note of the host communities’ “beliefs and perspectives” and “hire staff from within those communities” in order to be “more confident that we are promoting the right policies” (ibid).

Cultural Competency vs. Racism Curriculum

Instead of the term “racism,” the preference in public health literature – when considering health disparity – has been to discuss diversity, culture, and cultural competency. Taboada (2011) points out that “cultural competency is a long-standing principle of the American Public Health Association (APHA) and its affiliated institutions. For example, among the ASPPH’s MPH Core Competency Model is the Diversity and Culture competency which includes a list of “objectives that illustrate the integration of theoretical concepts and practical skills needed to achieve cultural competency” (Taboada, 2011). The third of these objectives (of the Diversity and Culture competency), states that students should be able to “explain why cultural competence alone cannot address health disparity” (ASPPH, 2016a). Interestingly, as suggested by Taboada (2011), there is no explicit mention or inclusion of the word “racism” within this objective or any of the others listed under the Diversity and Culture competency nor is there any mention of what else – if not cultural competency alone – is adequate to address health disparity. See Table 2.3 for the Diversity and Culture Competency and its objectives as exerted from ASPPH’s MPH Core Competency Model.

Table 2.3 – ASPPH’s Diversity & Culture Competency
The ability to interact with both diverse individuals and communities to produce or impact an intended public health outcome.
• Describe the roles of, history, power, privilege and structural inequality in producing health disparities.
• Explain how professional ethics and practices relate to equity and accountability in diverse community settings.

Table 2.3 – ASPPH's Diversity & Culture Competency
• ***Explain why cultural competence alone cannot address health disparity.***
• Discuss the importance and characteristics of a sustainable diverse public health workforce.
• Use the basic concepts and skills involved in culturally appropriate community engagement and empowerment with diverse communities.
• Apply the principles of community-based participatory research to improve health in diverse populations.
• Differentiate among availability, acceptability, and accessibility of health care across diverse populations.
• Differentiate between linguistic competence, cultural competency, and health literacy in public health practice.
• Cite examples of situations where consideration of culture-specific needs resulted in a more effective modification or adaptation of a health intervention.
• Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.

Exerted from the ASPPH's MPH Core Competency Model (ASPPH, 2016a)

There is research and effort supporting the use of cultural competency for addressing health disparities among people of color. In the literature, most of the discussion about health equity (Bassett, 2015; Bull & Miller, 2008; Nelson et al., 2015) as well as the implementation of the concept of cultural competency, has been targeted to health care providers (i.e., doctors, nurses, etc.) in clinical care settings (Kumagai & Lypson, 2009) with the intention of improving the quality of care and outcomes for diverse populations and/or people of color. In fact, some (Ansell & McDonald, 2015; Silverstein, 2013) research discusses the bias and discrimination that patients in health care settings often experience. Ansell and McDonald (2015) point to the Institute of Medicine's (IOM) 2002 report *Unequal Treatment* that found that "for almost every disease studied, Black Americans received less effective care than White Americans" (ibid).

The use of cultural competency can be useful toward informing best practice in how to interact with individuals in health care settings; however, not all masters level public health practitioners will be employed in health care settings – with patient or individual contact – where the implementation of culturally competent behaviors (like language skills) can be applied. Kumagai and Lypson (2009) offer a critique of cultural competency's lack of emphasis and

inclusion of "social justice" and mention that there is often a "disconnect between multiculturalism and social justice." They point to a study that identified activities like "international study abroad experiences, work with medical translator services, and lessons in medical Spanish for emergency department physicians" as meeting cultural competency education requirements for health care providers (ibid). Kumagai suggests that "if social justice is an educational goal of cultural competency, discussions of racism should be prevalent in curriculum content" yet notes that among a study conducted of 34 cultural competency curricula only 2 "involved discussions of racism" (ibid). A recent Harvard Public Health Review Editorial (Harvard Public Health Editorial Review Board, 2015) asserts that "it is the responsibility of all public health institutions to place social justice as a central tenet of their curricula and learning experience."

Similar efforts to incorporate cultural competency in master's level public health programs typically center on work with communities. Taboada (2011) notes that "public health programs have increasingly employed community service-learning (CSL) models for teaching cultural awareness and competency. In fact, one Harvard Public Health Review article (Damodaran et al., 2015), speaks of student "lament about the lack of focus on activism and community engagement" within their university. To the extent that the community involvement model exposes students to inequality and informs their understanding of social justice issues, it can be useful and worth implementing. However, it can be argued that more is needed than "the ability to interact" (ASPPH, 2016a) with communities of color (as suggested by the competency model) in order to understand how racism impacts health status and outcomes. This is especially true considering that while students must complete an internship type practicum experience in a public health setting, work with or in a community setting is not an explicit requirement for

MPH students in schools accredited by the Council on Education in Public Health (CEPH). This is a consequence that further complicates the usefulness of the community service model.

Finally, concepts like “diversity,” multiculturalism,” and “cultural competency” are not useless or inappropriate; however, they fail to provide a full perspective on the underlying issue of racism, which some public health stakeholders (Bassett, 2015; García & Sharif, 2015; Taboada, 2011) are now seeing as necessary to resolve race based health disparities.

Similar Studies: Student Perspective & Education and Curriculum Evaluation

This study does not set a precedent in the use of student knowledge and experience to examine and assess education and curriculum content. In fact, there are studies (Graff, 2007; Osteen, Vanidestine, & Sharpe, 2013; Sheridan & Hemert, 1999; Swank, Asada, & Lott, 2002; Taboada, 2011) in the literature that also assess and evaluate education and curriculum based on student perspective; however, these are generally not specific to public health but rather other (and sometimes similar) academic disciplines like social work. In terms of public health, there is some literature evaluating aspects of the curriculum using a student’s perspective but typically these are specific to using and evaluating community service based learning and cultural competency programs specifically (Taboada, 2011).

Assessing Racism Curriculum in Public Health: Needs and Thesis Goals

Booske et al., (2011) note the lack of research available on the general US populations’ awareness of racial/ethnic and socioeconomic health disparities. Unfortunately, the same is true in public health as there is a lack of similar literature regarding master’s level public health students. This determination is based on a thorough review of the literature that returned no articles of studies evaluating MPH student knowledge and awareness of racism or racism’s impact on health disparities. There were also no studies found that examined MPH student

feedback concerning the inclusion of racism content in the public health curriculum. It does stand to reason that if much of the research and literature among the field of public health is still requesting increased attention to and inclusion of the concept of racism (in considering race based health disparities) (Bassett, 2015; Feagin & Bennefield, 2014; Frenk, 2014; García & Sharif, 2015; Harvard Public Health Editorial Review Board, 2015; Jones, 2001, 2003; Thomas, 2001; Williams & Mohammed, 2009), as well as incorporation of this work in public health curriculum (Frenk, 2014; García & Sharif, 2015); there is also a lack of corresponding research available measuring knowledge and skills in this area, particularly from the student perspective.

Now that there is some increased recognition and conversation of the impact of racism on health, it follows that there is also a greater need to consider how well this work has been done by measuring the knowledge and awareness of these issues among public health practitioners. Bassett suggests a similar position by stating that "if we fail to explicitly examine our policies and fail to engage our staff in discussions of racism and health, especially at this time of public dialogue about race relations, we may unintentionally bolster the status quo even as society is calling for reform" (2015). This thesis may present a novel approach as it examines the efforts of public health education and curriculum to train its students – the future of the public health workforce.

In filling specific gaps in the literature related to this thesis' research questions, this study will examine…

- How well master's level public health core competencies – particularly as they relate to social justice perspectives (i.e., how racism may impact access to healthcare) – are incorporated in education/curriculum by measuring student knowledge and awareness of

various racism related concepts and whether this knowledge was obtained via their MPH program.

- Whether and to what extent community service based learning in and among diverse populations is occurring.
- What the characteristics of knowledge and awareness are among students in order to determine if previous educational, professional, or social experiences and interactions may have informed or influenced their existing knowledge versus their MPH program.
- Finally, what is the interest and comfort level for discussing and learning about racism's impact on health among MPH students by considering how well, if at all, MPH students perceive their MPH program has incorporated discussions and curricula related to racism.

CHAPTER 3 – METHODOLOGY

Introduction

The methods used in this study were designed to answer the study's hypotheses related to the inclusion of racism education in public health. Complete details of the study's methods are an essential component to understanding how the study was conducted and why certain approaches were utilized. Therefore, the approach described below includes specific details related to the study population and sample, research design, procedures, instruments, and data analysis.

Population and Sample

The target population for this study consisted of master's level public health students matriculating at Emory University's Rollins School of Public Health (RSPH). Emory's RSPH is located in Atlanta, Georgia, which was the likely geographic location of most study respondents. However, because Rollins has a distance program – the Executive Masters of Public Health (EMPH) – some students that participated in the study may have been residents of other states within the United States, as well as other countries. The RSPH has "six academic departments: behavioral sciences and health education, biostatistics, environmental health, epidemiology, health policy and management, and global health" (Emory University Rollins School of Public Health, 2016). According to Mr. Miguel Martinez, Senior IT Analyst with Emory's Office of Institution Research, Rollins had a total enrollment of 1197 students registered to attend classes on a full or part-time basis at the time of the study.

Because this study was designed to collect data that recalls the past educational experiences (i.e., classroom, coursework, lectures/seminars, workshops and extra-curricular activities) of matriculating master's level public health students, it was assumed that only students that had completed at least one-year of academic enrollment had enough experience

with the program to provide substantive feedback and respond adequately to the survey. Therefore, only second-year (having completed one full year of classes) Rollins students were asked to respond to the survey instrument; a point emphasized on study invitation materials during the recruitment process (see more about this in the Recruitment section below). According to Ms. Catherine Strate, Director of Enrollment Services with the Emory's RSPH, the RSPH considered students to be second-year if they had earned 18 credit hours. According to Mr. Martinez, there were approximately 564 second-year students enrolled in the RSPH at the time of the study.

Research Design and Recruitment

Research Design

This was a descriptive research study that utilized an online survey including both quantitative and qualitative questions. The online survey was developed and administered via and internet survey service provider called SurveyMonkey. No identifiable data (i.e., name, social security number, address, etc.) or health information was collected in this study. To increase anonymity, internet protocol (IP) addresses, which are unique to each computer, were made inaccessible to the research investigator per a feature in SurveyMonkey that allows for anonymous response. This means that IP addresses could not be tracked or connected to study respondents or included in survey results (SurveyMonkey, 2016).

Because this study utilized live human subjects, an application was submitted to Emory University's Institutional Review Board (IRB). On August 30, 2016, the IRB provided a letter granting "exempt" approval (Emory IRB00091001) for the study. See Appendix A for a copy of the IRB approval letter.

Recruitment

Two methods were used to recruit participants for the study – invitation emails and a flyer. The most desirable method for notifying students about the study and inviting them to participate was to contact them via their Emory email accounts. The study initially used the RSPH Student Community list serve to send the invitation email. The RSPH Student Community list serve was open to all RSPH students on a voluntarily basis (if the student registered to be added) but had limited student participation because enrollment in the list serve was not mandatory or automatic. This list serve was also later determined, by RSPH leadership, to be "defunct" or out of service at the time of the study. Therefore, the RSPH agreed to allow the study invitation email to be sent through the RSPH All Student list serve. Using the RSPH All Student list serve presented an optimal opportunity because all registered RSPH students were automatically added to and received email from this list serve.

In an effort to provide further promotion of the study, a flyer inviting students to participate in the study was developed. The flyer included a tear away tag at the bottom that contained the web address for accessing the online survey along with the principal researcher's contact information. Flyers were posted in strategic and well traveled and populated locations (e.g. the elevator, bulletin boards, etc.) within the RSPH building.

After researching with various RSPH administrative offices (e.g. EMPH program leadership, RSPH Enrollment Services, RSPH IT Department), it was determined that it was not possible to query out (or search the school's database to isolate) a list of only second year students in order to contact those students specifically. Therefore, it was decided to include the second-year requirement in the subject line of the invitation emails and by placing this text prominently on the flyer. See Appendix B, C, and D for a copy of the invitation emails and flyer.

The invitation emails and flyers contained essentially the same content. The invitation emails to participate in the study were sent in a letter format over the signature and contact information of the principal investigator and the flyer also included the principal investigator's name and contact information. Both the email and the flyer stipulated that there would be no offer of compensation or any consequences based on a student's willingness to participate in the study. Both the invitation email and flyer included a description of the study along with a link that, if selected, would take the student directly to the internet survey located on SurveyMonkey website.

Study Instrument

This study's data collection tool was an original survey instrument that had not been used in any other studies. The instrument was developed by the study's principal investigator with assistance from Dr. Iris Smith, the study's Thesis Chairperson and also a faculty member at the RSPH. Because the study instrument was newly developed for this study, a pilot test of the survey was conducted to test the survey's effectiveness. The pilot test was attempted with a subset of RSPH students (approximately 35 students all enrolled in one specific class) who were asked to volunteer to take the survey and then provide feedback (i.e., how long it took to complete the survey, if there were any confusing questions, etc.) on a written feedback questionnaire. Unfortunately, none of the students participated in the survey or responded to the feedback questionnaire. This lack of response and therefore feedback regarding the study instrument represents a limitation of this study and is discussed again in the Limitations section of Chapter Five.

The first page of the study instrument contained the informed consent letter and includes guidance regarding the study topic and other details (e.g., potential risks, confidentiality, who to

contact with questions or concerns, etc.) to help potential study participants decide whether or not to consent to complete the study.

The study instrument contained approximately nine to eleven questions related to the thesis topic and ten demographic questions. The number of topic questions was approximate because some questions did not require a response and also due to the survey's skip logic, which prevented participants from responding to some questions based on their answers to previous questions. The survey's thesis topic questions assessed whether participants had experiences in their classroom/coursework or outside of school that raised their awareness and knowledge of various concepts and terms pertinent to racism in public health. In addition, there were also some topic related questions that asked for details about the student's practicum experience. The survey's demographic questions covered items such as age, ethnicity, and school status (e.g., their Rollins department, major, year entered the program, number of semesters completed to date, etc.) As mentioned, there were no identifiers or health related questions in this study.

An online survey was selected as the study instrument as opposed to other data collection options – such as in-person focus groups – to provide study participants with increased anonymity because of the sensitive nature of the study. Many people may have found it difficult or unacceptable to talk about race and/or racism in a public setting or when they may have been identified – particularly as it pertains to expressing details regarding their individual feelings, knowledge and awareness. Also, securing as much anonymity as possible was advantageous as study participants were students being asked to consider and evaluate their educational experiences within the same institution where the study was being conducted. It was assumed by the principal investigator that this relationship could pose a potential conflict of interest, encourage bias and/or inhibit truthful responses.

Data Analysis

Once data was collected it was only accessible by the principal investigator. Quantitative data was analyzed and reported using frequency and percentage measurements provide by the online survey service provider SurveyMonkey. Qualitative data was analyzed manually by grouping, categorizing and evaluating responses according to common themes and similar comments.

CHAPTER 4 – RESULTS

Introduction

This chapter details results of the data collected in this study. Results from all of the questions asked in the study's survey instrument are included. Demographics are presented first followed by results and analysis for each of the study's topic related research questions.

Demographics

Only second-year Rollins students were encouraged to participate in the study. It was assumed that only second-year students had the necessary experience with the program to respond adequately to survey questions. (For more details on this see Chapter 3 Methodology.) Nonetheless, there were eight respondents that indicated that they only completed one semester of classes. Of the 564 second-year Rollins students that were invited to participate in the study, 164 responded, which represents a 29% response rate. The majority of survey respondents were female (n=114, 88%), White/Caucasian (n=67, 52%) and enrolled in the epidemiology department (n=40, 31%).This is consistent with the gender and ethnicity demographics of all second-year students in the RSPH as the majority are also female (n=433, 77%) and White/Caucasian (n=239, 42%) with White/Caucasian females (n=187, 33%) comprising the majority of second-year students in the school. Some students identified their ethnicity as "Other." In these cases, each student provided a qualitative response indicating two or more combined ethnicities and one respondent declined to provide additional description of their race/ethnicity to avoid revealing their identity. See Table 4.1 for a detailed breakdown of respondent demographics.

Table 4.1 – Demographic Characteristics of Respondents (n=164)		
Gender (n=130)	**%**	**n**
Male	12%	16
Female	88%	114
Other	0%	0
Race/Ethnicity (n=130)	**%**	**n**
American Indian/Alaskan Native	0%	0
Asian/Pacific Islander	11%	14
Black/African American	28%	36
Hispanic	3%	4
White/Caucasian	52%	67
Other	7%	9
Rollins Academic Department (n= 131)	**%**	**n**
Behavioral Sciences and Health Education	16%	21
EMPH	7%	9
Biostatistics	2%	2
Global Health	25%	33
Epidemiology	31%	41
Environmental Health	6%	8
Health Policy and Management	11%	15
Other	2%	2
Age (n=130)	**%**	**n**
Under 18 years old	0%	0
18 to 21 years old	0%	0
21 to 30 years old	86%	112
31 to 40 years old	10%	13
41 to 50 years old	4%	5
51 to 55 years old	0%	0
Educational Experience (n= 131)	**%**	**n**
Bachelors degree	96%	126
Masters degree	5%	7
Professional degree	7%	9
Doctorate degree (i.e., PhD)	1%	1

The target population for this study were students in a masters level graduate program and, as expected, the majority of respondents were between the ages of 21 to 30 years old (n=112, 86%) and no respondents were under the age of 18 (n=112, 0%). In addition, the majority of respondents completed at least a bachelor's degree; the number of respondents with advanced or professional degrees (beyond a bachelor's) was low in comparison.

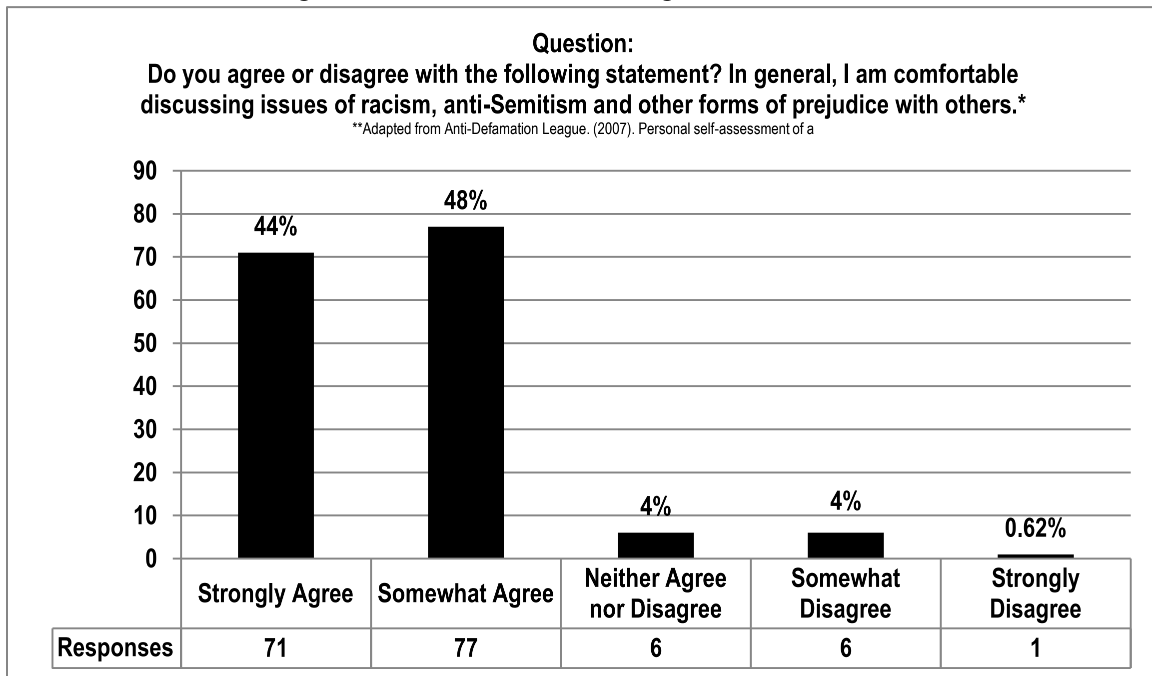
Racism Education in Public Health Curriculum

This study was based on two central research questions designed to measure whether knowledge exists among MPH students of the impact of racism on health outcomes and to what extent this knowledge is influenced by their academic program, i.e., curriculum content, internships, extra-curricular activities, etc. Therefore, each data result is discussed in terms of its relationship to the research questions. For a clearer and more straight-forward presentation of the results, research question number two will be discussed first, followed by research question number one.

Question #2: Is there currently any knowledge and awareness of racism as it pertains to public health among MPH students?

An overwhelming majority of students – as seen in Figure 4.1 – responded that they either "Strongly Agreed" (n=71, 44%) or "Somewhat Agreed" (n=77, 48%) that they are "comfortable discussing issues of racism, anti-Semitism and other forms of prejudice with others."

Figure 4.1 – Comfort Discussing Issues of Racism



In another question, respondents were presented with various anti-racism related topics and asked to rate their knowledge of the topic. The majority of students – for each topic provided – indicated being "knowledgeable" as opposed to being "comfortable teaching" the topic or only knowing "a little" or not being "familiar" with the topic. Nonetheless, a significant number of students did indicate feeling comfortable enough to teach each of these topics to others. Table 4.2 provides a breakdown of the topics and corresponding responses.

Table 4.2 – Familiarity with Racism Related Concepts
Question:
Please rate your familiarity with the following concepts:
(n=157)*

	I am not familiar with this concept/topic	I know a little about this concept/topic	I am knowledgeable about this topic	I would be comfortable teaching this concept/topic to others
The distinction between race as a social construct	3% (5)	16% (25)	55% (87)	25% (40)
Racism as a social determinant of health outcomes	0.64% (1)	6% (10)	59% (93)	34% (53)

Table 4.2 – Familiarity with Racism Related Concepts Question: Please rate your familiarity with the following concepts: (n=157)*				
	I am not familiar with this concept/topic	**I know a little about this concept/topic**	**I am knowledgeable about this topic**	**I would be comfortable teaching this concept/topic to others**
White Privilege	0.64% (1)	8% (12)	59% (92)	33% (52)
The relationship between perceived racism/discrimination and chronic disease	6% (9)	22% (35)	49% (77)	23% (36)

( ) = Numbers in parentheses represent the sample size *This applies to all rows

Characteristics of Knowledge

Students were considered most knowledgeable if they responded that they both "strongly agreed" that they were comfortable discussing racism related topics *and* if they were "comfortable teaching" *all* of the racism topics provided. Of the 157 total respondents to this question, only 13 respondents matched this criterion. Of the 13 students who, by their responses, indicated being most knowledgeable, the majority (n=5, 38%) were Black/African American, followed by White/Caucasian (n=4, 31%). The Health Policy and Management (HPM) and the epidemiology (Epi) department had (n=4, 31%) the same number of respondents represented among the most knowledgeable.

Research Question #1 – If racism is and should be considered a public health issue, how, if at all, is it represented in the public health curriculum and education?

To determine how much student knowledge of racism related topics may have been influenced by their MPH program versus from activities outside of RSPH, students were presented with four "venue" options and asked to identify where they were "exposed" to a particular topic. Students responding to this question (n=143) were allowed to check all of the venues of exposure for each of the racism topics. The venue of exposure most cited (550 times)

by students was "reading and other self study" as compared to 436 responses for "in class discussions" or the 421 responses received for "lectures, workshops or conferences at RSPH." Table 4.3 is a breakdown of the responses for each potential venue and racism related topic.

An overwhelming majority of students (110) said that they were exposed to the topic of "White privilege" via "reading and other self study" versus any of the curriculum or educational activities within the RSPH. Interestingly, this was also true for the public health mainstay of "cultural competency," where a majority of students (92) also indicated "reading and other self study" versus RSPH classes or activities. The only racism topic where there was a majority of students indicating exposure from class discussions was for the topic of "race as a social determinant of disease." See Table 4.3 for the full breakdown of results for the venues/exposure question.

Table 4.3 – Venues of Exposure to Racism Related Content

Question:
On the scale below, please indicate the venue(s) where you were exposed to information on the following topics while working on your MPH degree.
(You may check all of the venues that apply for each topic.)
(n=143)

	In class discussion	Lectures, workshops or conferences at RSPH	Lectures, workshops or conferences outside of RSPH	Reading and other self study	I have not been exposed to information on this topic
Race as a biological marker of disease	47% (67)	41% (58)	34% (49)	57% (81)	17% (25)
Race as a social determinant of disease	76% (109)	73% (104)	45% (65)	69% (98)	3% (4)
The relationship between perceived racism/discrimination and chronic disease	52% (74)	53% (76)	34% (48)	55% (78)	10% (14)
Cultural competency/working with diverse populations	54% (77)	50% (71)	49% (70)	64% (92)	9% (13)

Table 4.3 – Venues of Exposure to Racism Related Content Question: On the scale below, please indicate the venue(s) where you were exposed to information on the following topics while working on your MPH degree. (You may check all of the venues that apply for each topic.) (n=143)					
	In class discussion	**Lectures, workshops or conferences at RSPH**	**Lectures, workshops or conferences outside of RSPH**	**Reading and other self study**	**I have not been exposed to information on this topic**
White privilege	24% (35)	21% (30)	30% (43)	77% (110)	10% (15)
Institutionalized racism and its impact on health outcomes	52% (74)	57% (82)	37% (53)	64% (91)	10% (14)
Total for Each Venue	**436**	**421**	**328**	**550**	**85**

( ) = Numbers in parentheses represent the sample size

A qualitative question was included as a follow-up to the "venue/exposure" question to provide more information about which activities were most remembered, recognized or useful to students in imparting knowledge about racism and health. Among these qualitative responses (n=66, 46%), students most often mentioned courses in the Behavioral Sciences and Health Education (BSHE) department as having exposed them to racism and health topics. Of the BSHE courses that were specifically identified, those mentioned most often were BSHE 500 (Behavioral and Social Sciences in Public Health), BSHE 579 (Applied History of Public Health), and BSHE 535 (Macro Social Determinants of Health). Without indicating specific courses, some students said in general, that the BSHE department had most contributed to their knowledge of racism topics. For example, one student said, "I love the BSHE department and I am glad I am in this department because we always speak about the topics listed above." Another student did stipulate that they are "in the BSHE department and these are issues we discuss regularly in all classes, except for quantitative methods" while another student went so far as to

explain that BSHE's History of Public Health "is a requirement of all BSHE students but should probably be required of all MPH students."

Courses from other departments were mentioned infrequently including Epidemiology and Global Health; however, one student commented that "outside of BSHE, not very much explanation or discussion, just taken as a given that there may be racial/ethnic differences in outcome rates" and yet another student indicated that "a lot of these topics need to be included in the global health core classes but aren't."

For the venue, "lectures, workshops or conferences at RSPH" activities most commonly mentioned included the "Lunch and Learn" and the "Distinguished Speakers Series" and events sponsored by the Association of Black Public Health Students (ABPHS). There were also frequent mentions of Rollins opportunities like the Socio-Contextual Determinants of Health Certification and the James Weldon Johnson Institute Colloquium Series. In addition, lectures and readings provided by Dr. Camara Jones, an Emory professor, current President of the American Public Health Association and a prominent scholar addressing the impact of racism on health, were also frequently cited as having been informational to students.

Respondents that identified "lectures, workshops and conferences outside of RSPH" most often indicated that their exposure was obtained via their undergraduate experiences such as individual courses (i.e., clinical psychology, health disparities, African studies, etc.) or because of their major or minor fields of study like social work, anthropology, and women's studies, which were all mentioned more than once.

Among the "self study" responses, students indicated accessing racism topics in venues as varied as Facebook (White privilege) and "friends and roommates" to "readings" and via general "life experience." Some students also indicated a self-directed desire to seek out

additional learning and information about these topics, one example was the student that comment that “As a White person who is very privileged, I try and read and keep an open mind about my privileges and listen to others who are different than me to understand where they are coming from.”

Though respondents mentioned many RSPH activities, both in class/course work as well as other educational opportunities (i.e. lectures, certifications) within Rollins, there were still some students who expressed the idea that their RSPH program hadn’t provided much information on the racism related topics mentioned in the question. And, while this question was specifically asked later in the survey, students responded to this question that they felt more work on the impact of racism should be included at Rollins. Table 4.4 includes examples of these comments taken from the qualitative responses.

Table 4.4 – Venues of Exposure to Racism Content **Question:** **If possible, please describe in more detail the venue(s) where you were exposed to the topics mentioned in the previous question (i.e., the name of the class, lecture, title of the reading, who initiated the conversation, etc.)** **(n=66)**
Comment
Classes have been very limited in number
We need to discuss this more at Rollins
A lot of these topics need to be included in the GH core classes but aren’t.
These topics have been mentioned but not described in detail in the courses that I have taken at this point.
These topics aren’t something that is inherent in the curriculum at Rollins. We may briefly touch on these subject but they aren’t discussed at length in class lectures.
It’s mentioned in politically correct but not analytical or constructive way.
I spent a great deal of time talking about racism and privilege in college. I have spent considerably less time speaking about these issues with relation to health while here at Rollins, save for the few electives that I have taken. I specifically joined the SDoH Cert program so I gain more exposure to this type of research.
Outside of BSHE, not very much explanation or discussion, just taken as given that there may be racial/ethnic differences in outcome rates.
Honestly, most of my experience with this hasn’t been in any official RSPH setting, but instead through discussion on social media, with friend groups, etc.
Even though I am not getting a certificate for Social Determinants of Health or something related, I would be interested in more required classes on these topics since most optional classes I take are not topical, but methods related so I can be more marketable after graduation.

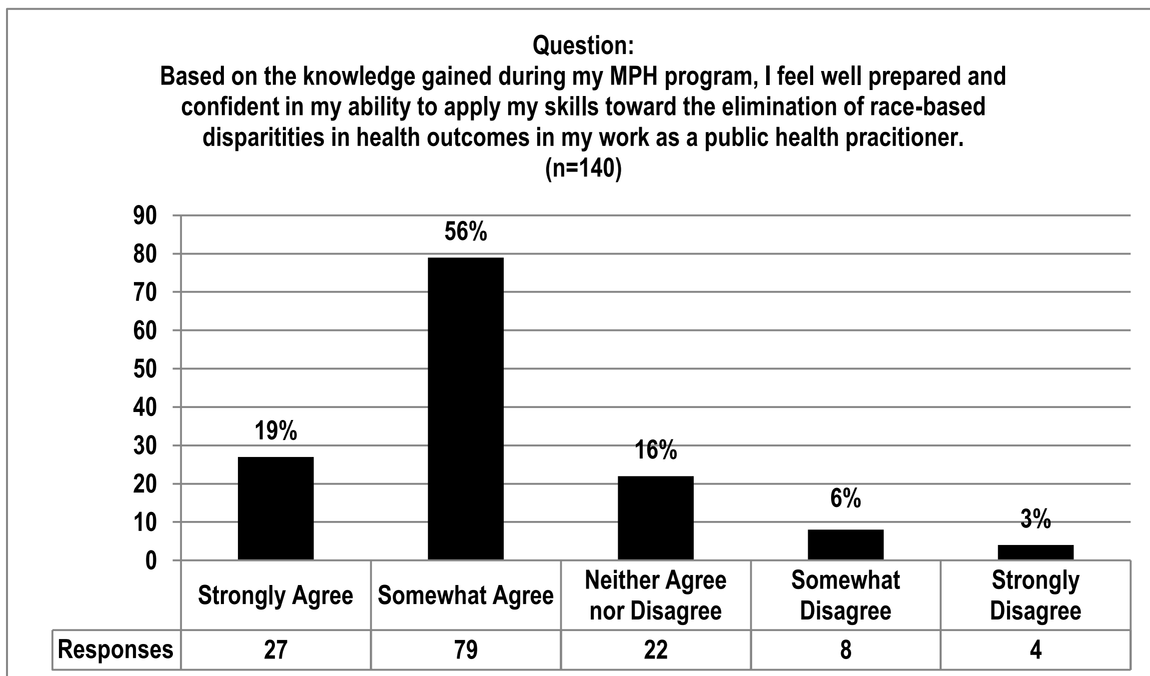
Table 4.4 – Venues of Exposure to Racism Content Question: If possible, please describe in more detail the venue(s) where you were exposed to the topics mentioned in the previous question (i.e., the name of the class, lecture, title of the reading, who initiated the conversation, etc.) (n=66)
Talking about White privilege seems to make people uncomfortable.

(Please note regarding tables listing qualitative responses: not all responses to a particular question have been included in the corresponding table. Some responses do not appear in their entirety and have been edited for length and to preserve anonymity but not for grammar, spelling or punctuation.)

Prepared as Practitioners

When asked to consider and apply their own knowledge and abilities, students overwhelmingly responded (n=79, 56%) that they "somewhat agree" versus "strongly agreed" (n=27, 19%) that they were confident, based on knowledge gained during their MPH program, in their ability to apply their skills to eliminating racism in their work as public health practitioners. See Figure 4.2 for a breakdown of all the responses to this question.

Figure 4.2 – Prepared as Public Health Practitioners

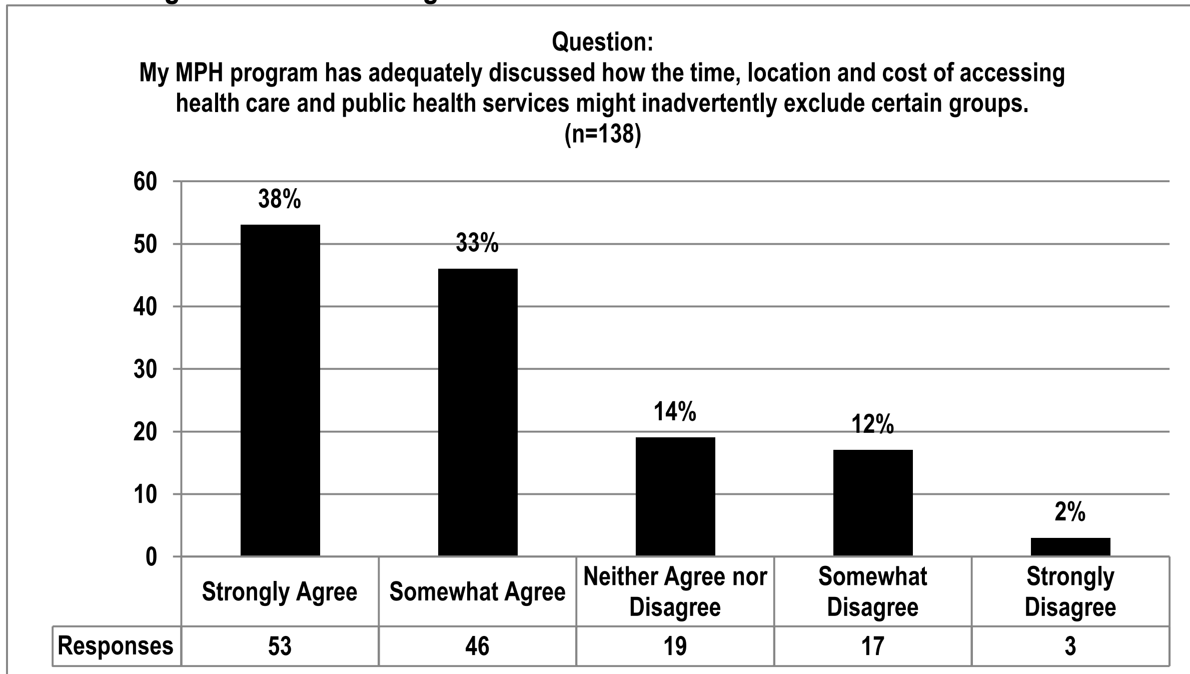


This response – where students indicate some agreement with the idea that they gained knowledge related to race-based disparities during their MPH program - appears to contradict the previous questions where students said their knowledge of racism related topics was due mostly to venues outside of Rollins and not the RSPH curriculum. See Chapter 5 for more details related to this result.

Addressing Access in Public Health Curriculum

The ability to access appropriate health care is an important issue when considering racism's impact on race based health disparity. A majority of study respondents (n=53, 38%) said that they "strongly agreed" that their MPH program had "adequately" discussed this issue. See Figure 4.3 for a breakdown of all the responses to this question.

Figure 4.3 – Addressing Access to Health Care and Public Health Services

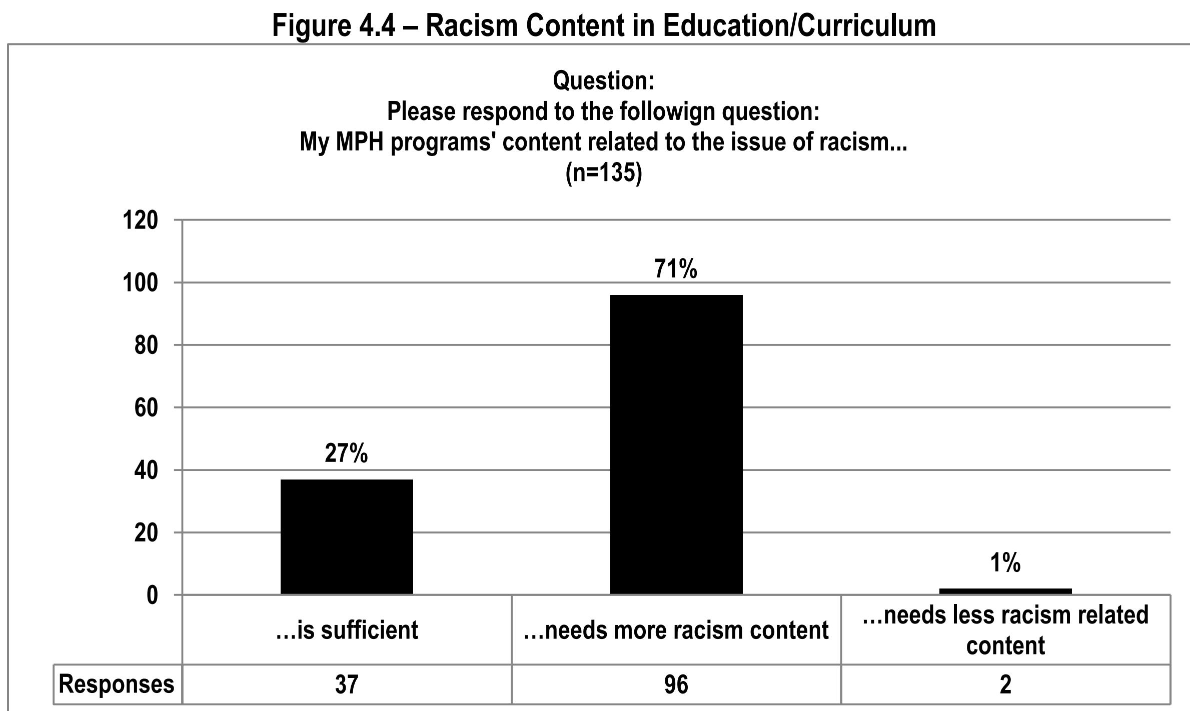


	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Responses	53	46	19	17	3

Appropriate Racism Content

In addition to considering specific racism related topics and concepts, students were asked to consider, in general, whether their MPH program had provided “sufficient” content related to racism. In keeping with student responses to previous questions where students most attributed their knowledge of racism related concepts to sources outside of RSPH, a majority of students (n=92, 71%) indicated that their MPH program needed “more content related to racism” as opposed to “less” (n=2, 1%) or that the content was “sufficient” (n=37, 27%) See Figure 4.4 for a breakdown of all the responses to this question.

Figure 4.4 – Racism Content in Education/Curriculum



Respondents were then asked in a qualitative question to provide greater detail of “why” and “in what ways” their MPH program’s racism related content should be either “more,” “less,” or is “sufficient.” Of the 37 students that responded that the amount of racism related content was “sufficient,” 49% (n=18) students commented to the qualitative question. Many of these

responses acknowledged the need and importance of race and disparity issues; however, they did not support the need for more required inclusion of related content within the curriculum. They often noted that sufficient opportunities already exist, particularly for students that "self select" to seek this information if they have an interest in this area. However, comments often reflected a feeling among this group of students that the impact of racism on health is but one issue and that they had other areas of interest within public health. In addition, there were also many students that felt that enough content was available and that more would not be value added. Some selected student comments reflecting these themes are in Table 4.5.

Table 4.5 – Racism Related Content "Sufficient" **Question:** **Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=18)**
Responses:
Not my area of interest. I understand general impacts on access to healthcare and environmental exposures but further information is not relevant to my career in emerging infectious diseases
The socio-contextual certificate and all of its related courses, lectures, and seminars provide ample opportunity for the RSPH community to discuss racism.
My program is research-focused. It is important to learn about these issues and ways in which I can help, but I need to make sure I learn everything else as well. I don't think there is enough time within the degree to give more attention to these topics.
It's sufficient if you choose to seek it out. Some students could go through their entire MPH without exposure to these topics. Those interested in these issues may be a self-selecting group.
I'm in the epidemiology department and my research doesn't relate to any racism-related issues. Didn't really see a need to have this in my classes.
I think that a basic understanding of this issue by all student is necessary and achieved. What is currently in the program should remain. However, there are many of us who have interests in public health that may not coincide directly with this topic and even feel that there are issues that are not adequately touched on in the program. For this reason, I do not think that an increase in required education about racism and health is necessary.
There are plenty of opportunities to engage in discussions on racism in healthcare; however I think students do need to seek it out for themselves as it is not build into everything required by students.

(Please note regarding tables listing qualitative responses: not all responses to a particular question have been included in the corresponding table. Some responses do not appear in their entirety and have been edited for length and to preserve anonymity but not for grammar, spelling or punctuation.)

Of the 96 respondents that said that there should be "more" racism related content in their MPH program, 74% (n=71) responded to the qualitative question providing detail of "why" and in "what" ways they think more racism related content is needed. The common themes expressed

among these respondent comments acknowledged that these issues are discussed in Behavioral Science and Health Education (BSHE) classes but not as much for other majors/departments like epidemiology (Epi), global health (GH), and health policy and management (HPM), etc. In addition, it was expressed that when there are related discussions in classes they should go into "more depth" and detail of the subject. More than once, students mentioned that the absence of more substantive conversations may be due to a lack of ability or knowledge and willingness of faculty and professors to engage further with these topics. Several students mentioned that they have to seek out – on their own – more information about racism's impact on health and that they would prefer that these issues be more available within their curriculum; some went as far as to suggest that this content should be "mandatory" or "required" of "all students" versus optional opportunities.

Comments also included tangible reasons for why these issues are important regardless of interests or major field of study. There were several comments from students regarding how these topics intersect with and are important to how we research and study disease. For example, one student commented that "race is used as a measurable, stand-in variable for a variety of other difficult to quantify variables such as socioeconomic status. This in itself is racism" while another student said that "I think that we need to think of race as a more complicated variable instead of something to be adjusted for and forgotten."

White privilege and perspective associated with public health in general and RSPH specifically was also mentioned because of its potential to hinder inclusion of racism related topics in the curriculum. One student commented that, "MPH programs are dominated by upper middle class White women and international students from China and India…a bigger issue is how can we discuss racism when the conversation is by White faculty for largely White

students? Would we talk about rape and exclude women?" while another noted that there is "still a lot of White privilege felt at Rollins."

Many students also offered examples of how they envision or suggest racism can be more incorporated into their MPH program's curriculum. One student suggested that "racism/race related content could be required during orientation" while another said that "it would be valuable to include a component that forced each student to engage with how racism has shaped health policy in this country, perhaps through writing a paper" and yet another suggested an "introductory course in GH can have round table discussions…and challenge students to think beyond their comfort level…provide opportunities for Rollins students to collaborate long term with communities of color." Table 4.6 includes some of the comments of respondents that indicated wanting "more" inclusion of racism related curriculum.

Table 4.6 – Racism Related Content "Need More" **Question:** **Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=71)**
Responses:
I feel like often in classes the idea of racism is swept under the rug like it did not occur and as if it is not still VERY prevalent as a driver in current health outcomes of minority populations.
Need more depth. Very basic concepts are explained a few times, but strategies for actually eliminating implicit bias or structural racism are entirely absent from the curriculum.
The Health Policy and Management department discusses it in classes, but does not focus any particular time on it as a subject. While it is mentioned, in some ways it is tip-toed around in the HPM department. Very few classes lead to serious discussions about intersectionality between race, income, gender, etc.
I think it's important to incorporate how unintentional bias and prejudice may impact policies created or enforcement of such policies that primarily negatively impact minorities. I also don't believe much instructional time is being spent on how we can reduce individual prejudice. While systemic health and economic issues caused by poor policy making and enforcement is harmful, many people experience direct racism and mistreatment at the interpersonal level. You see this surfacing in social media comment pages, for example, so I wonder If instructors can locate literature surrounding potential programs and interventions that aim to reduce personal racism, discrimination, and biases so that classes can begin to discuss how we can be more proactive. Lastly, I think while the impact of racism on health outcomes is discussed in the behavioral and social sciences, I believe less emphasis is placed on this subject in departments such as HPM and Biostatisics. While outside events are held to discuss social concerns like racism, it's crucial to include this in the classroom setting.
It's not taught in the core classes (HPM, BSHE, GH, or ENV) that all students are required to take. It is often mentioned as a side note, "racial disparities" however the how's and whys are not discussed or examined.
These discussions on race and structures of power and disenfranchisement only take place in specific courses and departments

Table 4.6 – Racism Related Content "Need More" Question: Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=71)
that are focused on it. The way the curriculum has been designed at Rollins makes issues of race and social determinants of health a topic or concentration instead of infusing it throughout the curriculum as a whole. We should be talking about these things in EVERY class because they touch everything.
It needs to be discussed more openly, and not glossed over, for instance as an exposure. Let's talk more about why it is an important exposure for so many diseases.
Health outcomes and disparities are not exclusive of race; however in almost all the classes I have been in this has not been explored. I feel that will we graduate and make the divide worse instead of working to bridge it unless we take it upon ourselves to not be blinded to the institutional racism that impact health behaviors and outcomes. Our introductory course in GH can have round table discussions and key elements on social determinants and challenge students to think beyond their comfort level, provide opportunities for Rollins students to collaborate long term with communities of color (work from within to challenge our preconceived notions)
I rarely learn about racism except that African American have higher preterm birth babies. the epi department needs to include more in required classes.
I think it's important that we start to address more areas in health where POCs have experienced health disparities due to the effects of racism. For instance, I would like to learn more about health outcomes in black women that do not relate to HIV. Black women face a disproportionately high risk of other negative sexual and reproductive health related outcomes. They also face issues in other areas of health as well, including mental health, nutrition, and environmental racism. I would also like to learn more about health outcomes where POCs may have better health outcomes as compared to their white counterparts, because they do exist, but you wouldn't know that from the way our content is taught, with white Americans often being the metric for most outcomes. We also need to talk more about Native Americans, because this ethnic group is all but erased from our curriculum. There needs to be a class devoted to cultural humility and working in a non-problematic vein with these communities.
Racism has demonstrated to be a hindrance to healthcare access. As future public health practitioners, we need to be equipped with the knowledge of this growing social construct in order to eliminate health disparities.
The events that address racism are mostly attended by minority students. Everyone should be required to learn about this topic. Perhaps a racism /race related content could be required during orientation.
It would be possible to graduate from HPM without ever having to truly engage with racism. It would be valuable to include a component that forced each student to engage with how racism has shaped health policy in this country, perhaps through writing a paper. I have gained this knowledge of my own accord, through electives and extracurriculars. It should be required as part of a core class in each department.
MPH programs are dominated by upper middle class white women and international students from China and India. Racism is a chapter in a textbook rather than a real part of living. But a bigger issue is how can we discuss racism when the conversation is by white faculty for largely white students? Would we talk about rape and exclude women (who are often the victims of rape)?
As I mentioned before, in many of my classes race is used as a measurable, stand-in variable for a variety of other difficult to quantify variables such as socioeconomic status. This in itself is racism, because it paints a picture of minorities as being less educated, more likely to engage in certain unsavory behaviors, earn less, and are more likely to live in dangerous neighborhood than whites. I think that discussions need to be held in classes why careful, thorough analysis of variables is needed, because using race in this manner is lazy epidemiology. As the upcoming leaders in public health, we need to be aware of our biases. We can take bias analysis classes to make sure our statistics and computer programs work correctly, but when we have ingrained biases, it shapes the way we go about the analyses in the first place.
I think race and other social determinants should just be included holistically regardless of the overall topic, not just is specialized lectures or classes.
I have classmates who are not aware of the health effects of institutionalized racism, and even refuse to believe we still have institutionalized racism in America. I have classmates in other departments (outside of BSHE) who are not aware of the historic public health atrocities that were motivated by racism (Tuskegee, Chinatown plague, 1900 etc)

Table 4.6 – Racism Related Content "Need More" Question: Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=71)
There needs to be more discussion had in the classroom/in mandatory spaces. RSPH has many optional opportunities for discussions on racism, but that is self selecting. More of these spaces need to be required so that everyone is having talks about racism not just those of us that know we need to discuss this.
From many conversations with peers, I have found they do not thoroughly understand the current conditions of racism, or understand the current issues of racial tensions. It concerns me that they may not be adequately prepared to serve minority populations if they are not understanding the issues entirely.
I believe that race, ethnicity, nationality, sexuality, etc. needs to be expanded upon so that it is not just a covariate. In my main epidemiologic coursework, we spend a lot of time discussing covariates, but we lose the concept of race as a real life consequence of various institutions and systems of oppressions. I think that we need to think of race as a more complicated variable, instead of something to be adjusted for and forgotten.
Particularly in the climate of race relations in the United States today, for public health professionals to effectively work towards reducing health disparities, we need to have a better understanding of how race and culture affect population health. This is particularly important for those of us who work for communities outside our own.
In every single class and mandatory introductory courses on the subject for every department.
It isn't discussed enough. I need to know about it from all fronts, epi, biostats, Env/occ health etc.
Other than discussing racial groups who may/ may not be covered by ACA, there is very little focus on the impact and effects of lack of access to proper healthcare and other determinants of health in most core HPM classes. Acknowledging the role racism plays in many healthcare policy and management issues could significantly change the perspective of a student when he/ she is determining and assessing necessary factors to produce final deliverables for a client.
There was still a lot of white privilege felt at Rollins. It seemed that some people still didn't "get" it. Perhaps they would be more receptive if it were presented within the context of classroom learning. I answered an earlier question with "somewhat disagree" because I do not feel CONFIDENT that I could make a difference for these marginalized communities in my work after I leave Emory.
I think race and health is glossed over a lot. Many times professors will make a flip comment referring to how race impacts health, but I can't remember the last time a professor really delved into racism and race. It seems to be a topic more focused on in readings than in class, and it seems like professors just assume we're all on the same page. Yes we are liberal, but I want a structured environment where my classmates and I can talk about race, privilege, and health.
The phrase "African-Americans are most at risk" is almost commonplace. "Everyone" knows that minorities have poorer health outcomes because they are underserved, there is low cultural competency, etc. However, while we link race, access, and health outcomes, there is little discussion of racism specifically. Discussing racism is important because it is the mechanism by which minorities have been left with poorer access to health services and poorer health outcomes. We need to spend more time considering the historical context of minority groups, as well as have in-class discussions of contemporary racism and how it may affect healthcare. We need to move beyond just saying "Minorities have higher rates of X" to "Minorities have higher rates of X because racism affects them in Y way. Here are some ways in which racism and discrimination affect their ability to receive the health care they need."
I know that other Rollins students haven't had the same experiences as me, and frankly sometimes they say things that are not racially sensitive. We all need more training
This is proving to be a defining contemporary social issue. While I'm aware of how racism affects health, I'm less comfortable in defining my role in how to fight against it.
I am interested in chronic disease. I have taken several courses on the subject matter and none of them mention the topic of perceived racism as a predictor/contributor to chronic disease. I also think it would be useful to have more talks that speak to the actions that can be taken to incorporate racial justice into our public health work. ABPHS exists but many allies are unsure of whether this club is friendly to people in racial majority groups.

Table 4.6 – Racism Related Content "Need More" Question: Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=71)
I would like to have more frank conversations and panels with people who have experienced racism first hand. I would like to hear their thoughts and potential solutions.

(Please note regarding tables listing qualitative responses: not all responses to a particular question have been included in the corresponding table. Some responses do not appear in their entirety and have been edited for length and to preserve anonymity but not for grammar, spelling or punctuation.)

Some students who felt there should be "more" racism curriculum also mentioned that there was often attention to racism related issues from a global perspective, however, there was little to no mention of these issues related to domestic or United States race relations. Specifically, one student commented that "Being in global health, we often discuss issues abroad and not much at home. It would be nice to discuss racism that includes Black, Hispanic, and Asian groups" while another said that "We often think globally and put less emphasis on disparities within our own country and system." See Table 4.7 for additional respondent comments that reflected this perspective.

Table 4.7 – Racism Related Content "Need More" – Global Health Perspective Question: Please briefly describe why and in what way(s) you think racism related content is sufficient in your program (n=71)
Responses:
The goal health classes don't address the history of imperialism and how it led to the global racial disparities we have today - how is it possible to do global health without knowing that?
Being in global health, we often discuss issues abroad and not much at home. It would be nice to discuss racism that includes Black, Hispanic, and Asian groups.
Global health needs to talk more about these issues in their core classes. Even though the focus is on global populations these issues are not addressed. Nothing about what happened during colonization and how white man's burden came about. These should be required topics to cover and extremely necessary to address cultural competency when working globally, just as much as they are locally.
As a GH student we briefly touch on power dynamics and cultural sensitivity in most classes, but I think the MPH should have a required ethics course that includes discussion of racism and privilege, both in the US and abroad.
We often think globally and put less emphasis on disparities within our own country and system.

(Please note regarding tables listing qualitative responses: not all responses to a particular question have been included in the corresponding table. Some responses do not appear in their entirety and have been edited for length and to preserve anonymity but not for grammar, spelling or punctuation.)

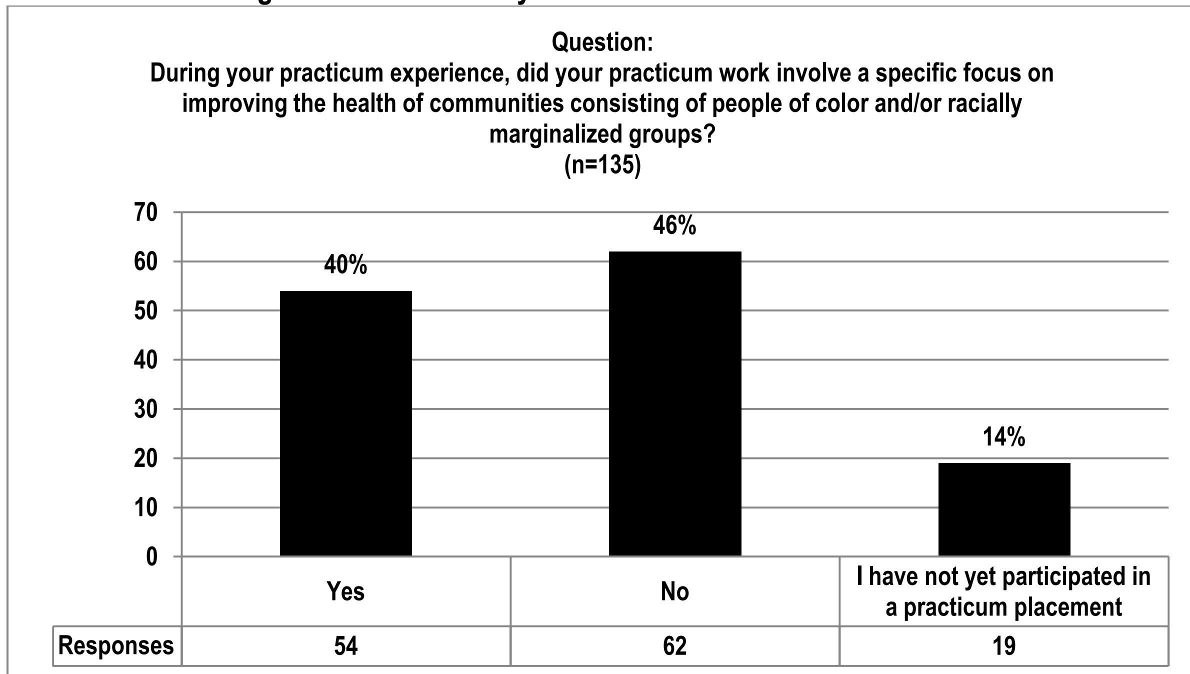
Finally, there were two respondents (n=2, 1%) that indicated that there should be "less" racism related content in their MPH curriculum and both students (n=2, 100%) answered the qualitative question detailing "why" and "in what ways" they thought that racism content should be less. Both students appeared to acknowledge the value of the subject matter by explicitly stating this or implying it by admitting to having taken courses in the topic. However, one student felt that "other topics should be prioritized especially outside of the U.S." while the other was unhappy with the way related conversations had occurred at RSPH because neither "Rollins professors or students can talk about race pragmatically" and therefore felt related discussions had been "a waste" of time.

Assessing Community Service

As discussed in previous chapters of this study, the community service model is a common approach used in schools of public health to aid students in gaining knowledge of and exposure to communities of color for addressing health disparities. Study respondents were asked if they were taking advantage of the community service option for their practicum placement as well as a qualitative question seeking details of the placement to assess the placement's appropriateness to addressing the social justice aspect of eliminating racism's impact on health.

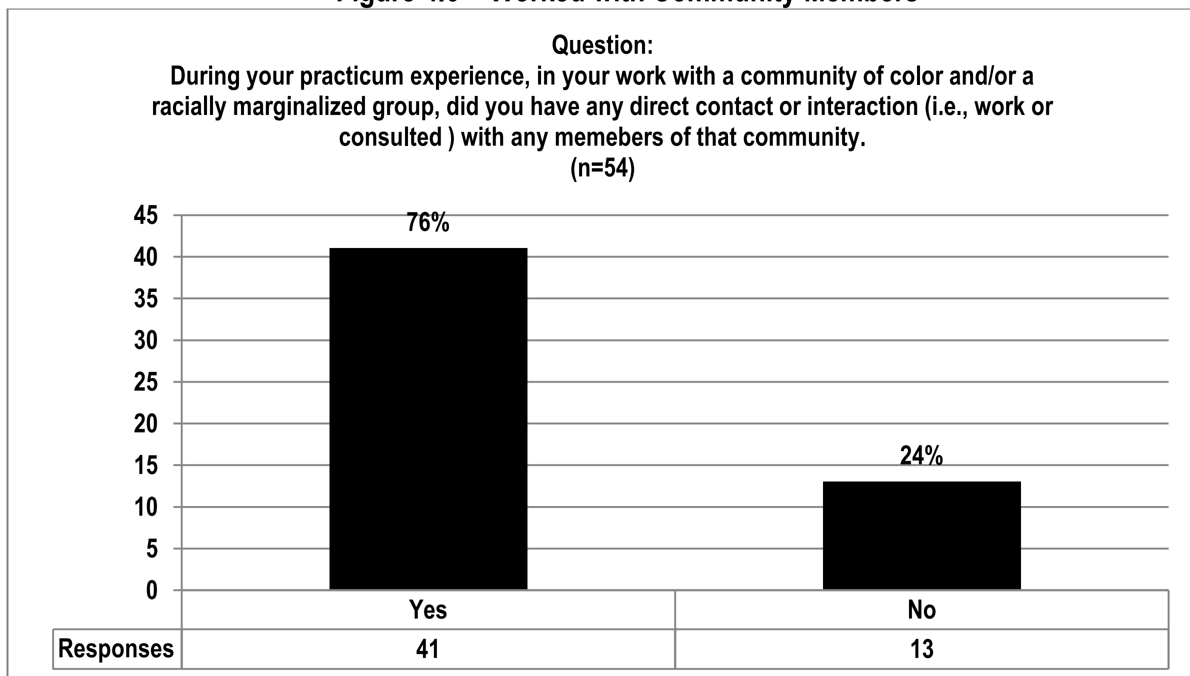
The greatest number of students (n=62, 46%) indicated that they did not work with a community of color during their practicum placement; nonetheless, the numbers of students that said that they did work in a community of color was not much lower (n=54, 40%). See Figure 4.5 for a breakdown of the responses to the question.

Figure 4.5 – Community Service Related Practicum Placements



Of the 54 students that said that they worked in a community of color, 41 (76%) said that they had “direct contact or interaction (i.e., work or consulted) with community members. See Figure 4.6 provides a breakdown of the responses to this question.

Figure 4.6 – Worked with Community Members



Students were asked to describe their placement in a qualitative question in order to determine the specifics of the placements and it's appropriateness to addressing the impact of racism on health. To this question, many students indicated having worked with populations of color both in and outside of the U.S. and identified efforts such as program planning, data collection/management, program evaluation, education, bed net distribution, facilitating focus groups and designing research studies working with health issues including HIV/AIDS, WASH, breastfeeding, Tuberculosis, healthy eating/active living, and Ebola.

The important consideration regarding practicum placements within communities of color is the extent placements provide a social justice perspective and avoid perpetuating racist power dynamics. As seen in Table 4.8, some respondents to the practicum placement question offered details that reflected a social justice framework via the practicum's focus on racism or exposure to feedback from members of the community. Nonetheless, some responses did not appear to mirror this same social justice perspective. For example, one respondent said (quoted edited to preserve respondent anonymity) they, "updated the database" for an agency that "provides health care services in prisons in low-resource settings" and indicated that they spent "a great deal of time in the prison." This was an important public health function; however, there is no mention of any direct contact with prisoners or opportunities to receive feedback to gain knowledge of prisoner experiences or circumstances nor does it involve dismantling any of the social circumstances that may result in incarceration. An example of a placement with more of a social justice perspective came from the respondent that said that they did "qualitative research with West Africans about the Ebola outbreak to discuss how they experienced the humanitarian aid, what could have been handled differently."

Table 4.8 – Practicum Placement Descriptions Question: Please briefly describe your practicum project work with a community of color and/or a racially marginalized group (i.e., what was your project topic, community you worked with, the type of work that you did and/or interaction that you had, etc.) (n=41)
Responses: Social Justice Focused
I worked with members of this community to evaluate the program that the organization was doing. My interactions with them consisted of facilitating focus groups, helping to conduct surveys, and to learn from what they had to say about their community.
This summer, I conducted qualitative interviews to access how women living with HIV have been stigmatized or discriminated against because of their status. All of the participants I interviewed were excited about the opportunity to tell their story.
As we got further into the research, our participants were majority black. So even though the main focus wasn't on black MSM, a majority of our respondents discussed race as a barrier to accessing HIV related care and services.

(Please note regarding tables listing qualitative responses: not all responses to a particular question have been included in the corresponding table. Some responses do not appear in their entirety and have been edited for length and to preserve anonymity but not for grammar, spelling or punctuation.)

For those practicum descriptions that did not explicitly exhibit a social justice perspective, it should be noted that the wording of this question did not specifically ask about social justice. This omission was in order to allow for study versus student interpretation of the placement's compatibility with social justice efforts.

CHAPTER 5 – DISCUSSION

Introduction

This chapter will discuss the study's findings, limitations, implications to the knowledge base and recommendations borne from the study's results.

Summary of Study

Problem

This study was premised on the idea that there is a critical need for the inclusion of eliminating racism content within the public health curriculum. Among the indicators of this need is the recent rise in racial tensions in the United States (Williams & Wines, 2016). In addition – and specific to the policies and practice of public health – research has shown racism to be a catalyst in the creation and perpetuation of health disparities among people of color (Frenk, 2014; Thomas, 2001). Race based health disparities also have a significant impact on the nation due to corresponding health care costs (Centers for Disease Control and Prevention, 2013; Kaiser Family Foundation, 2016) as well as the expected shift in US demographics that reflect an increase in the population of people of color (Kaiser Family Foundation, 2016). In addition, research shows that racism does not just negatively impact outcomes for people of color but for all of society including Caucasians (Lee et al., 2015). An additional consideration is the historical impact that racism has played in establishing and contributing to the current state of health disparities (Feagin & Bennefield, 2014).

In spite of the magnitude of the aforementioned issues, close examination of the public health community reveals a slow and/or hesitant effort to research, discuss, and openly embrace the reality of the relationship between racism and health (García & Sharif, 2015). However, as more public health stakeholders have taken note and legitimized the issue, it has become

important to consider how, if at all, the public health academic community has considered this issue. As a whole, the public health community's hesitance to acknowledge and move forward the concept and terminology of racism as well as racism's role in health outcomes is reflected in governing public health educational organizations and institutions (Taboada, 2011). There is also a tendency among the academic community to use "white framing" (Feagin & Bennefield, 2014) language and overarching terminology like "cultural competency" (Bull & Miller, 2008; Taboada, 2011) and efforts like "community service learning" (Taboada, 2011) without fully accepting and addressing their inability to reduce and eliminate racism not to mention their potential to contribute to and perpetuate racism (Bull & Miller, 2008; Kumagai & Lypson, 2009; Taboada, 2011).

In addressing these problems, the primary purpose and design of this study was to research whether racism related education and curriculum currently exists within MPH programs and the extent that this curriculum has influenced student knowledge of these issues. These questions were answered using data collected from MPH student responses obtained via an online survey of quantitative and qualitative questions.

Results

Student Comfort Level and Knowledge

Overwhelmingly students felt "knowledgeable" and many even expressed an ability to teach racism topics and concepts. Those students who indicated that they could teach these topics may have been influenced by their comfort with the idea of teaching based on their past experiences as teachers or their perception of their ability to teach. However, of all of the respondents (n=157) to this question, only a small number (n=21, 13%) indicated being able to teach *all* topics in the question. This indicates that for the majority of respondents their

consideration of and familiarity with the topic likely took precedent in determining their answer over their perception of their ability to teach in general.

While students indicated being knowledgeable, they most often attributed this knowledge to sources outside of their MPH program – from venues as diverse as their undergraduate education to friends and social media. Respondents to the venues question were allowed to check all of the venues they were influenced by regarding a particular topic. This provided a more unbiased response because it allowed students to consider all influences as opposed to just one. While this was a worthwhile approach it would have also been interesting to ask respondents which *one* venue they felt most impacted their knowledge of a particular topic to determine the venue that was most important versus the more objective approach used.

An additional measure of student knowledge was to determine the characteristics (i.e., ethnicity and academic department) of those students that indicated that they were knowledgeable (i.e., "strongly agreed" that they were comfortable discussing racism topics and were also "comfortable teaching" all of the racism topics mentioned). As noted in Chapter 4, of the 13 respondents who were considered knowledgeable, the majority were Black/African American with an equal number of students represented from the Health Policy and Management (HPM) and epidemiology (Epi) department. Both of these results are interesting given the fact that neither (Black/African American nor the HPM department) represented the majority of respondents to the survey. Since the majority of the 13 most knowledgeable students were Black/African American, it may be assumed that their ethnicity could have informed their knowledge of racism related issues. In addition, of those student that were most knowledgeable, there were only a small number (n=2, 15%) from the BSHE department, which is surprising considering that students said that BSHE classes, versus other departments, offered the most

exposure to racism topics. It is interesting that students who considered themselves most knowledgeable are matriculating in the departments (i.e., HPM and Epi) identified as offering less racism content. If students who are most knowledgeable are in departments where they feel that the racism content is lacking, this could support the idea that most students receive their racism content from outside of their MPH curriculum. Lastly, there is some indication that the "characteristic" educational background may have been informative because, of those students that were most knowledgeable, several mentioned social work, women's health studies, and anthropology, which were all undergraduate majors identified by students as being a venue that informed their knowledge.

Racism in MPH Education/Curriculum

In terms of racism content within and outside of the MPH curriculum, venues outside of the RSPH were most often indicated by students as having informed their knowledge of various racism and race based health disparity concepts. Because some students felt that school based opportunities (i.e., class discussion, etc.) were inadequate due to quantity and content, many students expressed that they have often "self selected" to seek related options by participating in extra curricula activities such as lectures, seminars, and certifications offered within their school and by school affiliated organizations. Further, students often expressed the desire to have these issues discussed in both classes and coursework on a mandated or required basis. It is not surprising then that when asked specifically about racism related curriculum content, that a significant majority of students also said that there should be an increase (versus "less" or that the amount was "sufficient") in their academic curriculum related to the impact of racism on health disparities.

When students were asked if, "based on knowledge gained during the MPH program" they were "well prepared" and "confident" in their "ability" to work as practitioners to eliminate race based health disparities, a large majority said they "somewhat agreed" versus "strongly agreed." This response seems to indicate that students felt that there was some knowledge gained by their MPH program, which appears contradict the previous questions where students indicated that their knowledge of racism related topics was due mostly to venues outside of Rollins and not necessarily because of the influence of the RSPH curriculum. Nonetheless, a more solid support of the MPH program's role in respondent's perceived sense of ability to work as practitioners (to eliminate race based health disparities) would exist if a majority had "strongly agreed" (versus only "somewhat agreed") that the program had prepared them. Further, this discrepancy could be due to the fact that this question's wording did not ask about the influence of Rollins or the MPH program's impact specifically. Rather, the question asked about "knowledge gained during" the MPH program which students could have interpreted in a general sense by considering all sources (i.e., RSPH extra-curricular activities outside of the formal curriculum, friends/peer discussions, social media, etc.) that they were exposed to during their time in the program. This may be particularly true considering that, as pointed out earlier, racism was a prominent issue before and during this study, which may have provided many opportunities outside of the curriculum for students to be exposed to the issue. Unfortunately, as mentioned previously, learning and knowledge gained outside of a required and mandated curriculum can result in inconsistent skill and understanding among students and ultimately the public health workforce.

Practicum Placements

The majority of students do not avail themselves of a community service option for gaining greater exposure to individuals and communities of color during their practicum

experience. Nonetheless, the majority of students that do community service in their practicum indicated that they engaged in “direct contact or interaction” with members of a community of color. These types of placements are important to public health and are of great merit, particularly to the extent that they offer opportunities to expose students to issues like White privilege. However, these engagements did not always exemplify the tenants of social justice that can counter the White privilege and power dynamic that often perpetuate racism in these types of placements. Placements were determined to lack a social justice perspective – even if students had contact with community members – if the student did not express having had opportunities to experience direct feedback from community members regarding their needs and experiences. For practicum placements where students participated in certain activities such as “bed net distribution” or “WASH evaluation in Haiti,” the power dynamics and social justice issues that exist in American culture may not extend to or at least manifest in the same way as they do in the United States. Therefore, these experiences still may not expose students to the influence and role of institutional and systemic racism on health that exists in the world and particularly in the US and as a result may not be suitable for educating students regarding how to dismantle the impact of racism on health.

It is possible that some students didn’t mention these types of interactions due to the fact that the wording of the question did not specifically ask students to describe their placement in terms of compliance with a social justice perspective but only asked for a description of their contact with community members. This was done so that the study, instead of the student, could interpret whether the placement offered a social justice perspective. If students had known that the full intent of the question was to consider a social justice perspective, they may have provided different or more pertinent details.

What is interesting about these findings is that while the majority of students who responded to this study seemed to have an interest in racism's impact on health disparities as well as the desire for an increase in required racism content, the majority were not utilizing the community service model and may not have been working with an anti-racist or social justice perspective in mind. This is important because the community service model could offer these students the exposure to eliminating race based health disparities that they seem to seek. Once again, this may be an example of desiring more knowledge of racism's impact on health, yet, when certain curriculum isn't required; students may or may not avail themselves of the content.

Limitations

The following discussion outlines areas where limitations existed in this study.

Survey Instrument

Because the study used an original, untested survey instrument developed by and for use in this study, a pretest or pilot study was attempted. However, because there were no responses to the pilot study there was no substantiation of the study instrument's content prior to conducting the main study, therefore, it is not possible to determine the validity and reliability of the instrument. In addition, this study used self-reported data based on respondent perception, which while appropriate, can only provide a subjective understanding or opinion versus knowledge based on more quantifiable facts about the MPH curriculum.

Generalizability

This study utilized only one MPH program in one state and therefore the results may not be applicable or equally reflective of responses that may be gained when implementing this study in other schools, locations, and MPH programs. Further, this study generated a 29% response

rate of the targeted second-year RSPH student population. This response rate may be considered less than a desired minimum necessary to achieve statistical significance.

Lastly, this study targeted only students who had at least matriculated to second-year status because of their level of exposure to the program. Yet, each of these students may have completed a different number of semesters as well as different courses (i.e., taken classes out of order, completed three versus four semesters, etc.) at the time they responded to the survey and as a result have different perspectives of the curriculum.

Implications

This study's results revealed the extent that the MPH curriculum contained racism related content and how much this content impacted student knowledge of racism's impact on health disparities. This study also showed the degree to which students preferred or did not prefer the inclusion of curriculum about racism's relationship to health disparities. As such, these results present implications primarily for public health academia and curricula – particularly to the study location, Emory University – and organizations that broadly govern and guide public health education (i.e., CEPH, ASPPH, etc.). However, the study results have far reaching outcomes that are also relevant to the general public health workforce and community

Results of this study offer an approach for reducing and eliminating health disparities by revealing the areas where education and training can be developed or modified to be more inclusive of racism related concepts and topics. The study's revelation that students desire more inclusion of racism topics in their MPH curriculum, and that most related knowledge is obtained outside of their MPH curriculum, should inform and encourage acceptance among leading public health organizations – academic and otherwise – in the establishment, promotion and revision of public health curriculum, polices, guiding principles, core competencies, missions, and

objectives, etc, that better reflect the role and relationship of racism's impact on health status and outcomes. Acceptance of this study's results and implementation of study recommendations can lead to the development of improved and consistent skills and awareness among the public health workforce of the education and curriculum needed to reduce and eliminate health disparities.

Finally, this study informs schools of public health by confirming that there is significant student demand and interest in the inclusion of more racism related content in curriculum as well as what and how to include this material. This information is particularly salient for the RSPH, where the study was conducted, as several responses to the study were specific to the Rollins program (e.g., faculty, classes, etc.) and RSPH affiliated organizations.

Recommendations

The following suggestions are based on results from this study including actual comments made in student responses to the survey instrument and supported by content from the academic literature. Suggestions are mostly applicable to schools of public health but some can also be useful to the entire public health community.

<u>Open dialogue</u>

It can be drawn from the results of this study that there is a need to provide more properly facilitated (i.e., with facilitators that are comfortable, appropriately skilled, and experienced in working with social justice and racism related issues) opportunities within schools of public health to openly and safely discuss racism and its impact on health disparities. One student responded that they were "terrified of saying non-PC things" and "would love more opportunities to increase…cultural sensitivity in a nurturing, understanding environment." Kumagai and Lypson (2009) cite the merits of "engaging dialogue in a safe environment, a change in the traditional relationship between teachers and students, faculty development, and

critical assessment of individual development and programmatic goals." In response to this study, many students appreciated the RSPH's Lunch and Learn Series or regularly scheduled (as opposed to one-time event) town halls, community chats or similar types of efforts – focused on racism and health disparities. These opportunities can be offered with sponsorship by student organizations - particularly those whose memberships consist of students of color like the RSPH's Association of Black Public Health Students (ABPHS). However, these organizations should consider their engagement and inclusion efforts because, as one student responded, they were aware of the ABPHS but were "unsure of whether this club is friendly to people in racial majority groups." Similar organizations may want to consider providing roles and more tangible inclusion of students outside of the group's focused ethnicity or at least the establishment of student organizations focused on racism issues where membership is open to all students, regardless of ethnicity. One caution regarding these types of extra-curricular events is that while they represent activities and opportunities that may be useful and result in positive change, efforts that are not required will result in participation by only those students that "self-select" to participate where many will likely "opt-out" resulting in a lack of uniform understanding and application of these principles within the public health community for both academia and the professional work force.

Partnering

Collaborating with expert organizations and agencies devoted to educating about racism and social justice issues can guide and facilitate efforts to educate schools of public health – including students, faculty, and staff. In addition, Historically Black Colleges and Universities (HBCU) – particularly those that have an MPH or similar (e.g., social work, health professions, etc.) academic program – can also provide consultation and support. Also consideration should

be given to related academic fields (e.g., social work, sociology, etc.) and corresponding curricula that routinely incorporate social justice principles. These types of partnerships will encourage greater understanding of vulnerable and at-risk populations as well as increase – among the public health community – awareness of racism, recognition of any biases and prejudices and the formation of effective strategies and skills for working with all populations including people of color. Social work, a "field" (American Public Health Association, 2016) considered by the APHA to be a part of the public health workforce, presents a good example. Racism curriculum has been widely incorporated in the social work academic curricula at the master's level and there is literature available discussing these efforts (Loewenstein, 1976; Loya & Cuevas, 2010; Mitchell, 2012; Osteen et al., 2013; Phan et al., 2009; Swank et al., 2002).

Curriculum

Schools of public health should develop specific curricula that are inclusive of content on racism's impact on health including classes/courses, specific exercises, activities, lectures and related readings that can be incorporated into existing curricula requirements. Modifications to the existing required curriculum is advantageous over voluntary options and individual courses because, as stated by Bull and Miller (2008) "focusing on single courses and cultural competence alone is unlikely to alleviate health disparities." The inclusion of racism content should extend to all of the five public health core disciplines.

Diversity

It can be useful for the public health community to intensify efforts toward diversity. In agencies and organizations these efforts should be targeted to expanding the workforce and in schools of public health the student body as well as faculty and school leadership. It is especially important to recruit colleagues and faculty with expertise in educating around issues of

eliminating racism and the impactful role of racism on health outcomes in order to better facilitate incorporation of racism related content.

Practicum/Community Service

Because the community service model is an important component to exposing students to individuals and communities of color, it should be required that all or some portion of the practicum placement period should be with a community of people of color. To facilitate this and avoid perpetuating racism and dysfunctional social dynamics during the practicum experience, it is suggested that schools of public health should extend the length of time required to complete practicum placements. Increasing the length of practicum placements will encourage greater opportunity for sustained and embedded improvements for the communities being served and increased understanding, knowledge, and skill building for students in placements. In addition, there should be inclusion in the curricula of an instructional class or classes either prior to or during the placement to prepare students by raising their awareness, knowledge and skill around social justice issues and to allow them to confront their own potential bias, prejudices, and misconceptions. The social work curriculum uses this model and it can be informative of how to implement this approach in public health.

Guiding Principles and Policy Changes/Updates

Schools of public health as well as public health agencies and organizations can update their mission statements, principles, goals, and objectives, etc., to ensure adherence to the tenants of social justice by using related language (i.e., racism, White privilege, class and power dynamics, etc.) where appropriate regarding health disparities.

Future Research

This study considered student perception to measure their knowledge of racism concepts and topics as well as their abilities as public health practitioners. While this is an acceptable approach, it may not prove to be the most accurate measure of student skill. Further research is needed to accurately measure student's ability to apply their skills and knowledge. This research should include use of any type of survey instrument that provides a measurement of students' ability and skills and that concretely tests (versus accepting their perception) their ability to apply knowledge acquired via their curriculum of how racism impacts health. In addition, it may also be useful to study how MPH students compare to other academic fields (i.e., social work) where social justice curricula already exists to determine if there are measureable differences in knowledge, awareness and skill.

Advocacy

It is incumbent on all public health practitioners – whether at the student or professional level – to advocate for changes, inclusion, or increased attention of racism's impact on health wherever there is a need, particularly within public health agencies and institutions.

Conclusion

Racism continues to be – as it has been throughout history – a burdensome and complex blight in society with the potential to adversely impact the health – both mental and physical – of not just people of color but all members of society. W.E.B. Du Bois once said that "the problem of the twentieth century is the problem of the color-line" (White, 2011) and clearly, 16 years into the 21st century, the "problem" remains. Racial tensions are so extreme and intense that they have even escalated since the start of this study due to the outcome of the 2016 presidential election with riots and protests (Azadeh, 2016) as well as increased reports of racially motivated

attacks and bullying (Yan, Sgueglia, & Walker, 2016). To add insult to injury, now that the election is over, America's health care system hangs in the balance as it is expected that there will be efforts to "repeal and replace" (Pearlstein, 2016) the Affordable Care Act, which has – since inception – provided millions of Americans access to health care coverage (Department of Health and Human Services, 2016) and has the potential to reduce health disparities. These impending efforts represent a significant issue for the entire public health community.

Some may argue that the deep racial divisions exposed by the 2016 election expose volatility in society that should give pause to moving forward the issues discussed in this thesis. However, this study counters that perspective and demonstrates the need for the entire public health community to recognize that these issues are within their purview because, in the words of political activist and Black Panther Party leader Eldridge Cleaver, "you're either part of the problem or part of the solution" (Kifner, 1998). Therefore, it is incumbent upon our profession – now more than ever – to take action to incorporate necessary racism content throughout all public health domains.

REFERENCES

American Public Health Association. (2016). What is Public Health? Retrieved from http://apha.org/what-is-public-health

Anderson, L. S., Royster, M. O., Bailey, N., & Reed, K. (2011). Integrating Service-Learning into an MPH Curriculum for Future Public Health Practitioners: Strengthening Community-Campus Partnerships. *Journal of Public Health Management and Practice, 17*(4), 324-327. doi:10.1097/PHH.0b013e3182140bcc

Ansell, D. A., & McDonald, E. K. (2015). Bias, Black Lives, and Academic Medicine. *New England Journal of Medicine, 372*(12), 1087-1089. doi:doi:10.1056/NEJMp1500832

ASPPH. (2016a). MPH Core Competency Model. Retrieved from http://www.aspph.org/educate/models/mph-competency-model/

ASPPH. (2016b). Who is Applying to Graduate Schools and Programs of Public Health. Retrieved from http://www.aspph.org/connect/data-center/resources/

Association of Schools & Programs of Public Health. (2016). About. Retrieved from http://www.aspph.org/about/

Association of Schools of Public Health. (2006, May 22, 2006). Diversity and Public Health. Retrieved from http://explorehealthcareers.org/en/Article/102/Diversity_and_Public_Health

Azadeh, A. (2016, November 11). Anti-Trump protesters march for 3rd night; Portland police call it a 'riot'. *CNN News*. Retrieved from http://www.cnn.com/2016/11/11/us/oregon-protest-riot/index.html

Bassett, M. T. (2015). #BlackLivesMatter--a challenge to the medical and public health communities. *N Engl J Med, 372*(12), 1085-1087. doi:10.1056/NEJMp1500529

Blay, Z. (2016). Alton Sterling, Philando Castile, And The Indignity Of Black Death. Retrieved from http://www.huffingtonpost.com/entry/alton-sterling-philando-castile-and-the-indignity-of-black-death_us_577e6270e4b0c590f7e8265a

Booske, B. C., Robert, S. A., & Rohan, A. M. (2011). Awareness of racial and socioeconomic health disparities in the United States: the national opinion survey on health and health disparities, 2008-2009. *Prev Chronic Dis, 8*(4), A73.

Bull, M. J., & Miller, J. F. (2008). Preparing teacher-scholars to reduce health disparities. *Nurs Educ Perspect, 29*(3), 156-160.

Calhoun, J. G., Ramiah, K., Weist, E. M., & Shortell, S. M. (2008). Development of a Core Competency Model for the Master of Public Health Degree. *American Journal of Public Health, 98*(9), 1598-1607. doi:10.2105/AJPH.2007.117978

California Newsreel. (2003). Race the Power of an Illusion. *Background Readings: Ten Things to Know About Race.* Retrieved from http://www.pbs.org/race/000_About/002_04-background-01-x.htm

Centers for Disease Control and Prevention. (2013). Health Disparitites and Inequalities Report. *Morbidity and Mortality Weekly Report, 62*(Suppl 3), 3-6.

Centers for Disease Control and Prevention. (2014). NCHHSTP Social Determinants of Health: Definitions. Retrieved from http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

Centers for Disease Control and Prevention. (2016). U.S. Public Health Service Syphilis Study at Tuskegee. Retrieved from http://www.cdc.gov/tuskegee/timeline.htm

CNN. (2016). Trayvon Martin Shooting Fast Facts. Retrieved from http://www.cnn.com/2013/06/05/us/trayvon-martin-shooting-fast-facts/index.html

Cole, N. L. (2016). Definition of White Privilege: The U.S. Racial Hierarchy in the 21st Century. Retrieved from http://sociology.about.com/od/Ask-a-Sociologist/fl/White-Privilege.htm

Council on Education for Public Health. (2005). Efforts to Achieve Gender and Ethnic/Racial Divesity Among Public Health Faculties and Student Bodies. Retrieved from http://ceph.org/assets/DiversityEfforts.pdf

Council on Education for Public Health. (2016). Homepage. Retrieved from http://ceph.org/

Cubias, D. (2009). The Great American Melting Pot (?). Retrieved from http://www.huffingtonpost.com/daniel-cubias/the-great-american-meltin_b_225187.html

Damodaran, S., Gourevitch, R. A., Lin, T., Patel, N. A., Phu, R., & Rice, K. (2015). Climbing Down the Ivory Tower: Challenging Racial Injustice Through Community Health. Retrieved from http://harvardpublichealthreview.org/climbing-down-the-ivory-tower-a-student-run-health-equity-conference-on-challenging-racial-injustice-through-community-health/

Del Real, J. A. (2016, March 12). 'Get 'em out!' Racial tensions explode at Donald Trump's rallies. *The Washington Post*. Retrieved from https://www.washingtonpost.com/politics/get-him-out-racial-tensions-explode-at-donald-trumps-rallies/2016/03/11/b9764884-e6ee-11e5-bc08-3e03a5b41910_story.html

Department of Health and Human Services. (2008). *CDC's State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases: Social-Ecological Model*. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/Health/Health%20Manager%20Resources/Health%20Manager%20Resources%20Program%20Staff/CDCsStateBased.htm.

Department of Health and Human Services. (2010). *Healthy People 2020*. Retrieved from Washington, DC:

https://www.healthypeople.gov/sites/default/files/HP2020_brochure_with_LHI_508_FNL.pdf

Department of Health and Human Services. (2015). The ACA is Working for the African-American Community. Retrieved from http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-working-african-american-community/index.html#

Department of Health and Human Services. (2016). ACA is working for Middle-Class Families. Retrieved from http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-working-middle-class-families/index.html

DiClemente, R. J., Salazar, L. F., & Crosby, R. A. (2013). *Health Behavior Theory for Public Health: Principles, Foundations, and Applications*. Burlington, MA: Jones & Bartlett.

Emory University Rollins School of Public Health. (2016). About Us. Retrieved from https://www.sph.emory.edu/about/index.html

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Soc Sci Med, 103*, 7-14. doi:10.1016/j.socscimed.2013.09.006

Frenk, J. (2014, December 2014). Racism and public health: Statement from Dean Julio Frenk. *Harvard Public Health Review.* Retrieved from https://www.hsph.harvard.edu/news/features/racism-and-public-health-statement-from-dean-julio-frenk/

García, J. J.-L., & Sharif, M. Z. (2015). Black Lives Matter: A commentary on racism and public health. *Am J Public Health, 105*(8), e27-30. doi:10.2105/AJPH.2015.302706

Giscombe, C. W., & Hamilton, N. (2013). Of all the forms of inequality, injustice in health care is the most shocking and inhumane. Retrieved from http://www.rwjf.org/en/culture-of-health/2013/01/_of_all_the_formsof.html

Graff, D. L. (2007). A study of baccalaureate social work students' beliefs about the inclusion of religious and spiritual content in social work. *Journal of Social Work Education, 43*(2), 243-256.

Harvard Public Health Editorial Review Board. (2015). *Racism Is a Public Health Problem*. Retrieved from http://harvardpublichealthreview.org/hphr-editorial-racism-is-a-public-health-problem/.

Jones, C. P. (2001). Invited commentary: "Race," racism, and the practice of epidemiology. *Am J Epidemiol, 154*(4), 299-306.

Jones, C. P. (2003). Confronting Institutionalized Racism. *Phylon, 50(1-2)*, 7-22.

Kaiser Family Foundation. (2012). Disparities in Health and Health Care: Five Key Questions and Answers. Retrieved from

https://kaiserfamilyfoundation.files.wordpress.com/2012/11/8396-disparities-in-health-and-health-care-five-key-questions-and-answers.pdf

Kaiser Family Foundation. (2016). Disparities in Health and Health Care: Five Key Questions and Answers. Retrieved from http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

Kifner, J. (1998, May 2). Eldridge Cleaver, Black Panther Who Became G.O.P. Conservative, Is dead at 62. *The New York Times*. Retrieved from http://www.nytimes.com/1998/05/02/us/eldridge-cleaver-black-panther-who-became-gop-conservative-is-dead-at-62.html

Krieger, N. (2015). Police Killings, Political Impunity, Racism and the People's Health: Issues for Our Times. *Harvard Public Health Review, 3*. Retrieved from http://harvardpublichealthreview.org/police-killings-political-impunity-racism-the-peoples-health-issues-for-our-times/

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Acad Med, 84*(6), 782-787. doi:10.1097/ACM.0b013e3181a42398

LaVeist, T. A. (2000). On the study of race, racism, and health: A shift from description to explanation. *Int J Health Serv, 30*(1), 217-219.

Lee, Y., Muennig, P., Kawachi, I., & Hatzenbuehler, M. L. (2015). Effects of Racial Prejudice on the Health of Communities: A Multilevel Survival Analysis. *Am J Public Health, 105*(11), 2349-2355. doi:10.2105/ajph.2015.302776

Loewenstein, S. F. (1976). Integrating Content on Feminism and Racism into the Social Work Curriculum. *Journal of Education for Social Work, 12*(1), 91-95.

Loya, M. A., & Cuevas, M. (2010). Teaching Racism: Using Experiential Learning to Challenge the Status Quo. *Journal of Teaching in Social Work, 30*(3), 288-299.

Mitchell, D. A., & Lassiter, S. L. (2006). Addressing Health Care Disparities and Increasing Workforce Diversity: The Next Step for the Dental, Medical, and Public Health Professions. *American Journal of Public Health, 96*(12), 2093-2097. doi:10.2105/AJPH.2005.082818

Mitchell, J. A. (2012). Integrating Education on Addressing Health Disparities into the Graduate Social Work Curriculum. *Journal of Teaching in Social Work, 32*(5), 471-486.

National Association of Social Workers. (2016). Social Justice. Retrieved from https://www.socialworkers.org/pressroom/features/issue/peace.asp

Nelson, S. C., Prasad, S., & Hackman, H. W. (2015). Training providers on issues of race and racism improve health care equity. *Pediatr Blood Cancer, 62*(5), 915-917. doi:10.1002/pbc.25448

Osteen, P. J., Vanidestine, T. J., & Sharpe, T. L. (2013). Multicultural Curriculum and MSW Students' Attitudes about Race and Diversity. *Journal of Teaching in Social Work, 33*(2), 111-128.

Pearlstein, S. (2016, November 12). Donald Trump is about to face a rude awakening over Obamacare. *The Washington Post*. Retrieved from https://www.washingtonpost.com/news/wonk/wp/2016/11/12/donald-trump-is-beginning-to-face-a-rude-awakening-over-obamacare/

Phan, P., Vugia, H., Wright, P., Woods, D. R., Chu, M., & Jones, T. (2009). A Social Work Program's Experience in Teaching about Race in the Curriculum. *Journal of Social Work Education, 45*(2), 325-333. doi:10.5175/JSWE.2009.200700056

Randolph, E. (2015, June 18). The Murders at Mother Emanuel Church in Charleston. *The New York Times*. Retrieved from http://takingnote.blogs.nytimes.com/2015/06/18/the-murders-at-mother-emanuel-church-in-charleston/

Ravitz, J. (2015). After Confederate flag comes down, Charleston church starts new chapter. Retrieved from http://www.cnn.com/2015/07/12/us/charleston-south-carolina-emanuel-ame-church-new-chapter/index.html

Shabad, R. (2016). Joe Biden slams Donald Trump on wall, Muslim entry ban. Retrieved from http://www.cbsnews.com/news/joe-biden-to-slam-donald-trump-in-speech-monday/

Sheridan, M. J., & Hemert, K. A.-V. (1999). The Role of Religion and Spirituality in Social Work Education and Practice: A survey of student views and experiences. *Journal of Social Work Education, 35*(1), 125-142.

Shoichet, C. E. (2015). Is racism on the rise? More in U.S. say it's a 'big problem,' CNN/KFF poll finds. Retrieved from http://www.cnn.com/2015/11/24/us/racism-problem-cnn-kff-poll/index.html

Silverstein, J. (2013). I Don't Feel Your Pain. *Slate.* Retrieved from http://www.slate.com/articles/health_and_science/science/2013/06/racial_empathy_gap_people_don_t_perceive_pain_in_other_races.html

SurveyMonkey. (2016). Making Responses Anonymous. Retrieved from http://help.surveymonkey.com/articles/en_US/kb/How-do-I-make-surveys-anonymous?uid=8DG_2B13l_2Bz6Dub8LVg9FPl4hE8_2BwIFdS4qRJ_2F8s4zc7X4vHxqDW4iUuWokFQubwahp4oZnQhsTfsn0pTvDK_2FDhOWcyN9Pf2djBRYH6IVnEX4_3D

Swank, E., Asada, H., & Lott, J. (2002). Student Acceptance of a Multicultural Education: Exploring the Role of a Social Work Curriculum, Demographics, and Symbolic Racism. *Journal of Ethnic & Cultural Diversity in Social Work, 10*(2), 85-103.

Taboada, A. (2011). Privilege, power, and public health programs: a student perspective on deconstructing institutional racism in community service learning. *J Public Health Manag Pract, 17*(4), 376-380. doi:10.1097/PHH.0b013e3182140c63

Thomas, S. B. (2001). The color line: Race matters in the elimination of health disparities. *Am J Public Health, 91*(7), 1046-1048.

Walker, B., Jr. (1989). The Future of Public Health: The Institute of Medicine's 1988 report. *J Public Health Policy, 10*(1), 19-31.

White, K. (2011). The sustaining relevance of W. E. B. Du Bois to health disparities research. *Du Bois Review, 8*(1), 285-293. doi:http://dx.doi.org/10.1017/S1742058X11000233

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *J Behav Med, 32*(1), 20-47. doi:10.1007/s10865-008-9185-0

Williams, D. R., & Mohammed, S. A. (2013). Racism and Health II: A Needed Research Agenda for Effective Interventions. *Am Behav Sci, 57*(8). doi:10.1177/0002764213487341

Williams, T., & Wines, M. (2016, July 18). Shootings Further Divide a Nation Torn Over Race. *The New York Times*. Retrieved from http://www.nytimes.com/2016/07/09/us/shootings-further-divide-a-nation-torn-over-race.html?_r=0

Yan, H., Sgueglia, K., & Walker, K. (2016, November 29). 'Make America White Again': Hate speech and crimes post-election. *CNN News*. Retrieved from http://www.cnn.com/2016/11/10/us/post-election-hate-crimes-and-fears-trnd/

APPENDICES

Appendix A – IRB Approval Letter

EMORY UNIVERSITY | Institutional Review Board

Date: August 30, 2016

Nancy Stephens, MPH candidate
Principal Investigator
*SPH: Behavrl Sciences & Health

RE: **Exemption of Human Subjects Research**
IRB00091001
Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Dear Ms. Stephens:

Thank you for submitting an application to the Emory IRB for the above-referenced project. Based on the information you have provided, we have determined on **08/30/2016** that although it is human subjects research, it is exempt from further IRB review and approval.

This determination is good indefinitely unless substantive revisions to the study design (e.g., population or type of data to be obtained) occur which alter our analysis. Please consult the Emory IRB for clarification in case of such a change. Exempt projects do not require continuing renewal applications.

This project meets the criteria for exemption under 45 CFR 46.101(b)(2). Specifically, you will conduct a study administered through Survey Monkey. You will not collect IP addresses and no stigmatizing information and no identifiers will be collected. The following documents were approved during the review process:

- Stephens_Thesis_Protocol_Rev082516.docx
- Stephens_Thesis_Survey_Rev082516.pdf
- Stephens_Thesis_Invite_RecruitLtr.docx
- Stephens_ConsentLtr_Rev082516.docx

Please note that the Belmont Report principles apply to this research: respect for persons, beneficence, and justice. You should use the informed consent materials reviewed by the IRB unless a waiver of consent was granted. Similarly, if HIPAA applies to this project, you should use the HIPAA patient authorization and revocation materials reviewed by the IRB unless a waiver was granted. CITI certification is required of all personnel conducting this research.

Unanticipated problems involving risk to subjects or others or violations of the HIPAA Privacy Rule must be reported promptly to the Emory IRB and the sponsoring agency (if any).

In future correspondence about this matter, please refer to the study ID shown above. Thank you.

Sincerely,

Will Smith, MPH
Research Protocol Analyst
This letter has been digitally signed

CC: Leon Juan *SPH: Global Health

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: http://www.irb.emory.edu/
An equal opportunity, affirmative action university

Appendix B – Recruitment Email – Sent September 23, 2016

EMPH Thesis Study Request-2nd year RSPH Students Only

All Public Health Students on behalf of Robinson, Kara B
Fri 9/23/2016 3:15 PM

To: RSPH-Students@EMORY.EDU <RSPH-Students@emory.edu>;

Posting on behalf of Nancy Stephens, EMPH. Please direct all questions or inquiries directly to Nancy.

Nancy K. Stephens
MPH Candidate 2016
EMPH Program – Prevention Science
Rollins School of Public Health
Emory University
Nancy.karen.stephens@emory.edu
706.304.8837

Subject: Racism Curriculum in Public Health Study – 2nd Year Students

Dear Student,

Please take a few minutes to participate in a study (Emory IRB00091001) examining whether knowledge exists among MPH students regarding the impact of racism on health outcomes and to what extent this knowledge is influenced by their academic program, i.e., curriculum content, internships, extra-curricular activities, etc. This study is open to 2ND YEAR ROLLINS STUDENTS ONLY.

Data for this study is being collected in a survey containing 9-11 topic related questions and 9 demographic questions. Your participation in this study is voluntary and will not be compensated. Your responses to the survey will be anonymous as no identifiable information (i.e., name, contact information, etc.) will be collected and IP addresses will NOT be stored.

If you are would like to participate in the study, please click the link below to access the survey.

https://www.surveymonkey.com/r/racismstudy

Thank you for your attention and for participating in the study! If you have any question, please contact me or the Emory IRB at 404-712-0720 or 877-503-9797 (in the US only) or irb@emory.edu.

Nancy K. Stephens
MPH Candidate 2016
EMPH Program – Prevention Science
Rollins School of Public Health
Emory University
Nancy.karen.stephens@emory.edu
706.304.8837

Appendix C – Recruitment Email – Sent October 12, 2016

Survey Closing Soon

All Public Health Students on behalf of Robinson, Kara B
Wed 10/12/2016 3:45 PM

To: RSPH-Students@emory.edu <RSPH-Students@emory.edu>;

Posting on behalf of Nancy Stephens, EMPH. Please direct all questions or inquiries directly to Nancy. This is the 2nd posting for this survey. Please only complete the survey one time.

Subject: Racism Curriculum in Public Health Study – 2nd Year Students

Dear Student,

Please take a few minutes to participate in a study (Emory IRB00091001) examining whether knowledge exists among MPH students regarding the impact of racism on health outcomes and to what extent this knowledge is influenced by their academic program, i.e., curriculum content, internships, extra-curricular activities, etc. This study is open to 2ND YEAR ROLLINS STUDENTS ONLY.

Data for this study is being collected in a survey containing 9-11 topic related questions and 9 demographic questions. Your participation in this study is voluntary and will not be compensated. Your responses to the survey will be anonymous as no identifiable information (i.e., name, contact information, etc.) will be collected and IP addresses will NOT be stored.

If you are would like to participate in the study, please click the link below to access the survey.

https://www.surveymonkey.com/r/racismstudy

Thank you for your attention and for participating in the study! If you have any question, please contact me or the Emory IRB at 404-712-0720 or 877-503-9797 (in the US only) or irb@emory.edu.

Nancy K. Stephens
MPH Candidate 2016
EMPH Program – Prevention Science
Rollins School of Public Health
Emory University
Nancy.karen.stephens@emory.edu
706.304.8837

Kara Robinson, EdD, MS
Associate Dean of Admission & Student Affairs
Rollins School of Public Health, Emory University
1518 Clifton Road, NE
Grace Crum Rollins Building (GCR), Suite 164 (1st Floor)
Atlanta, GA 30322
(404) 727-3956 (office) | (404) 727-3317 (direct) | (404)727-3962 (fax)
klbrow2@emory.edu

Appendix D – Recruitment Flyer

Attention: 2nd Year Students

"Of all the forms of inequality, injustice in health care is the most shocking and inhuman."

— The Rev. Dr. Martin Luther King Jr. at the Second Annual Convention of the Medical Committee For Human Rights, Chicago, March 25, 1966

Racism Curriculum In Public Health

Please complete a very brief survey!

(9-11 topic related questions and 9 demographic questions)

You are invited to participate in a study (Emory IRB00091001) examining whether knowledge exists among MPH students of the impact of racism on health outcomes and to what extent this knowledge is influenced by their academic program, i.e., curriculum content, internships, extra-curricular activities, etc.

This survey is open to 2ND YEAR ROLLINS STUDENTS ONLY and is available via the link below. Your participation in this study is voluntary and your responses will be anonymous. No identifiable information will be collected and IP addresses will NOT be stored.

https://www.surveymonkey.com/r/racismstudy

If you have any questions regarding this study, please contact Nancy Stephens at nancy.karen.stephens@emory.edu or the Emory IRB at 404-712-0720 or 877-503-9797 (in the US only) or irb@emory.edu.

Appendix E – Survey Instrument (Including Informed Consent Letter)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Emory University Online Consent For a Research Study

In order to participate in this study, please consent by selecting an option at the end of this page.

You are being asked to participate in a research study. This letter is designed to tell you everything you need to know to help you decide whether or not to consent (agree) to be in the study or not to be in the study.

Participation:

You are being invited to participate in this study because you are a 2nd year student (15 or more credit hours in the traditional program, 17 or more credit hours in the EMPH program) matriculating in a masters level graduate public health program. Your participation in the study is entirely voluntary. Should you choose not to participate in the study, there will be no negative repercussions associated with your decision. Please note that if you being providing responses to the survey you may decide to stop at any time; however, your response to that point will be recorded and included with the survey results as a partially completed survey.

Confidentiality & Risks:

Your responses are completely confidential as there are no identifying questions (name, address, SSN, etc.) asked in the survey and your IP address will be anonymous (i.e., not included in the survey results) and will not be accessible to the researcher. As a result, you will not be linked in any way to your responses. There is only the slight potential of a breach of confidentiality of IP addresses by the internet survey service provider.

Compensation:

There will be no compensation – in any form (i.e., monetary, course credit, etc.) – provided to study participants.

Questions & Contacts:

If you have any questions about survey content (i.e., if anything is unclear, etc.) or the study topic (i.e., racism in public health education, etc.) please contact Nancy Stephens at 706-304-8837 or nancy.karen.stephens@emory.edu. If you have any questions, comments, or complaints about the research or your rights as a research participant, please contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 (in the US only) or irb@emory.edu.

Consent:

By clicking the link below you are indicating that you have read the description of the study and this consent letter and that you are voluntarily agreeing to participate in the study and that your responses may be included in the researcher's thesis study and associated publications.

Thank you in advance for your participation!

- ◯ Click here if you agree to participate in this study
- ◯ Click here if you do not agree to participate in this study

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Examining Educational Experiences - Coursework and Classes

Do you agree or disagree with the following statement?

In general, I am comfortable discussing issues of racism, anti-Semitism and other forms of prejudice with others.*

*Adapted from Anti-Defamation League. (2007). Personal self-assessment of anti-bias behavior. Retrieved from www.adl.org/education.

- Strongly Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Strongly Disagree

Please rate your familiarity with the following concepts:

	I am not familiar with this concept/topic	I know a little about this concept/topic	I am knowledgeable about this topic	I would be comfortable teaching this concept/topic to others
The distinction between race as biology and race as a social construct	○	○	○	○
Racism as a social determinant of health outcomes	○	○	○	○
White privilege	○	○	○	○
The relationship between perceived racism/discrimination and chronic disease	○	○	○	○

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Examining Educational Experiences - Coursework and Classes

On the scale below, please indicate the venue(s) where you were exposed to information on the following topics while working on your MPH degree. (You may check all of the venues that apply for each topic.)

	In class discussions	Lectures, workshops or conferences at RSPH	Lectures, workshops or conferences outside of RSPH	Reading and other self study	I have not been exposed to information on this topic
Race as a biological marker of disease	☐	☐	☐	☐	☐
Race as a social determinant of disease	☐	☐	☐	☐	☐
The relationship between perceived racism/discrimination and chronic disease	☐	☐	☐	☐	☐
Cultural competency/working with diverse populations	☐	☐	☐	☐	☐
White privilege	☐	☐	☐	☐	☐
Institutionalized racism and its impact on health outcomes	☐	☐	☐	☐	☐

If possible, please describe in more detail the venue(s) where you were exposed to the topics mentioned in the previous question (i.e., the name of the class, lecture, title of the reading, who initiated the conversation, etc.)

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Examining Educational Experiences - Coursework and Classes

Based on the knowledge gained during my MPH program, I feel well prepared and confident in my ability to apply my skills toward the elimination of race-based disparities in health outcomes in my work as a public health practitioner.

- Strongly Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Strongly Disagree

My MPH program has adequately discussed how the time, location and cost of accessing health care and public health services might inadvertently exclude certain groups.*

*Adapted from Anti-Defamation League. (2007). Personal self-assessment of anti-bias behavior. Retrieved from www.adl.org/education.

- Strongly Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Strongly Disagree

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Examining Educational Experiences - The Practicum Experience

During your practicum experience, did your practicum work involve a specific focus on improving the health of communities consisting of people of color and/or racially marginalized groups?

- ◯ Yes
- ◯ No
- ◯ I have not yet participated in a practicum placement

During your practicum experience, in your work with a community of color and/or a racially marginalized group, did you have any direct contact or interaction (i.e., work or consulted with) with any members of that community.

- ◯ Yes
- ◯ No

Please briefly describe your practicum project work with a community of color and/or a racially marginalized group (i.e., what was your project topic, community you worked with, the type of work that you did and/or interaction that you had, etc.)

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Examining Educational Experience

Please respond to the following question:

My MPH programs' content related to the issue of racism…

- ...is sufficient
- ...needs more racism related content
- ...needs less racism related content

Please briefly describe why and in what way(s) you think racism related content is sufficient in your MPH program.

Please briefly describe why and in what way(s) you think more racism related content is needed in your MPH program.

Please briefly describe why and in what way(s) you think less racism related content is needed in your MPH program.

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Demographic Information

Please identify your Emory/Rollins academic department

What year did you begin your MPH program at Emory (i.e., took your 1st class)?

How many semesters of your MPH program have you completed to date?

How many credit hours have you completed in your MPH program to date?

Please indicate previous degrees earned to date (please check all that apply):

- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional degree (i.e., MD, JD)
- ☐ Doctorate degree (i.e., PhD)

Please indicate the major field of study for each degree earned in the previous question.

Appendix E – Survey Instrument (cont'd)

Examining MPH Student Knowledge and Awareness of Racism: Implications for the Public Health Curriculum

Demographic Information

Please provide your age.

- ◯ Under 18 years old
- ◯ 18 to 21 years old
- ◯ 21 to 30 years old
- ◯ 31 to 40 years old
- ◯ 41 to 50 years old
- ◯ 51 to 55 years old
- ◯ 56 to 60 years old
- ◯ 61 or older

Please indicate your gender.

- ◯ Male
- ◯ Female
- ◯ Other

Which race/ethnicity best describes you?

- ◯ American Indian or Alaskan Native
- ◯ Asian / Pacific Islander
- ◯ Black or African American
- ◯ Hispanic
- ◯ White/Caucasian
- ◯ Other (please specify)