An alumni’s open letter for people considering the Health Equity Minor

To the current and future public health leaders and scholars pushing for a more equitable future,

My name is Hadija Steen Mills [they|she] and I’m a queer, mixed-Black parent of twins born and raised on the Dakota land commonly known as Minneapolis. I want to begin this open letter by acknowledging the land I and the University of Minnesota occupy as the land of the Dakota people.

This is, “the land where the waters reflect the skies” or Mni Sota Maḳoce. This land is sacred and as an occupier of this stolen land, I commit to furthering and uplifting those who experience oppression. The Morrill Act of 1862 established the University of Minnesota as a land-grant institution, which has long lasting economic and wealth distribution impacts.

THE CONTEXT

I write this letter in the fall of 2022 as I complete my Master of Public Health (MPH) in Maternal Child Health (MCH) with a Health Equity Minor. Prior to my current tenure in the University, I completed a self-designed degree in sexual health with a focus on reproductive justice and health disparities. This letter is intended as a grounding within your own journey, within the School of Public Health, and as you explore a Minor in Health Equity.

While the Health Equity Minor is strategically purposeful in its history and creation, my own experience within the Minor left me craving a programmatic forward that grounded me in its full intention and potential. Thus, I am writing this letter to all who are contemplating the Minor or just beginning their journey of Minor coursework. I hope it provides context, points of reflection, and leaves you invigorated to challenge systems and think critically about the structures that perpetuate oppression.

But what is Health Equity? The Center for Disease Control and Prevention writes, “Health equity is achieved when every person has the opportunity to “attain his or her [sic] full health potential”, and no one is, “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.” (*Health Equity* | *CDC*, 2022)

The Health Equity Minor is distinct from other minors offered by the School of Public Health (SPH) in that it is not limited to a specific set of skills or a sole minoritized population, but instead is a throughline to the charge of being a public health steward and meeting the goals of improving health for *all* communities. Founded in 2007 by SPH students, Aliyah Ali (MPH), Melissa Boney (MPH), Rachel Hardeman (MPH, PHD), Eduardo Medina (MPH, MD); the Minor was expanded to all University graduate students in 2016. Due to its incomparable origins and standing, it deserves and warrants an additional point of care and intention.

THE CHARGE

It is with this framework and the Minor's unique standing that I offer you a challenge as you consider undertaking a Health Equity Minor as an addendum to your graduate education. I propose a series of "How" questions for your rumination and reflection:

> How does your positionality influence your work to further health equity?
>
> How will you be a good steward of the knowledge gained and station furthered through accreditation?
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> How can you move from practice to praxis?
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> How will you not perpetuate harm- especially for those pushed to the margins and who already experience harm at the hands of oppressive systems?

These reflection questions provide an opportunity to think deeply and answer the questions in the context of the Health Equity Minor's learning objectives while also investigating your role and intentions in being a scholar fighting for a more equitable future.

It is hoped that this reflection, forethought and intention avoids the continuation of health equity tourism, a harmful practice defined as, "the practice of investigators—without prior experience or commitment to health equity research—parachuting into the field in response to timely and often temporary increases in public interest and resources" (Lett et al., 2022). Upon the completion of the Minor you will be entrusted with a completion marker (your degree) affording you an advantage for future opportunities, projects, collaborations, and funding. As a current and future champion for a more equitable future, being aware of health equity tourism is an important piece of accountability.

The Minor has five learning objectives intended to be a throughline throughout the respective required and elective courses. While individual course syllabi and objectives taken to complete the minor may vary, the five objectives, created in 2007, drive the inclusion of courses for the Minor and the design of the Minor's Capstone course.

The learning objectives are:

1. Learn about the extent and structural nature of health inequities, and methods for documenting and communicating inequities without doing harm by focusing on policies rather than people.
2. Analyze the roots of health inequities in our cultural histories and the process by which these gaps are generated and perpetuated.
3. Understand the independent and interconnected roles of our system of government, healthcare, and public health in generating equity.
4. Explore potential practice and policy solutions for fostering health equity, examining both intended and unintended consequences.

5. Recognize the unique strengths and integral role of cultural communities and social groups in defining the health problems they experience and directing the solutions.

Within these learning objectives I desired an opportunity to examine myself as a conduit within the current and future landscape as an accountable public health representative. With that desire and a spirit of collaborative growth, I invite you to consider the learning objectives in the following context.

THE INVITATION

How does your positionality influence your work to further health equity?

I define positionality as the ever-changing interplay between a person’s identities and their surroundings. Everyone’s existence in the social hierarchies of power can change depending on a myriad of factors such as the physical location and relationship to others. Positionality is not fixed and therefore requires ongoing reexamination. Thinking about who you are today, how do those identities charge you to push for equitable futures?

How does this relate to objective 2?

How will you be a good steward of the knowledge gained and station furthered through accreditation?

Health equity as a field of study exists as a contradiction for many, as it is a digestible container for what is in fact, many people’s lived experiences of daily survival. This distillation of the lived experiences of communities pushed to the margins into an area of study deserves pause. Thinking about who you hope to be at the end of your program, what measures will you take to be an agent who does not further oppress and is accountable to the societal gains afforded by a degree?

How does this relate to objective 4?

How can you move from practice to praxis as a champion for health equity?

Throughout your program you will gain a myriad of new skills. These skills are something to be honed and practiced. Yet the embodiment of the theoretical learning that also encompasses everyday enactment of the tenets of praxis. I define praxis as the internalization of skills beyond a purely learned asset to an ingrained value. It is deeper than a practiced set of skills and borders on an iterative ritual. Practice is a linear process that holds up an ideal that there is an end and that something can be achieved, whereas praxis is never complete since a new level of growth only opens more opportunities for deeper investigation. This requires that you not fall victim to the notion that booksmarts (in the realm of practice) outweigh streetsmarts (in the realm of praxis). Such a mindset would not be community led nor community centered, but in fact would be a perpetuation of oppressive hierarchical standards.

How does this relate to objective 5?

How will you not perpetuate harm- especially for those pushed to the margins and who already experience harm at the hands of oppressive systems?

As individuals with the claim of an advanced degree, we are given immense power. I argue we are not given the tangible skills for how to *not* turn that power into harm, intentional or otherwise. This is the opportunity and the time to think through what skills you will need to operationalize systems of accountability for yourself. You are then able to internalize, investigate, and reinforce these systems prior to being an independent member of the public health community. Ask your peers and educators, especially for courses within the Minor, what are the concrete ways to be a public health leader who does not leave a legacy of violence and oppression in their wake.

How does this relate to objectives 1, 3, and 4?

THE CLOSING

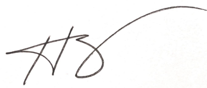
As I reflect on my experience within the Health Equity Minor, I wish I had understood the intentionality behind the minor from day one. I hope you accept my charge as an offering of activation. Deeply and truly, I hope this opportunity to reflect will empower your choices and that this brief letter gives you an opportunity to think critically about the Minor and your role within the greater ecosystem of public health.

Below I include a limited introduction to common terms you will likely come across in your Minor coursework. It is not exhaustive, but is instead a starting point for your own research.

This letter truly comes from a place of partnership, even if it is across time and space. In the spirit of accountability, I welcome opportunities for ongoing engagement.

I hope it gives you some grounding into the Minor and I am grateful for your commitment to creating a more equitable world. I cannot wait to collaborate, read your publications outlining societal contributions, or learn from you in the future.

In continued movements for collective healing,



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A BRIEF INTRODUCTION TO SOME COMMON TERMS

- Intersectionality (Bauer, 2014; Crenshaw, 1989)
    - "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things." (*Kimberlé Crenshaw on Intersectionality, More than Two Decades Later*, 2017)
- Public Health Critical Race Praxis (PHCRP) (Ford & Airhihenbuwa, 2010a, 2010b, 2018)
    - "A semi-structured process for conducting research that remains attentive to issues of both racial equity and methodologic rigor. As praxis (i.e., an iterative methodology), it combines theory, experiential knowledge, science and action to actively counter inequities. PHCR may be used either alone as a broad framework or in conjunction with other theories or methods. It informs research on the causes of health disparities. It also guides efforts to understand how racialization may influence disciplinary conventions (e.g., academic promotion standards that place little value on building community capacity), including modes of knowledge production (e.g., the tendency to perceive minority populations from a deficits perspective) that may inadvertently reinforce inequities." (Ford & Airhihenbuwa, 2010b)
- Forms of racism
    - Interpersonal
        - "Interpersonal racism—Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization." (Hardeman et al., 2022)
    - Intermalized
        - "Internalized racism— A manifestation of an indoctrinated society steeped with oppression and a form of racism that leads people to internalize societal beliefs and stereotypes about their racial/ethnic group membership and/or other group membership (sexual orientation, gender, etc.). Internalized racism enlists oppressed individuals to perpetuate the myth that a hierarchy of worth exists and operates so those most oppressed by the system are not immune to the reproduction of a hierarchy. Internalized racism also exists as an inhibitor to a full incarnation of self-love." (James, 2020; Jones, 2000) (James, 2020; Jones, 2000)
    - Systemic

        - Systemic oppression is the manifestation of inequitable systems that benefit those who belong to dominant identity groups and strategically disadvantage non-dominant identities.(*Lens of Systemic Oppression*, n.d.)
    - Institutional
        - “Institutional racism—An overt manifestation and subset of structural racism, institutional racism is not explicitly incorporated into the current iteration of the tool, but instead is combined under the larger category of structural racism. It is important to note that this combination does not negate the need for accountability for the systems that overtly and actively enact harm.” (Hardeman et al., 2022)
    - Structural
        - “The totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes.”(Bailey et al., 2017)
        - “There is no “official” definition of structural racism — or of the closely related concepts of systemic and institutional racism — although multiple definitions have been offered. All definitions make clear that racism is not simply the result of private prejudices held by individuals, but is also produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms. Confronting racism, therefore, requires not only changing individual attitudes, but also transforming and dismantling the policies and institutions that undergird the U.S. racial hierarchy.” (Bailey et al., 2021)

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