An Antiracist Health Equity Agenda for Education

Thalia González, Alexis Etow, and Cesar De La Vega

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Abstract: With growing public health and health equity challenges brought to the forefront — following racialized health inequities resulting from COVID-19 and a national reckoning around the deaths of unarmed Black victims at the hands of police — an antiracist health equity agenda has emerged naming racism a public health crisis.

Antiracism and Public Health

Research and policy advocacy has increasingly elevated the negative influence of structural discrimination (e.g., racism, sexism, classism, ableism) on health. While not new discourse,[1] national protests against police killings and violence against Black people, coupled with stark health disparities of COVID-19 in BIPOC communities,[2] have generated intense scrutiny of racism — as the most significant operant force of structural discrimination — and its invidious influence within all U.S. institutions and systems.[3] From this confluence of social, political, legal, and public health contexts a broad movement has emerged that we name an *antiracist health equity agenda*. The agenda is multi-pronged, cross-sectoral, and transdisciplinary and marked by an overarching aim to: (1) identify and elevate racism as a fundamental driver of health inequities; (2) engage in antiracist reform of health determinant institutions and systems; and (3) eliminate racial health disparities (Figure 1). As an agenda rooted in an antiracist health equity vision, it is both evolving and grounded in prior critical race-conscious work.[4]

Thalia González, J.D., *is a Senior Scholar in the Center on Poverty & Inequality at Georgetown University Law Center and Professor at Occidental College, Politics Department. Thalia earned her B.A. from Arizona State University and received her J.D. from Northwestern University Pritzker School of Law.* **Alexis Etow, J.D.,** *is a Managing Director at ChangeLab Solutions, a national public health nonprofit organization based out of Oakland, CA. Alexis earned her B.A. from Princeton University in Princeton, New Jersey, and received her J.D. from Washington College of Law at American University in Washington, DC, USA.* **Cesar De La Vega, J.D.,** *is a Senior Policy Analyst at ChangeLab Solutions. Cesar earned his B.A. from University of California, Los Angeles (UCLA) and his law degree from Stanford Law School. He currently resides in Los Angeles, CA, USA.*

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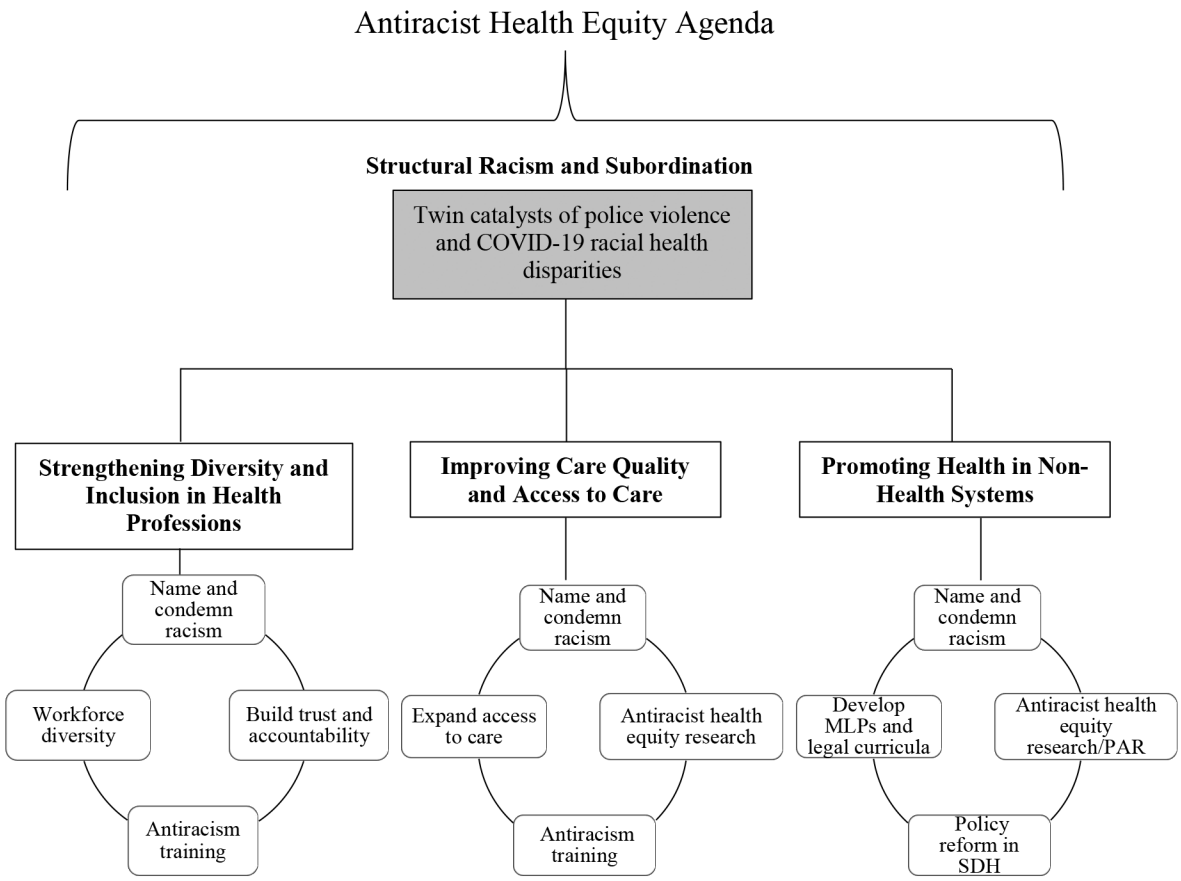
Figure 1
The Antiracist Health Equity Agenda



As Figure 1 illustrates, the agenda assumes a wide variety of forms and targets a range of health-impacting systems and actors. A systematic landscape analysis of medical, public health, and legal literature reveals key areas of focus across several lines: equity-focused and antiracist training in health and related professions; research (e.g., methodologies and designs promoting and embodying racial equity); access to care and care quality; and workforce diversity in health professions. At the forefront of the agenda is a solutions-driven orientation that centralizes racial equity across the social determinants of health.

However, the agenda is not limited to academic attention and action. It is also reflected in a broader public discourse and movement inclusive of policy statements and declarations, issue briefs, toolkits, opinion pieces, and action plans at community, county, and state-levels by stakeholders from frontline impacted communities, and health and legal organizations across the country. Within the public sphere of the agenda, a central element includes formal declarations that racism a public health crisis. Since 2017, the American Public Health Association has cataloged more than two hundred resolutions with a significant surge occurring in 2020.[5] These declarations serve a key first step as they not only acknowledge the relationship between racism and health but, as importantly, establish a governmental duty to dismantle racist systems.[6] Additionally, they function to engage new stakeholders in public dialogues on the necessity to define and respond to racism as a public health crisis.

Confronting Racism in Discipline and Policing as a Public Health Imperative

Despite more rigorous attention on the centrality of racism to the field of public health, there has been little to no focus on school policies and practices deeply rooted in structural discrimination, and more specifically racism as drivers of health disparities. This article aims to alter this pathway and urges the public health community to take action as part of holistic race-conscious approaches to health equity and address the

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long-standing disparities in school disciplinary actions. The time has come for public health and health law professionals to join with frontline communities and civil rights and educational justice advocates working to reduce health risks for BIPOC students.

The social control and subordination of Black people vis-à-vis education is not a new phenomenon. Historical evidence is clear that schools regularly employed violent policing and discipline rooted in racism and anti-Blackness.[7] Laws and policies at the federal, state, and school district levels — grounded in structural discrimination — have operated for decades to formalize the legacy of racism through discipline and policing practices.[8] For example, in the 1960s in response to desegregation, local and state-level policies and laws gave teachers, administrators, and law enforcement authority to identify students as "predelinquent," giving rise to the contemporary school-to-prison pipeline.[9] The disproportionate impact of these laws and policies was, and continues to be, felt most significantly by BIPOC students.

Inequities across race and gender in discipline and policing have been the subject of research by academics and advocates for decades. And contemporary data affirms the persistence of the disparate use of discipline and policing against BIPOC students. When compared to their white peers, longitudinal data is clear that BIPOC students are punished and policed at higher rates than their white classmates. For example, in 2016, the Department of Education Office for Civil Rights found that Black preschoolers are 3.6 times as likely to receive 1 or more out-of-school suspension as their white peers.[10] In 2020, analysis of U.S. Department of Education data revealed an upward trend in discipline disparities for Black girls across all categories, who have the highest rate of overrepresentation compared to white youth of any other race and gender group.[11] The downstream consequences of racialized and gendered discipline are far-reaching and include school pushout and entry into the criminal justice system.

The Relevance of Education Policies to Public Health

The co-influential nature of health and education — education creates opportunities for better health and poor health puts educational attainment at risk — is well accepted.[12] As a significant social determinant of health (SDH) education functions as a strong predictor of both positive and negative health outcomes at individual- and community-levels including disease, disability, mental health, substance abuse, morbidity, and mortality.[13] By age 25 individuals with a high school degree can expect to live over 10 years longer than those without one.[14] One additional year of schooling is associated with 6.85 percentage points (pp) reduction in poor health and 3.8 pp and 4.6 pp reduction in difficulty completing activities of daily living (i.e., bathing, dressing, eating, getting in and out of bed, and walking across a room) and instrumental activities of daily living (i.e., making meals, shopping, making phone calls, taking medications, and managing money), respectively.[15] Research affirms that education is a predictor of social and economic stability, community wellbeing, and risk for incarceration.[16] The relationship between school environments and health also includes protective health factors, such as school connectedness, peer connectedness, and positive school climate. Individually, and as importantly cumulatively, each of these factors serve to diminish risks of health-harming behaviors for youth (e.g., early sexual initiation, drug use, emotional distress, suicide ideation and attempts, and violence).[17]

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Positioning Discipline and Policing in the Antiracist Health Equity Agenda

To illustrate the centrality of discipline and policing within the antiracist health equity agenda, we apply the revised SDH framework developed by public health law scholar Ruqaiijah Yearby.[18] By mapping discipline and policing onto the revised SDH framework, the urgency for an antiracist health response within education becomes evident (Figure 2).

As Figure 2 illustrates, there are several reasons that education policies and practices must be interrogated through a race-conscious framework. First, racism is the foundation of punitive and zero tolerance laws and policies. Second, discipline and policing are experienced in a disparate manner when comparing peer groups. Third, these policies and practices operate at multiple independent and overlapping levels of influence *within* schools and are reinforced by discrimination *outside* of schools. And fourth, discipline and policing directly impacts the health status of BIPOC students across multiple domains and produces a downstream risk for entry into health-harming systems (Figure 3).

Given the lack of data, a challenge exists to understanding the short- and long-term effects of discipline and policing on individual or population health outcomes in BIPOC communities. We hypothesize that their impacts are likely farther reaching than just students who have experienced these health-harming practices. They may, for example, create unknown levels of emotional and psychological stress on peers, families, and communities. Further, it is significant that the potential proximate health effects of discipline and policing does not occur in isolation from contemporary and historic social contexts — all of which are grounded in ideologies, norms, and structures of subordination and racism. School-based practices and policies exist against and within community conditions with disproportionately high levels of stress,[21] complex trauma,[22] and adverse childhood experiences,[23] all of which negatively influence health. For BIPOC students who are exposed to community violence, especially at the hands of police, such experiences can amplify the cumulative influences of early-life adversities on their physical and mental health in adulthood.[24] As a result, the health consequences of discipline and policing may operate to compound pre-existing health disparities for BIPOC students whose experience with racism[25] outside school is also coupled with disproportionality of harms associated with COVID-19.[26] This is a dangerous potential dose-response effect.

Roadmap for Action

The overlooked and understudied health impacts of discipline and policing offer key points of intervention for public health professionals, researchers, and students committed to race-conscious approaches to achieving health justice. Below we offer initial steps for action, focusing on three key pathways: research, policy and advocacy, and teaching and training. To reform the policies and practices that impact education, we urge reforms centered on prevention, intervention, and health promotion.

Figure 2

Discipline and Policing and the Revised SDH Framework[19]

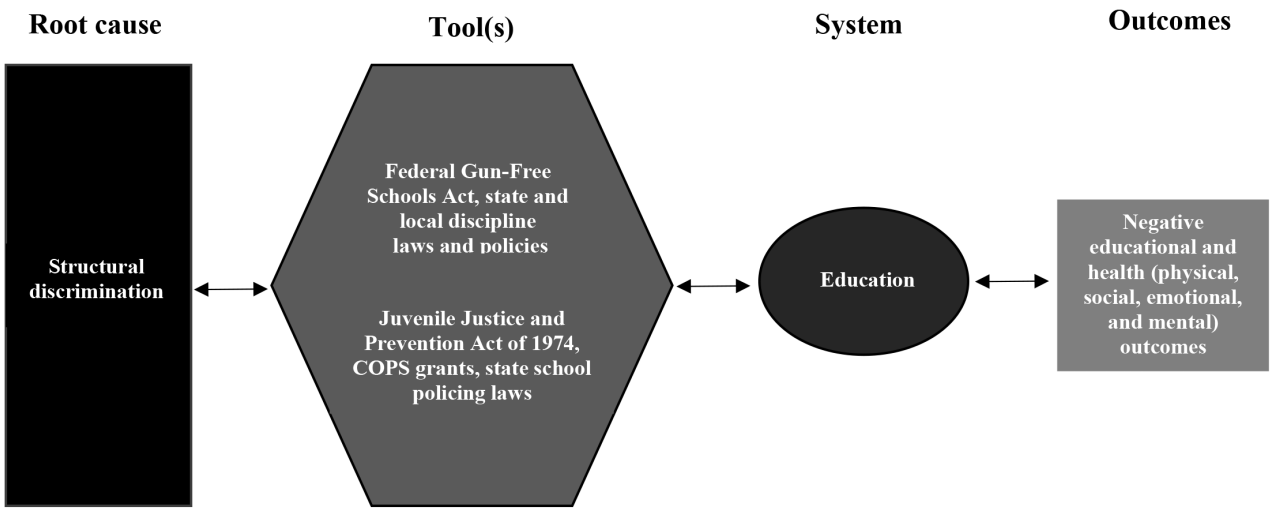

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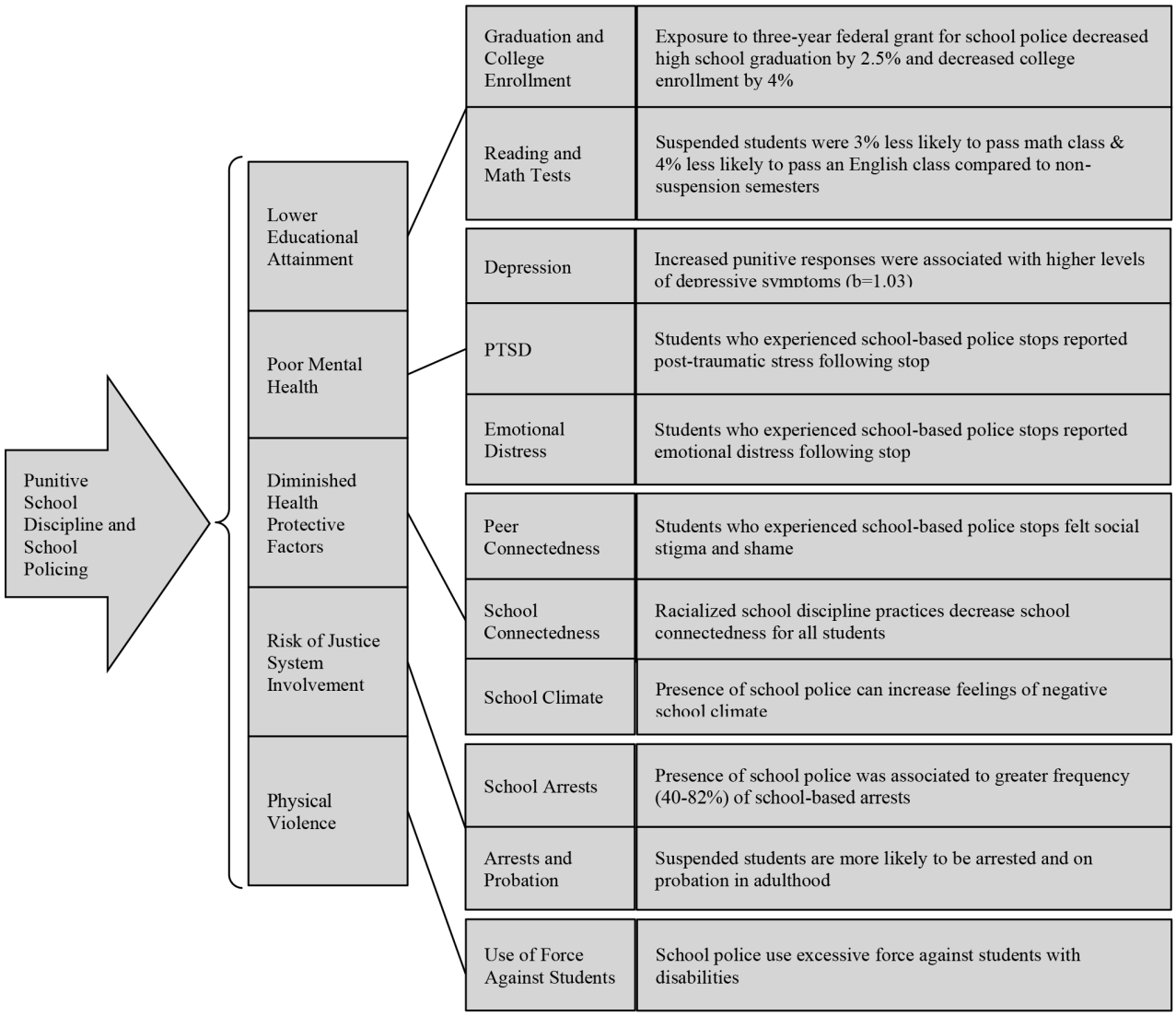
Figure 3
Health Outcomes of Discipline and Policing[20]



Research

There is an emerging body of academic and public discourse beginning to shed light on discipline practices and policing as an urgent matter of public health that drives racial health inequities.[27] Yet, as discussed above, there exists a research gap examining the range of pervasive and persistent health inequities stemming from racialized educational practices and policies. There is also a limited body of scholarship exploring the health associations between school-based interventions, including restorative justice practices and trauma-informed approaches. These omissions from the evidence base provides an ideal opportunity for public health researchers and practitioners, utilizing methodologies such as legal epidemiology and community-based participatory research,[28] to extend the antiracist health equity agenda to an overlooked population: BIPOC students.

Advocacy and Policy Reform

Health law professionals can also provide decision-makers with critical insights into how laws and policies shape social determinant systems and drive health inequities while centering the voices of those most impacted by health-harming systems. For example, they are well positioned to expand the antiracist health equity agenda through policy reports, legislative analyses, and law review articles — all aimed at

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dismantling the deeply-rooted disciplinary inequities experienced by BIPOC students. Additionally, they can leverage institutional and philanthropic resources to hold symposia and roundtables centering community expertise. Further, there is much-needed attention to state law reform. Analysis of the current legal scheme of health-harming laws (e.g., punitive school discipline)[29] and health-promoting laws (e.g., school-based restorative justice, social and emotional learning, trauma-informed approaches, and mental health supports and services) reveals significant inconsistency.[30] Yet another opportunity is examining actionable ways to operationalize the over 200 declarations issued to date declaring racism a public health crisis. Despite evidence of the intrinsic links between education and health, less than ten of such declarations address racism in education, and more specifically racialized disparities in education policies and practices.[31]

An additional pathway for action lies in developing public health responses to community-based demands for dismantling the school-to-prison pipeline, including school police reform, with opportunities for development and implementation of systemic reviews, analysis of phase out plans, and recommendations for budget reallocations.[32] Moreover, public health and medical communities (including local health departments), well-versed in the negative impacts of racism and childhood trauma on healthy development, have an important role to play as critical partners in expanding school-based policies and providing guidance on COVID-19 school operating plans with specific attention to the physical, social, and emotional needs of staff, students, and families.

Training the Next Generation

Coupled with direct systemic reforms, faculty within public health programs and law schools are well situated to train and educate the next generation of antiracist health equity leaders. One such model is medical-legal partnerships (MLPs).[33] In addition to providing on-the-ground training for the next generation of health law leaders, MLPs fill a critical gap by facilitating multidisciplinary partnerships to holistically support marginalized youth and their families. Though presently overlooked in the context of discipline and policing, MLPs provide a key avenue for addressing the health harms of these racialized policies through direct services (e.g., legal assistance and social support), research (e.g., health effects of discipline or policing), and policy reform (e.g., legislative testimony and drafting model codes). There is also an opportunity for interdisciplinary collaboration across education, medicine, civil rights, and Critical Race Theory to create courses and curriculum specific to education laws and policies as well as advance new training in legal epidemiology, Antiracist Health Praxis, and other methodologies.

Conclusion

This article aims to serve as a catalyst and roadmap for cross-disciplinary collaborations and commitments to generate new evidence on the relationship between education policies and differential health outcomes, craft new legal responses to racism in education, and train the future generation of scholars, advocates, and practitioners. As BIPOC students continue to face steep health, mental health, and structural challenges amidst the ongoing COVID-19 pandemic, the work of antiracist health equity approaches in education are vital. Within the movement to disrupt the pathways that lead to racial health inequities, ending discriminatory discipline and school-based policing policies is a concrete, and fundamental, next step. As public health professionals, we have an opportunity — and responsibility — to uproot and redress racialized policies that have long-harmed our most important asset: our children.

Note

The authors have no conflicts to disclose.

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