

TOWARD EQUITY in HEALTH

*a new global approach
to health disparities*

editor Barbara C. Wallace



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**A New Global Approach
to Health Disparities**

**Barbara C. Wallace, PhD
Editor**

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Dedication

This book is dedicated to the memory of Janene Martha Murray (January 13, 1959 to May 14, 2007), Princeton University, Class of 1982.

May Janene know the deep gratitude I hold for all she did to support and contribute to my developmental trajectory as a researcher, scholar, writer, and professor.

Of note, Janene died at age 48 from a health condition where there are major disparities for African Americans, Native Americans, and Latinos. May her physical end signal a beginning: one wherein a new paradigm prevails; all enjoy respect, acceptance, empathy, and equal access to opportunity; and there is a new social justice and civil rights movement for the achievement of equity in health for all.

No man is an island, entire of itself; every man is a piece of the continent, a part of the main. . . . Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.

—John Donne, 1624

May we hear the bell toll and awaken! Once awake, may we become involved in mankind, view ALL as part of the main, and take action to bring about equity in health for all! BiakoYe! Unity!

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Preface

This volume seeks to launch a new field of equity in health, as a new global approach to inequities in health. The goal is to shift the discourse toward a focus on moving from *InEquity in Health* to *Equity In Health* and spur a global movement in response to the major civil rights issue of the twenty-first century involving injustice in health. This contribution also seeks to serve as a tool for training global leaders for this movement—whether professionally trained members of transdisciplinary teams, community health workers, or peer educators.

The origin of the vision for bringing about equity in health for all, fostering a major paradigm shift, and training global health leaders who are capable of working with cultural competence on collaborative transdisciplinary teams arose in January 2003. At that time, I provided leadership in founding the Research Group on Disparities in Health (RGDH) at Teachers College, Columbia University within the Department of Health and Behavior Studies. The RGDH was envisioned as a setting in which to provide support, nurturance, and systematic mentoring for those junior colleagues, and pre- and post-doctoral fellows committed to reducing and eliminating health disparities, toward the goal of forging equity in health for all. The goal was for them to emerge as culturally competent researchers not only equipped with the knowledge, attitudes/beliefs, and skills/behaviors to be model researchers and health educators addressing disparities in health, but also to emerge as global health leaders.

Given this vision, a weekly Research Seminar in Disparities in Health was launched, attracting the participation of pre- and post-doctoral fellows from diverse places across the nation and around the globe. Fellows of every race, ethnicity, religion, sexual orientation, and socioeconomic status have sat around the table at the research seminar and worked out their personal vision for the trajectory of their careers—typically articulating a commitment to addressing disparities in health with a goal to realize equity in health for all through teaching, training, research, practice/interventions, and service.

Within the setting of the RGDH, in the spring of 2005, an annual research conference was envisioned for bringing together a national and international audience similarly committed to health disparities and bringing about equity in health for all. A model for what was envisioned existed: the long-standing Annual Winter Roundtable on Cross Cultural Psychology and Education at Teachers College, Columbia University—founded by Dr. Sam Johnson in 1982, and subsequently directed by Dr. Robert Carter, and now Dr. Madonna Constantine. The Annual Winter Roundtable on Cross Cultural Psychology and Education has evolved into the nation's premier cross-cultural conference. In 1982,

as a poor graduate student, I yearned to attend the First Annual Winter Roundtable, yet was unable to do so, lacking funds. However, I eventually presented as a Teachers College faculty member in 1994, and each year since then—even organizing the volume that arose from the 1998 conference as coeditor of the proceedings with Dr. Carter. In this manner, I discovered the potential of a conference to be a significant setting in which participants can present new and cutting edge research, theory, and practice, while receiving expert feedback that contributes to the systematic evolution of one's work being renewed, revitalized, and inspired in the process.

My vision was to create the same kind of annual forum for addressing health disparities. A collective was essential to the formation of the vision and charting of the mission so a conference planning committee was formed, constituting a transdisciplinary team (i.e., Edmund Gordon, Robert Fullilove, Gbenga Ogedegbe, Lisa Lewis, and numerous predoctoral fellows with the RGDH).

With Teachers College, Columbia University as the ideal platform, and its Center for Educational Outreach and Innovation (CEO&I) as the ideal partner—the Spring 2006 First Annual Health Disparities Conference was launched. The theme for the First Annual Health Disparities Conference, held the second weekend in March 2006, was “Declaring a Decade of Health Disparity Reduction: Toward Evidence-Based Approaches.” The March 2006 conference was hailed by the staff of CEO&I as the most successful first-time conference in the history of Teachers College. It was also during the first day of the two-day event that the conference body collectively declared “A Decade of Health Disparity Reduction,” putting forth a powerful call during a plenary session.

Among those things that concretely and immediately reflected the power of the conference call and declaration was an oral publishing agreement for this edited volume by 4:00 p.m. the first day of the 2006 conference. The result is the present edited volume—representing, in large measure, the proceedings of the conference, insofar as it includes mostly invited papers from among the many presented at the conference.

Intended Audience

The intended audience for the book includes all those interested in closing gaps in health, addressing disparities in health, and moving from the current widespread inequity in health to the achievement of equity in health for all, within a twenty-first century civil rights movement for health. This includes all those working in health education, health promotion, disease prevention, public health, the health care delivery system, and both patient- and population-level health.

Thus, the broad audience for whom this volume is intended includes policy makers, funders, providers, researchers, interventionists, educators, and community members—whether government officials, epidemiologists, health care administrators, leaders in health care insurance systems, physicians, psychologists, health educators, social workers, nurses, anthropologists, lawyers, demographers, economists, sociologists, computer/information technology specialists, teachers, community health workers, or peer educators. All will find a vision translated into roles and functions for each within the field of equity in health. Moreover, the training this volume provides will prepare them for service as global leaders on the transdisciplinary teams that must engage in collaborative

work alongside community members, forging equity in health for all within a twenty-first century global civil rights movement.

Overview of the Book

The introduction to the volume identifies the forces driving and embodied within a new field of equity in health (chapter 1, Wallace), while also identifying these as the thirteen guiding principles for the new field. Part I of the volume introduces new theory, paradigms, and perspectives, starting with the work of Walker (chapter 2) who provides a comprehensive overview of the challenges involved in eliminating health disparities. In chapter 3, Airhihenbuwa and Okoror offer a compelling example of the kind of new perspectives needed to guide the field of equity in health, specifically offering an Africanist perspective that highlights the important role of evidence-based and culturally appropriate models for reducing global health disparities. Prochaska puts forth in chapter 4 new paradigms for inclusive health care, articulating the need for both individual patient and population health approaches, while highlighting the role of home-based interactive computer technology in having a wide impact.

Part II introduces new procedures and policies deemed vital for a new field of equity in health, specifying some of the implications for funders, researchers, and policy makers. Buchanan and Allegrante (chapter 5) discuss the tensions between scientific and ethical considerations when it comes to evaluating public health proposals, specifically discussing the types of proposals that agencies should be funding and the types of evidence that should matter—offering recommendations in this regard. Lahiri and Pulungan illustrate in chapter 6 the new kind of sophisticated data analysis that examines income related health disparities and their determinants, focusing on New York state, while making racial/ethnic and geographical comparisons; these point toward a need to redistribute income via equal access to educational or employment opportunities. In addition to these kinds of detailed and highly sophisticated data analytic strategies being valued in the field of equity in health, along with such pointed conclusions, so is the need for a new generation of research that searches for those underlying mechanisms which may be contributing to disparities, including factors such as provider bias—as covered by Ogedegbe, Schoenthaler, and Fernandez in chapter 7. Beyond the need for new procedures in research, there is also a need for new policies to counter those that have been destructive to communities, led to the incessant displacement of communities, and effectively created the social context for the emergence of health disparities; Fullilove provides a thorough discussion of such policies in chapter 8.

In Part III, contributors review the legacy and role of racism in contributing to disparities, while also discussing the implications and recommendations for research and practice. Constantine, Kindaichi, Graham, and Watkins offer in chapter 9 strategies for reducing disparities in African Americans' receipt and use of mental health services. David and Collins (chapter 10) explore whether the field should be pursuing the contemporary trend to focus on genetics (too often reflecting our racist legacy) or social forces, concluding how public health planners need to look to social and environmental rather than genetic differences in any campaign to eliminate health disparities; and, what is essential in the United States for understanding health outcomes is a model

that incorporates both race as a social construct and social class, while solutions may involve the development of a broad political unity, or class unity, that challenges the status quo. The legacy of racism may also be seen in the distrust of African American patients, subtly influencing the level of attention they pay to health messages prompting them to pursue screenings for conditions such as colon cancer, while Franklin, Oscar, Guishard, Faulkner, and Zauber (chapter 11) frame the behavior of such patients within a psychosocial model of resilience, underscoring the role of adaptive coping strategies. Through the chapters in Part III, both the legacy and role of racism in contributing to the manifestation of health disparities emerges, as well as implications and recommendations for the types of new theories, models, and approaches needed to guide research and practice.

Part IV of the volume covers the key role of collaborations, partnerships, and community-based participatory research in the field of equity in health. In this regard, Rashid, Anuwo, Skillen, Melanson, and Wagner (chapter 12) call for collaboration on national research priorities to eliminate health disparities. Drawing upon the pioneering work across decades at Moorehouse College in developing the model of community-based participatory research and collaborative relationships with partners in the African American community, Hayes (chapter 13) outlines the process of successful grant-writing to obtain funds to support community-based health disparities research and services. With regard to collaborations developed in New York City to benefit Chinese immigrants, Kwong, Ho-Asjoe, Chung, and Wong (chapter 14) describe how cardiovascular health disparities were addressed via the Chinese-American Healthy Heart Coalition, while distilling principles for effective collaborations that others may follow; they emphasize the use of a community-wide multipronged integrated approach to providing culturally competent and linguistically appropriate health education and health care services for medically underserved Chinese immigrants, as well as the use of an asset-based community development intervention approach focused on increasing social capital. Illustrating the very best within the tradition of federally funded community-based participatory research, including community members in every project phase, El-Bassel, Witte, and Gilbert (chapter 15) provide an example of the best case scenario outcome: a new emergent evidence-based model for reducing HIV/AIDS risk with serodiscordant couples worthy of dissemination, and adaptation to new culturally distinct populations.

The next part of the book, V, presents new Internet technology for use in achieving wide dissemination of health information, interventions, and training that attains a global reach. In this regard, Moretti and Witte (chapter 16) describe the use of new media designed by education technologists to improve learning; they illustrate the potential of such media to disseminate an evidence-based model for HIV/AIDS risk reduction, enrich the training experience, and expand the possibilities for disseminating content arising from various fields. Adams and Leath (chapter 17) describe a role for health informatics and information technology in shaping a global research agenda to eliminate health disparities, covering international developments. Woo (chapter 18) describes how evidence-based approaches can be integrated to frame the creation of an online multimedia peer education smoking cessation program for Korean youth, while seeking to engage them in her program via a film script writing contest soliciting stories on quitting smoking.

Part VI of the book covers the training of community health workers and peer educators, suggesting how they play a vital role in the field of equity in health. In chapter

19, the authors (Wallace, Konuwa, & Ayebofo) describe a model of training community health workers and peer educators for HIV/AIDS prevention in Africa, one that integrates African Healing Wisdom and evidence-based behavior change strategies. Bahl (chapter 20) responds to the crisis, common to many parts of the world, involving the incarcerated population and their need for interventions to address their health, especially HIV/AIDS prevention, describing her work in India implementing a peer education training program—one developed while a graduate student at Teachers College, Columbia University. Indeed, several chapters (19—Wallace, Konuwa & Ayebofo; 20—Bahl; and 18—Woo) all reflect the challenge put forth by the editor of this volume for future global health leaders training at the university to go beyond the acquisition of mere knowledge about evidence-based approaches, and to design, implement, and evaluate interventions for the vulnerable and at-risk populations “back home” in their countries of origin. What is essential to the new field of equity in health is the training of such future global leaders who “go back home” to forge equity in health—not constituting a “brain drain”—while the Research Group on Disparities in Health (RGDH) at Teachers College constitutes a magnet attracting those seeking training to guide the design of evidence-based approaches to research and intervention. In chapter 21, the authors’ (Johnson & Wallace) work, which is rooted in the same RGDH training model, results in the development of an approach to training peer educators within urban America where Black men who have sex with men (MSM) are a particularly vulnerable group; yet, through training, Black MSM can emerge as leaders and valued partners in conducting ethnographic community-based participatory research. Thus, the training of peer educators and community health workers—who may emerge as ideal partners in community based participatory research—emerges as central within the new field of equity in health.

In Part VII, attention is turned to other special populations also considered the most vulnerable and what it will take to close gaps in health. With regard to men who have sex with men (MSM), Nanín, Fontaine, and Wallace (chapter 22) recognize how they are currently living at the intersection of two epidemics—one involving HIV/AIDS and another involving Methamphetamine drug use, while going on to offer recommendations for researchers and clinicians working with this special population. The vulnerability of lesbian and bisexual women of color is contextualized as involving exposure to the multiple threats of racism, heterosexism, and homophobia—all of which contribute to health care disparities, while Greene, Miville, and Ferguson (chapter 23) offer a recommended intervention and research agenda in light of all of these factors. Moving from special subpopulations of men and then women within the larger Gay, Lesbian, and Bisexual community to the youth, Rosario, Schrimshaw, and Hunter (chapter 24) open a window into their lives, exploring ethnic/racial disparities in gay-related stress and health. Next, Keller and King (chapter 25) explore health disparities impacting people with disabilities, underscoring the need for future global health leaders to embrace the value of pursuing equity in health for all within a movement that also represents the needs of the special population of people with disabilities.

Finally, Part VIII of the volume covers the task of closing the education and health gaps by addressing these dual inter-related disparities through effective engagement. First, Ross and Smalls (chapter 26) discuss the kind of classroom-based interventions that hold the promise of closing the gap, or reducing academic disparities between low- and high-income students; at the core of interventions is the learn unit—which can be measured as the key component of effective engagement for learning, while suggesting a

meaningful interaction between a teacher and a learner wherein successful transmission and acquisition of knowledge occurs. Next, Bridglall and Gordon (chapter 27) describe the role of supplementary education—typically, a form of additional structured education that takes place outside of the school classroom—and how it can prepare learners for high academic achievement and effective engagement in the process of learning that is key to academic success. Toward the goal of closing the academic achievement and health gaps, an example of a supplementary education program rooted in an academic, community and faith-based coalition is described; key program features include ensuring effective engagement in the learning process via the use of marbles given to reward/shape behavior, and youth involvement in community service via the National Association for the Advancement of Colored People (Campbell & Wallace, chapter 28). Next, a peer mentoring/tutoring program for at-risk urban youth attending a college preparatory high school is described, emerging as an effective intervention, especially having success in reducing academic failure in the major subject areas of math and science for Black males (Chew & Wallace, chapter 29). In the next chapter, 30, Perez-Rivera and Langston-Davis illustrate the manner in which schools may also be settings for the infusion of health education across the curriculum in response to an epidemic such as asthma, highlighting the importance of face-to-face engagement to foster learning; at the same time, linguistically and culturally appropriate materials that physicians can use in educating patients and their families also find a central role in comprehensive community-wide health education.

To conclude the volume, the future of the field of equity in health is discussed, in light of all that has been organized and presented (Wallace, chapter 31). The volume effectively establishes the foundation for a new field of equity in health, while training global leaders for work within a twenty-first century global civil rights movement for equity in health for all.

Barbara C. Wallace, PhD

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—Barbara C. Wallace, PhD, Editor

Introduction: The Forces Driving and Embodied Within a New Field of Equity in Health

Introduction

Health is a state of well-being with physical, emotional, mental, and spiritual dimensions that serves as an essential foundation for human life with implications for how all other aspects of life are pursued and evolve. It is also an essential resource to be valued by individuals, families, communities, and our larger global community. Health may vary in how it is defined, qualified, and pursued within diverse communities and for individuals. Not all enjoy a good state

of health, and there are vast differences with regard to the markers and indicators of this state, with health varying across races/ethnicities, diverse groups, special populations, socioeconomic classes, geographic regions, and countries within our global community. It is often through contact with others and via processes of simple social comparison or complex statistical analyses that we arrive at an awareness of how states of health can profoundly vary across groups and locals.

There are implications for what it means to be a global community with the capacity to: (1) travel, observe, and use technology to broadcast images suggesting states of health for groups scattered over vast regions around the globe; (2) rapidly mobilize to take action and quickly respond to a health issue or crisis in literally any region around the globe, dispersing resources where needed; and (3) differentially interpret what is being observed, what we elect to broadcast, and how we choose to respond, given historical legacies and contemporary forces of oppression, domination, and discrimination. Vital differences and distinctions also emerge with regard to: (1) our potential to act as a global community with a keen sense of our interdependence, the essential right to health, and what social justice dictates that we do as vital social action (i.e., the Asian Tsunami of December 2004) on the one hand; and (2) our potential to allow forces of oppression, domination, and discrimination

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to serve as a barrier to our responding appropriately to all health crises (i.e., the case of Hurricane Katrina in August 2005) on the other hand.

Because of vast differences with regard to access to the resources associated with the pursuit and maintenance of health, there is a need for a global health transformation—one wherein we value and pursue equity in health for all as a global interdependent community with vast resources at our disposal for sharing and deployment to any group in need located on any part of the globe. To value and pursue equity in health means that we engage in fair play, act with impartiality, and allow a sense of social justice to guide us as we ensure that all human beings are free to enjoy the right to health and pursuit of physical, emotional, mental, and spiritual well-being—consistent with how any diverse groups may define it and elect to pursue it. This brings to mind the indigenous people who apparently wanted to be left alone in the aftermath of the Asian Tsunami, shooting arrows at hovering helicopters to underscore this point. Thus, acceptance of and respect for diversity and the right of cultural groups to determine their own health, health standards/outcomes, and way of life suggest constant principles of the highest order. Such overarching ever-present guiding principles are essential in this new era of expanded awareness of and contact with the multiple groups in our global community.

Meanwhile, historical legacies and contemporary forces of oppression, domination, and discrimination compromise the pursuit of equity in health. It requires paying special attention to the needs of those groups that have suffered injustice, and taking action to improve their health, in particular—to ensure they enjoy the right to health and social justice. This may even include new policies for the distribution of resources and access to opportunities.

Some use the terms “health disparities” or “health equity” interchangeably, while noting how there is little consensus about the meaning of the terms “health disparities,” “health inequalities,” or “health equity” (Braveman, 2006, p. 167). Also noted is how “health equity” is a term rarely encountered in the United States, although one more familiar to public health professionals outside of America. Braveman (p. 181) defines health disparities as “systematic, potentially avoidable differences in health—or in the major socially determined influences on health—between groups of people who have different relative positions in social hierarchies according to wealth, power, or prestige.” Moreover, since “these differences adversely affect the health or health risks” of “groups already at a disadvantage by virtue of their underlying social positions, they are particularly unfair” (p. 181). Consistent with the focus in this edited volume, Braveman (p. 181) provides additional clarification “by noting that pursuing health equity—that is, striving to eliminate health disparities strongly associated with social disadvantage—can be thought of as striving for equal opportunities for all social groups to be as healthy as possible.” However, totally justifiable is a “selective focus on improving conditions for those groups who have had fewer opportunities” (p. 181). This may involve “removing obstacles for groups of people—such as the poor, disadvantaged racial/ethnic groups, women, or persons who are not heterosexual—who historically have faced more obstacles to realizing their rights to health and other human rights” (p. 181).

Consistent with this perspective, this volume seeks to forge equity in health for all. The volume seeks to be a milestone in the study of health disparities, marking a major paradigm shift, while launching a new field of equity in health—as a new global approach to health disparities. One goal of the volume is to foster movement toward framing the

discourse in the United States as one focused on the achievement of equity in health. Another goal is to encourage and train researchers and interventionists in the United States to view the national and international health domains as intricately inter-related and include both in their purview, taking a global approach. Our further discussion, as evidenced in this text, demarcates the nature of the shift in the guiding paradigm, the nature of the desired movement toward equity in health, the parameters of the new field of equity in health, while illustrating how researchers and interventionists may practically approach the reality of our interdependence as one global community.

In seeking to be a milestone in the year 2007—the publication date of this volume—it is important to recognize other key milestones. Prior key milestones in the field of health disparities are noted (Satcher & Pamies, 2006) as including (1) the 1985 U.S. Department of Health and Human Services' *Report of the Secretary's Task Force on Black and Minority Health*, citing a continuing disparity in the burden of death and illness by race (blacks and minorities compared to American population as a whole) (p. xix); (2) the January 2000 *Healthy People 2010 Report* which “targeted the elimination of health disparities in health as two of its primary goals” (p. xix); (3) the publication of the 2003 Institute of Medicine (IOM) report, *Unequal Treatment*—which allowed health disparities to emerge “as a topic of national importance and worthy of much attention and discussion” (p. xix); (4) the resulting charge issued by Congress to the Agency for Healthcare Research and Quality to compile “an annual report on the status of disparities,” as well as resulting increases in “research funding from the government and foundation community” for the study of health disparities (p. xix); and (5) more sophisticated analyses of health disparities being published in leading health journals (p. xix).

We are living in a distinct historical period in time, one which Ayebofo (2005) describes as the time of milestones and the weeding out of the destructive forces. Oddly, some of the prior milestones contain that which may need to be weeded out as a destructive force.

For example, consider how Levine et al. (2001) take as the point of departure for their analysis the two overarching goals of Healthy People 2010—to increase the quality and years of healthy life and to eliminate health disparities (i.e., disparities between African Americans and other population groups)—as goals assumed to be attainable based on absolute improvements in health during the twentieth century; and, more specifically, improvements since 1979 when the first objectives were published. Levine et al. (2001) investigated the validity of the hypothesis that future success could be built on the foundation of past success, concluding there has been “no sustained decrease in black–white disparities in either age-adjusted mortality or overall life expectancy at birth at the national level since the end of World War II” (p. 480). Moreover, this is “despite decades of funding for social, health-related, and other programs designed to reduce racial disparities” and even regular “assurances in support of Healthy People objectives” which appear in just about “all requests for research applications from federal health agencies over the past two decades” (p. 480). Optimistic forecasts for the future are deemed “poor regardless of whether inequality is measured by relative overall age-adjusted mortality, relative life expectancy, or lags in either measure, and regardless of whether the 1940 or year 2000 standard population is used for age-adjustment” (p. 480).

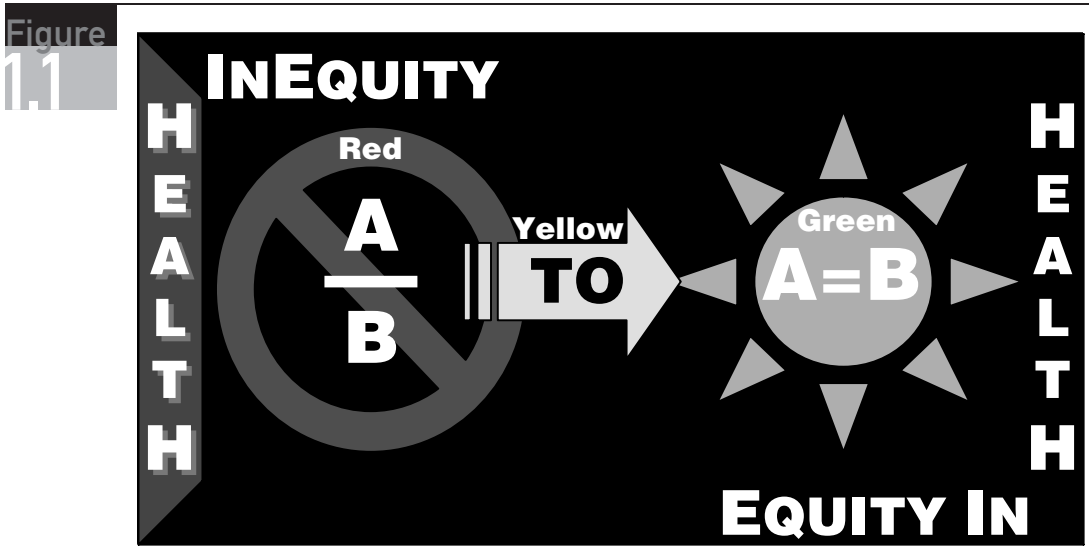
With regard to the value of other evidence of improvements, Levine et al. (2001) assert that “it would be illusory to consider national public health programs a success

based on other indicators as long as inequalities in mortality and life expectancy fail to improve” (p. 480). Moreover, they argue that “the millions of premature deaths among African Americans over the course of the twentieth century challenge the hegemony of current models designed to improve health” (p. 480). They conclude that major change is needed, encompassing “the ways that medical and public health practitioners are trained, compensated, and evaluated” (p. 481). Also needed is “further research on the translation of prevention studies into practice,” and “meaningful evaluation of federally funded research in terms of its impact on the inequality trends” they observe in their research (p. 481). More pointedly, they envision how “the aim of public health should not be simply elimination of disparities, but rather attainment of the best health for all people regardless of race, ethnicity, or social class” (p. 482).

Hence, as another milestone, the work of Levine et al. (2001), assists in broadening and shifting the discourse beyond eliminating health disparities—consistent with this volume’s goal: to shift the national discourse in the United States beyond a focus on simply the elimination of disparities, and call for movement toward equity in health for all. This book seeks to be a milestone by also facilitating the weeding out of anything that constitutes a destructive force—whether a paradigm, model, theory, approach, or practice, resulting in a clearing for new growth.

This book’s context is now anchored in over two decades of pertinent research with regard to health disparities, as well as other critical bodies of research and knowledge. There is also a great momentum for change from the twentieth century civil rights, social justice and human rights movements. Indeed, a global movement *From InEquity in Health to Equity In Health* is called for, given what Washington (2007, p. 3) cites in two powerful quotes: the declaration of Donna Christian-Christensen, MD, a Delegate to Congress and Chair of the Congressional Black Caucus Health Braintrust, that “Health disparities are the civil rights issue of the 21st century.” Moreover, the leader of the civil rights movement in the United States, Martin Luther King, Jr. placed this civil rights issue we now face in the twenty-first century within context, stating, “Of all the forms of inequality, injustice in health is the most shocking and the most inhumane” (Washington, 2007, p. 2).

Given the impetus for a twenty-first century global health civil rights movement, there is justification in launching a new field of equity—one driven by thirteen guiding principles reflective of contemporary forces driving the change this volume embodies, as listed below: (1) The Drive for a Major Paradigm Shift; (2) The Drive for New Models of Health Care and Training; (3) The Drive for New Theories, Perspectives, and Identities; (4) The Drive for Evidence-Based Approaches; (5) The Drive for Transdisciplinary Teams and Community-Based Participatory Research; (6) The Drive for Globalization and Global Collaboration; (7) The Drive for Cultural Competence and Cultural Appropriateness; (8) The Drive for Health Literacy and Linguistic Appropriateness; (9) The Drive to Ensure the Right to Health; (10) The Drive for Social Justice and Acknowledgment of Forces in the Social Context; (11) The Drive to Protect and Support the Most Vulnerable; (12) The Drive to Repair Damage, Restore Trust, and Take Responsibility; and (13) The Drive to Redistribute Wealth and Access to Opportunity. This chapter will introduce the scope of this volume by reviewing these thirteen guiding principles for a new field of equity in health.



The symbol of the Research Group on Disparities in Health: Reflecting a recommended paradigm shift *From Health InEquity to Equity in Health*.

(1) The Drive for a Major Paradigm Shift

There is a symbol representing the drive for a major paradigm shift. This symbol represents the following: the Research Group on Disparities in Health (RGDH—founded and directed by the author); and, the annual conference the RGDH sponsors and out of which this volume grew (i.e., the Annual Health Disparities Conference at Teachers College, Columbia University) (see Figure 1.1). Therefore, this symbol is also on the back cover of this edited volume, being accompanied by the motto guiding the suggested twenty-first century global health civil rights movement *From InEquity in Health to Equity In Health*.

Red for Stop the Old Paradigm

With regard to this symbol, located at left there is a red circle with a diagonal slash combined with A/B . The red reminds us to stop that which does not work any more: the paradigmatic thinking, behavior, and ways of being in the world associated with hierarchical domination, symbolized by A/B ; more specifically, given any actor A and any actor B , we may conceptualize the problematic interpersonal dynamic of unacknowledged domination and hierarchical authority in all forms that foster oppression (Wallace, 2003). The symbolic formula includes a dividing line with A in the top position and B in the bottom position, suggesting how a line is drawn ($/$), thereby depicting all forms of hierarchical domination as A/B . This captures the generic problem of a line drawn to subjugate and oppress *any* human based on any characteristic, trait, belief, or behavior (e.g., slavery, colonialism, genocide, ethnic cleansing, racism, classism, homophobia, heterosexism,

disregard of people with disabilities). The formula conveys how *A* subjugates and denies the basic humanity of *B*; it captures how many people repeatedly and compulsively assert the privilege of acting in the role of the dominant superior, *A*, by placing *B* in a subordinate position as the inferior—to be controlled and dominated (Wallace, 2003).

Yellow for Take Caution in Moving “To” or Forward

Moving from left to right, at the center of the symbol is a yellow arrow with the word “TO,” providing direction; it directs us to move “TO” or forward with caution. This embodies the process of moving across stages of change or identity statuses (Wallace, Carter, Nanín, Keller, & Alleyne, 2003)—as individuals, organizations, professions, and societies—toward a new paradigm. This draws upon an integration of the stages of change—*precontemplation*, *contemplation*, *preparation*, *action*, *maintenance*—of Prochaska and DiClemente (1983, 1992) and the use of motivational interviewing to enhance intrinsic motivation to move across the stages of change toward taking action (Miller & Rollnick, 1991, 2002); the yellow arrow suggests this integration and a reality. First, there is the reality of how individuals, organizations, professions, and societies may be in different stages of change or readiness to move forward and shift to a new paradigm: some may be in *precontemplation*, and not even thinking about a paradigm shift; others may be in *contemplation* and only thinking about it; others in *preparation*, having made a determination that it is important to shift to a new paradigm; others are in an *action* stage, having taken actions consistent with the new paradigmatic ways of thinking, behaving, and being in the world—for less than 6 months; and, others are in a *maintenance* stage, having engaged for more than 6 months and perhaps many years in the new paradigmatic ways of thinking, behaving, and being in the world (Wallace, 2003, 2005a; Wallace et al., 2003). Second, we can use motivational interviewing principles and techniques to foster movement toward taking action and shifting to the new paradigm—whether on the level of individuals, organizations, professionals, societies, or a global community (Wallace, 2003, 2005a; Wallace et al., 2003). An individual, organization, academic field, research discipline, or overall society might be characterized by stage of change with regard to the task of moving “TO” or forward toward a new paradigm; and/or stopping all the problematic paradigmatic ways of thinking, behaving, and being in the world associated with the old paradigm (*A/B*). This implies work on identity and our guiding theories and models and approaches to research, so they all move toward being in accord with a new paradigm.

The yellow associated with caution also suggests the new heightened state of awareness and alertness associated with a conscious attempt to recondition ourselves by doing the following: (1) stopping old paradigmatic ways of thinking, behaving, and being in the world; (2) potentially consciously catching or observing one’s self or organization engaging in the habitual execution of old paradigmatic ways of thinking, behaving, and being—even if this is a temporary lapse or relapse; (3) after stopping the old paradigmatic ways of thinking, behaving, and being, going on to create a space or clearing for the emergence of something new, and then consciously directing one’s self to execute new ways of thinking, behaving, and being in the world that are consistent with the new paradigm; and, (4) systematically rehearsing and refining over time new paradigmatic ways of thinking, behaving, and being in the world so that they become automatic natural

responses from which a sense of natural reinforcement and gratification arises. All of us living in the aftermath of centuries of domination and oppression are in need of such a reconditioning process which may transpire over time. Not surprisingly, this process in many ways parallels that of reconditioning a survivor of abuse and trauma; this process is rooted in an integration of theory (see Wallace, 1996 for details).

Also symbolized by the yellow arrow, among the things that we are moving toward is the cultivation of social capital (see Kwong, Ho-Asjoe, Chung, & Wong, chapter 14) and global leadership capable of overcoming the legacy of practices of domination and oppression that have transpired in places such as the United States and around the globe. Moreover, the new paradigm needs to be firmly established, or to take root in the very foundations of our individual beings, families, professions, disciplines, institutions, and local and global communities.

Green for Go: The New Paradigm

All of these foundations (e.g., individual, disciplines, communities, etc.) may each be symbolized as a green circular whole (at the far right of the symbol). At the core of a green foundation is the symbol of the new paradigm: $A = B$, suggesting a relationship of equality, freedom, justice, and the conditions for all reaching their full human potential prevailing (Wallace, 2003). The goal of interpersonal relationships reflecting a *non-hierarchical state of equality*—a term put forth by Taylor (1994)—is recommended by the $A = B$ formula. This non-hierarchical state of equality constitutes the desired status to be reached and reflected in all levels of human interaction—ranging from the personal to the global.

Of note, the whole green circle as the foundation for the new paradigm, $A = B$, also has rays spanning out, reminiscent of a sun, or arrows suggests the multi-pronged actions that may follow from the new paradigm—spreading out in all directions and reaching all parts of the global community. The green symbolizing “go” also suggests that all is clear for movement and action, within an approach that is holistic, inclusive, and supports resources being distributed, reaching out to all. This is also consistent with a global collaborative approach and sense of our interdependence, reminding us of our vast potential to collaborate, share, and disperse resources to literally any place on the globe; this also suggests a new definition and reconceptualization of globalization.

Researchers and interventionists may need to first undergo their own personal paradigm shift, and then provide leadership in ensuring their academic disciplines, models, and theories also pursue a paradigm shift, searching for new models and ways of conducting the business of their profession. Even as entire fields and/or academic disciplines, such as public health or psychology, must seek a restructuring, there may be paradigms that are of great value and must be retained; a need to integrate and combine some paradigmatic approaches; and need to forge entirely new ways of thinking and doing the work of a one’s profession, including the design of new interventions and research strategies (see Buchanan & Allegrante, chapter 5; Prochaska, chapter 4). There are also implications for how we must shift to a search for underlying mechanisms influencing health outcomes (see Ogedegbe, Schoenthaler, & Fernandez, chapter 7), as we seek to identify and uproot all past influences of the old paradigm.

The results of a major paradigm shift also include new policies and procedures. This includes eliminating those policies and procedures that are destructive to our

communities (see Fullilove, chapter 8), and pioneering new ways of analyzing data so our conclusions speak to the need to restructure how we distribute resources in society—and even how to tailor our resulting approaches by race/ethnicity given how the data speaks to us (see Lahiri & Pulungan, chapter 6). Thus, a shifting in our personal paradigms, and the subsequent shifts in our professions, may interact with larger societal shifts that all reflect the new paradigm based on a non-hierarchical equality prevailing on all levels and in all interactions.

(2) The Drive for New Models of Health Care and Training

The shift to a new paradigm necessarily includes a drive to create new models of health care and training, while also having implications for evaluation and research. As Levine et al. (2001) have asserted, new models of health care and training are needed. They pointed out how all models of health care that devalue prevention are inadequate. Equally inadequate are simple assurances of equal access to care or equality in “curative and/or palliative care services once access is achieved” (p. 481). Comprehensive prevention needs to achieve “parity as an integral part of regular care” (p. 481).

Levine et al. (2001) bolster their argument for valuing prevention, given how more than 80% of the U.S. population visits a health care provider in any given year. They categorize this as unsurpassed opportunity for the initiation of solutions that may involve primary, secondary, and/or tertiary prevention. However, our health care system must be redesigned to accomplish such a mission, while providers must be trained in new ways to work within such a new system. Moreover, Levine et al. (2001) point out how the vast majority (9 out of 10) of the leading health indicators established for Healthy People 2010 (i.e., physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, and immunization) are amenable to prevention. They underscore the need to go beyond a current primary focus on curative and/or palliative treatment which dominates today, also being reactive, and serving to increase “the overall prevalence of disease” (p. 481). Such an increase occurs because “it prolongs the duration of illness while having little impact on incidence.” Within such a model, “black people can be expected to continue to have higher mortality rates than white people, because the higher occurrence of preventable risk among blacks will continue to produce higher risks of becoming ill or injured in the first place” (p. 481).

The extent of their challenge to the hegemony of current models designed to improve health in the United States suggests how Levine et al. (2001) are assisting in fostering a major paradigmatic shift. Not only are changes needed in the entire medical system infrastructure and medical practice, but also in research.

Change is also needed in how public health programs are constructed. “A public health program can be defined as a structured intervention with the intent of improving the health of the total population or a subpopulation at particularly high risk” (Brownson, Baker, Leet, & Gillespie, 2003, p. 4). Thus, the overall health care system, medical field, and public health systems should change in response to the drive for new models of health care and training (e.g., see Johnson & Wallace, chapter 21; Moretti & Witte, chapter 16; Wallace, Konuwa, & Ayebofo, chapter 19; Woo, chapter 18).

(3) The Drive for New Theories, Perspectives, and Identities

The new paradigm also requires new theories and new perspectives (see Airhihenbuwa & Okoror, chapter 3; Walker, chapter 2), as well as a menu of integrated theories and approaches from which we may choose, selecting that which is most appropriate, given diversity, for example, and different needs for diverse groups at various times (Wallace, 2005b; and, see Nanín, Fontaine & Wallace, chapter 22).

An important goal is to avoid engaging in “blame-the-victim” or “deficit-oriented” research. It is also vital to avoid locating key variables—seen as deficits or evidence of an inherent inferiority—within the individual. And, it is absolutely important to appreciate the role of factors located in the social context; this includes the role of factors associated with the old paradigm of A/B, or hierarchical domination, and the forces of oppression that followed from it.

It is important to avoid theories that over-emphasize genetics (see Walker, chapter 2). Such theories betray their racist roots (see David & Collins, chapter 10).

Airhihenbuwa (2006, p. 34) cautions against a “focus only on individuals and their attitude or actions,” given how such “individual-based theories undermine the cultural and political contexts that shape behaviors.” Indeed, it is a flaw of Western theories that they focus on the individual and their agency as individuals (Airhihenbuwa, 2006). Nairn, Pega, McCreanor, Rankine and Barnes (2006) have also highlighted critiques of theories with individualist, pathologizing roots.

Kwong et al. (chapter 14) demonstrate the value of using the asset-based community development approach, as these frameworks give rise to interventions that can significantly enhance social capital and increase community assets and resources for a particular neighborhood. Such approaches can ultimately alter the social milieu and economic position at a community or neighborhood level, demonstrating the importance of going beyond a focus on the individual.

Diderichsen, Evans, and Whitehead (2001, p. 14) also critique how the “pervasive clinical orientation of epidemiology has resulted most often in the identification of “individual” attributes that differentiate health risk (e.g., age, dietary habits, etc.). However, Diderichsen et al. suggest, instead, how any “practical framework must capture the idea that the physiological end-pathways leading to an individual’s ill health are inextricably linked to the social setting” (p. 14).

Also, epidemiology lacks theory development, while other theories are far too reductionistic, individualistic, or partly biomedically driven, as Elder (2001) underscores and explains. Even some psychosocial theories used in health psychology and health education may not be appropriate globally when approaching country- or population-level health issues; they may also not gel well with indigenous or traditional cultures, let alone the value placed on community identity versus the individual level. An emphasis on health communication, learning theory, media advocacy, or community self-control strategies involving careful monitoring of selected behavior in light of selected goals may be more appropriate in the global context (Elder, 2001; and see fuller discussion in Wallace et al., chapter 19).

Diderichsen et al. (2001, p. 13) discuss how some tend to “blame the trend in health care and medical research toward an excessive focus on individuals—their biological and

behavioral risks of illness—to the relative neglect of population groups and the societal forces that create health divides.” Meanwhile, one result is a focus on proximal causes of illness. On the other hand, there are those who think gains in health will best be achieved by seeking a better understanding of more distal or upstream determinants. Instead, Diderichsen et al. assume the position that adequate understanding of and interventions against social inequities in health requires both looking upstream into “the mechanisms of society,” as well as “downstream into the mechanisms of human biology and the clinical issues of how people cope with disease and disabilities” (p. 13).

A viable recommended approach is to structure research in such a way as to investigate multiple relationships, drawing upon multiple theories as needed. This may guide the examination of the relationship between certain selected factors in the larger social context, or the experience of specific sources of stress in the social context, or the prevalence of certain adaptive strengths in the population under study, as well as demographic and other subject variables. This is what this volume strongly advocates. In this manner, researchers are encouraged to follow important trends valuing theory to guide such research—whether Multiculturalism, Positive Psychology, a Strengths-Based Approach, Optimistic Thinking/Learned Optimism (Wallace, 2005b), or the Psychosocial Theory of Resilience (see Franklin, Oscar, Guishard, Faulkner, & Zauber, chapter 11), or PEN-3 Model (see Airhihenbuwa & Okoror, chapter 3).

The goal is to be able to conceptualize and document subjects’ strengths and evidence of resiliency, as well as to view many problem behaviors as merely attempts to cope and adapt in a stressful social context. Also recommended is a focus upon which attempts to cope with stress in the social context reflect maladaptive affective, behavioral, and cognitive coping responses versus those that seem to reflect adaptive affective, behavioral, and cognitive coping responses (Wallace, 2005a). In this manner, a population can be approached as being able to reveal much more than the prevalence of a disease entity or problem behavior. The population can be approached as holding important information about both the prevalence of maladaptive and adaptive coping responses, given a theoretical framework that encompasses adaptive strengths in response to stress and other factors in the larger social context. Information on adaptive coping responses can serve as evidence of strengths and resilience, as well as form the basis for recommendations with regard to the content of future health education and health promotion targeted for delivery to individuals with the same or similar characteristics as those who were studied; findings might generalize in this manner. The resulting content for health education and health promotion may also be utilized in consultation work, community-based media campaigns, or social marketing efforts striving to disseminate “what works” or constitutes adaptive coping for those facing certain kinds of stress in the larger social context.

Theories guide how we understand and approach disparities in health. In this regard, Airhihenbuwa (2006, p. 37) notes how the United States has spent “tens of millions of dollars” on “projects for researchers to eliminate racial and ethnic health disparities.” However, the entire endeavor has failed to follow the wisdom of W.E.B. Du Bois (1899/1996) and his study of *The Philadelphia Negro*, dating back to 1899; therein, Du Bois concluded that any data or health statistics need to consider the absolute condition of Negroes, instead of focusing on their relative status—merely comparing Blacks to Whites. Airhihenbuwa emphasizes how only a focus on the absolute condition, or the larger context would allow an adequate analysis of social-cultural infrastructure.

In the process, one might identify that which “nurtures a state of resilience among many African Americans such that they are able to cope and thrive in social and political contexts where the assault on their identity remains chronic and systemic” (p. 37). Theories are needed that consider the social–cultural infrastructure, as well as coping and adaptation.

This is not to deny that some attempts to cope may be deemed more or less adaptive or maladaptive. Thus, another guiding rationale involves seeking to identify the underlying mechanisms that may be creating or sustaining disparities in health—such as potential maladaptive coping responses by providers to patient diversity, racism, or health practitioner behavior/bias/stereotypes—as information which might inform how these factors can be addressed in order to reduce health disparities (see Ogedegbe et al., chapter 7). Theories or the guiding rationales they provide for research need to encompass such underlying mechanisms operating in the social context.

Kunitz (2007, p. 6) reviews a large body of contradictory findings, illustrating how “anomalous findings need to be acknowledged and not ignored, as so often happens.” These findings are typically ignored because of the manner in which scientists tend to be “wedded to their theories,” holding “deeply held preexisting values” that effectively shape their “interpretation of data and the abstractions inferred from them” (p. 6). This serves to blind scientists from even acknowledging anything that contradicts their view. It is only when an overwhelming body of contradictory evidence accumulates that a shift to a new paradigm occurs, and the inherited ideas embodied in theories which have been long influencing interpretations of data should give way to something new.

This something new should be a full appreciation of the larger social context and the forces operating within it. For example, Airhihenbuwa (2006) identifies four concentric circles spanning out from around the person: (1) spouse, family, community, culture; (2) information, education, language, communication; (3) schools, curriculum, institutions, policy; and (4) housing, employment, environment, and government. This description of four concentric circles suggests the larger sociocultural context. However, we need to stop primarily targeting the person at the center of these concentric circles, and debunk “individual-based preventive models and embrace a focus on the confluence of factors in the concentric outer circles that collectively circumscribe the health decisions of the individual” (Airhihenbuwa, 2007, p. 150). Such a focus on the outer circles “addresses the root causes of individual problems” (p. 151).

Indeed, a more appropriate approach is to start with government policy which “exacts the most impacting influence on social change that can transform the outer layers for the benefit of individual health outcomes even when individuals have no intention of changing” (Airhihenbuwa, 2007, p. 159). Secondly, one needs to focus on socioeconomic status (SES), and “SES is influenced to a great degree by government policy,” while the poor are the most vulnerable—even as SES, independently, does not explain inequality (p. 160). Third, absolutely crucial is a focus on the role of culture so as to understand the contexts of preventive health behavior (p. 161). Fourth, gender relations are vital (especially for an epidemic such as HIV/AIDS, and issues such as condom negotiation or a male’s multiple partners). Fifth, spirituality, which tends not to be actively or sufficiently engaged in prevention (pp. 162–163). We need new theories and guiding models that adequately acknowledge these five contextual domains, as does the UNAIDS/Penn State framework, providing a basic structure for HIV/AIDS prevention in places such as Africa (Airhihenbuwa, 2007).

Or, we need theories and models such as the PEN-3 model (Airhihenbuwa, 2007), which encompasses the domains of (1) Cultural Identity, (2) Relationships and Expectations, and (3) Cultural Empowerment (see Airhihenbuwa & Okoror, chapter 3). Such a model also allows us to understand and respect the cultural identity of the people in a community where research is being conducted. The PEN-3 model is a cultural model vital in enlisting community voices to inform the development, implementation, and evaluation of programs; and, in guiding attention to the positive and existential behaviors within communities, effectively building on strengths located in the communities and people who live there when working on changing a behavior of interest. Thus, in all instances we should appreciate how there is also a cultural context where issues of identity for both the people and the researcher are pertinent. For “global health issues are identity and social issues;” moreover, they “should be analyzed using frameworks that can be derived from the social and behavioral sciences” (Airhihenbuwa, 2006, p. 32).

The transformation of the identity of the researcher to be consistent with the new paradigm advanced in this volume is also vital. Indeed, all who seek to work with communities around the globe should first and foremost assume personal responsibility for deconstructing an identity rooted in Western theories, and for reconstituting and rearranging their own identity, following the analysis and promptings of Airhihenbuwa (2006, 2007, chapter 3). The goal is to create an identity so they can perceive that which is of value in a social cultural context that is new to them, and actively seek to approach or enter that social cultural context via what Airhihenbuwa (2006) eloquently refers to as the “gate” or point of reference of those people in that social cultural context.

The era of generating research and delivering interventions in a multiplicity of settings, communities, and countries, following a misguided “one size fits all” approach is over, as is the legitimacy of acting as if our Western theory extends to all globally (Airhihenbuwa, 2006). Instead, this outdated approach should be declared as yielding to a much-needed paradigm shift and reconstituting and rearranging process, as we sort through our theories—weeding out that which is destructive (Ayebofo, 2005). We should weed out what is destructive in our theories and, therefore, in our own perspectives and identities which are closely tied to our theories.

Airhihenbuwa (2006) speaks to the nature of the challenge facing many Western educated researchers and practitioners who now seek to be a part of the new era, given how attached to and deeply engrained they may be within an approach that is part and parcel of their very identity. For so many, theory may be akin to an opiate, with theoreticians “behaving as a drug addict,” given how “problems are defined and solutions sought in the social and behavioral sciences” (p. 40). There is a compulsive tendency to “define problems and solutions as sharing common gateways to all cultures leading to the conclusion that what works in the United States or Europe should work in Africa or, for that matter, anywhere” (p. 40). Hence, a vital error is made in ignoring the “critical roles of social cultural contexts that nurture such behaviors” (p. 40).

Also, there is a “need to debunk Westernized theorizing about African health issues” (Airhihenbuwa, 2006, p. 36). And, a corresponding need to recognize how such Westernized theorizing does not apply with a multitude of groups within our global community. In addition to considering issues of identity, we must consider the intersection of multiple identities and related issues of stigma in the social context (see Greene, Miville, & Ferguson, chapter 23; Johnson & Wallace, chapter 21; Nanín et al., chapter 22; Rosario, Schrimshaw, & Hunter, chapter 24). However, even where disease

causation is multi-factorial, many of the factors are rooted in social injustice (Levy & Sidel, 2006b, p. 11). Hence, our theories should also encompass a viable approach to social injustice.

The drive for new theories, perspectives, and identities emerges as an essential guiding value for the field of equity in health. We should evolve to the point where we have a menu of approaches and theories from which to choose when designing research and interventions (Wallace, 2005b).

(4) The Drive for Evidence-Based Approaches

It is also crucial to move toward a menu of evidence-based approaches (Wallace, 2005b) for each health challenge we face. This is now the standard in many fields that have systematically evolved over decades (Hester & Miller, 2003; Wallace, 2005b). This volume's approach is rooted in the value that the field of equity in health generates a growing menu of evidence-based approaches to reducing disparities—decade by decade. All of this is consistent with assertions that we are living in an age of evidence-based practice (Sammons, 2001).

This book's approach seeks to value and promote the very best of patient and population level research (see Prochaska, chapter 4), and the very best research within the traditions of the National Institutes of Health and the Centers for Disease Control that has led to the identification of evidence-based models (see El-Bassel, Witte, & Gilbert, chapter 15; and Rashid, Amuwo, Skillen, Melanson, & Wagner, chapter 12). However, despite the prevalence of “new evidence-based guidelines for clinical preventive services, many patients are not receiving scientifically proven interventions” (Brownson et al., 2003, p. ix).

Evidence is important for many reasons. There are certain primary uses of evidence (Fielding, 2003), such as the following: first, public health practitioners, particularly those with executive and managerial responsibilities, may want to know “what is the evidence for alternative strategies, be they policies, programs, or other activities” (p. v). Sometimes practitioners are so busy they fail to inquire with regard to “the most important things I can do to improve the public's health” (p. v). Population-based data may provide direction as to what a practitioner can do, especially if it addresses factors such as “health status, health risks, and health problems for the overall population” (p. v) or specific sub-populations. There may be other important data on a “population's attitudes and beliefs about various major health problems” (p. v). Of great importance are data on potential interventions, including the menu of available options and what is known about each one, in terms of evidence—as well as “their individual and conjoint effectiveness in improving health in the populations” being served (p. v). In sum, the result may be a “rational prioritizing of opportunities, constrained only by resources and feasibility” (p. v).

The implication is that there is a role for the integration of theories, or their selection for use, depending on factors such as client characteristics or attitudes or preferences. A menu of options permits tailoring interventions in light of multiple client characteristics (Wallace, 2005b).

Toward the goal of making the practice of public health more evidence based, Brownson et al. (2003, p. 4) suggest how evidence-based “public health involves the

development and implementation of effective programs and policies” wherein a public health program can be defined as a structured intervention. Here the intent may be to improve the health of “the total population or a subpopulation at particularly high risk” (p. 4).

Taking from the evolution of evidence-based medicine, Brownson et al. (2003) note how key skills “include the ability to track down, critically appraise, and rapidly incorporate scientific evidence into a clinician’s practice” (p. 5). Differences between evidence-based approaches in medicine and public health include the quality and volume of evidence. For example, Brownson et al. explain how

medical studies of pharmaceuticals and procedures often rely on randomized controlled trials of individuals; the most scientifically rigorous of epidemiological studies. In contrast, public health interventions are likely to rely on cross-sectional studies, quasi-experimental designs, and time-series analyses. These studies sometimes lack a comparison group, which may limit the quality of evidence for some interventions. . . . (pp. 6–7)

Brownson et al. recommend a six-stage sequential framework to promote greater use of evidence in day-to-day decision making: (1) develop an initial statement of the issue, perhaps identifying gaps between some current status of a program or organization and desired goals, and, ideally stating “the health condition or risk factor being considered, the population(s) affected, the size and scope of the problem, prevention opportunities, and potential stakeholders” (p. 13); (2) quantify the issue by identifying sources of existing data, such as vital statistical data, perhaps from a survey—ideally with a representative cross section of the population of interest—permitting quantification of prevalence of “behaviors, characteristics, exposures, and disease at some point (or period) of time in a defined population” (p. 15); (3) accumulate knowledge about previous and ongoing strategies to address the issue, such as via a formal literature review; (4) develop a list of options, given the prior three steps, listing intervention options, also prioritizing them; (5) develop an action plan and implement intervention, via strategic planning, including the identification of goals (long-term desired change) and objectives—“a short-term, measurable, specific activity that leads toward achievement of a goal”—as well as the course of action, or plans for how to achieve what is desired (pp. 16–17); and (6) evaluate the program or policy to determine the degree to which “program or policy goals and objectives are met”—even as they note how “the strongest evaluation designs acknowledge the roles of both quantitative and qualitative evaluation” (p. 16).

Brownson et al. (2003) present an array of strategies for how to select, implement, and evaluate evidence-based programs, interventions and policies, requiring multidisciplinary teams that design the overall action plan. Options include those that reflect the highly valued standard of community-based participatory research (see El-Bassel et al., chapter 15; Hayes, chapter 13), and enlisting community voices and participation to ensure cultural appropriateness (see Airhihenbuwa & Okoror, chapter 3).

When discussing how to translate evidence into recommendations and public health action, Brownson et al. (2003) recommend the use of expert panels and consensus conferences (to review scientific evidence)—a mechanism “used by the National Institutes of Health (NIH) since 1977 to solve important and controversial issues in medicine and public health” (p. 69); practice guidelines, or recommendations, typically offering advice on how to improve effectiveness and impact of interventions—effectively translating

research findings and results of demonstration projects into “accessible and usable information for public health practice,” (p. 71) whether for clinical or community settings; “best practices” in public health—reviews describing discoveries of what worked best in a practitioner’s experiences, or via some grass-roots approach, or results of an evidence-based or expert opinion regarding what works (pp. 75–76).

Thus, there are many uses for and types of evidence. Sources of evidence may also be multiple.

Consider the use of quantitative and qualitative data, or “triangulation” in the data collection and analysis process. This involves multiple methods of data collection and/or analysis to determine points of commonality or disagreement; on the one hand, quantitative data may show how variables are related for large numbers of people, but not why these relationships exist; on the other hand, qualitative data may help to explain or give meaning to quantitative findings (Brownson et al., 2003, p. 207).

There are also approaches to acquiring evidence that are controversial. For example, in the United States, there is a dominant tradition that focuses on racial/ethnic differences in health or health care by largely comparing racial/ethnic groups (Braveman, 2006). This is despite the warning of W. E. B. Du Bois (1899/1996) over a century ago, as shared earlier through the work of Airhihenbuwa (2006), that seeking to understand the relative status of groups, instead of the totality of the conditions that creates vulnerability to high rates of morbidity and mortality, is not an adequate data collection approach.

However, within the tradition of seeking to understand the relative status of groups, Braveman (2006) offers a recommended evidence-based approach. Braveman explains how definitions impact data collection and policy. First, there are “different approaches to defining health disparities/equity” and corresponding measurement implications (p. 188). Such a discussion is important, because there can be important implications for health policy and the taking of action. Experience has shown that “a definition can have a significant impact on policies, particularly when resources are scarce and the definition is vague” (p. 188). For example, in the United States, the term “health disparities” is “generally assumed to refer to racial/ethnic disparities,” while there is also the prevalent erroneous belief that “such disparities are rooted in biological and/or “cultural” differences rather than underlying social disadvantage.” In such cases, explicit guidance is needed with regard to what constitutes an adequate measurement approach—“not only for research on specific research questions but also for ongoing surveillance to assess the magnitude of the health gaps and how they change over time in relation to policies and conditions in all sectors that influence health” (p. 188). Braveman goes on to acknowledge how public health surveillance “is certainly not sufficient to reduce health disparities, but without monitoring how the size of disparities between more and less advantaged social groups changes over time in relation to policies, there is a lack of accountability for the differential effects of policies on vulnerable groups” (p. 188). Hence, a kind of moral imperative to take seriously “what we should measure and monitor and why” emerges (p. 188).

Of note, consider the following (Braveman, 2006):

While epidemiology—the study of the distribution of diseases and risk factors across different populations—is concerned with health differences in general, which are important, the terms “health disparities” or “health inequalities” refer to a very specific subset of differences deemed worthy of special attention because of social values, including ethical concepts of distributive justice and core human rights principles (p. 188).

Braveman (2006) offers a recommended evidence-based approach within the context of what has traditionally been done in the United States. It may be summarized as follows: First, select the health or health-related indicators of concern and categorize people into social strata (by social position); and, secondly, calculate rates of the health indicator in each social stratum and display this graphically. More specifically, calculate rate ratios (e.g., relative risks) and rate differences to compare each stratum with the a priori most advantaged stratum that corresponds to it (e.g., all other income groups compared to the highest income group). Next, proceed to examine any changes over time in the rate ratios and rate differences. Moreover, if feasible, use a summary measure to assess multiple parameters at the same time. Finally, conduct multivariate analyses in the overall sample and within strata shown to be at elevated risk compared to the most advantaged stratum, to identify particular issues warranting further attention through research or action (p. 187).

The work of Kunitz (2007, p. 3) also analyzes influences on the kind of evidence we value and collect: for example, consider the “way inherited ideas about industrial growth, economic expansion, social change, and causes of disease have shaped explanations of the health of populations”; and, how “inherited ideas have become assimilated to political ideologies that influence how epidemiologic and demographic data are understood, causal inferences made, anomalies ignored, and abstractions drawn.” In other words, it is the “inherited ideas about the consequences of social and economic change and of causes of disease” and how these ideas have been “assimilated into different political ideologies that influence the choices we all make of the evidence we accept and ignore” (Kunitz, p. 175) that create a contemporary challenge and danger.

Thus, the drive for evidence-based approaches lies at the core of the field of equity in health. The goal is to arrive at a menu of evidence-based options for specific health challenges (Wallace, 2005b), as we move forward decade by decade.

(5) The Drive for Transdisciplinary Teams and Community-Based Participatory Research

There is also a drive for research to be conducted from the multiple perspectives that are brought to the table when there are transdisciplinary teams, as well as critical stakeholders, at the table. New forms of collaboration among all such parties are vital for future research envisioned (see El-Bassel et al., chapter 15; Hayes, chapter 13; Rashid et al., chapter 12; Walker, chapter 2).

Brownson et al. (2003) explain how a “stakeholder is anyone who is involved in program operations, is served by the program, or will use the evaluation results,” while stakeholders should be representatives of all these groups; and, they should be actively involved in “the design of the program or policy as well as in the design, implementation, and interpretation of evaluation results” (p. 196). This is consistent with the latest standards for community-based participatory research (see Hayes, chapter 13; and, El-Bassel et al., chapter 15).

Key stakeholders must bring the perspective of the cultural community in which research and interventions will be conducted. Community members should be seen

as “working alongside” professionals, researchers, and interventionists (Comas-Díaz, Lykes, & Alarcon, 1998), consistent with the new paradigm and value of a nonhierarchical equality prevailing. Ideally, professionals and community members enjoy a mutual respect and recognition, as well as a free-flowing dialogue among equals—as other vital aspects of the new paradigm (Wallace, 2003).

There is a strong rationale for the use of transdisciplinary teams (see Walker, chapter 2). Consistent with this, Brownson et al. (2003) discuss how public health relies on a number of disciplines, and people in public health have no one single academic credential, also working on multidisciplinary teams, while engaged in problem solving that depends on the expertise of group members bringing “diverse experiences and educational” backgrounds (p. 11). Professions represented might include “management and administration, epidemiology, biostatistics, behavioral science, environmental health, and health economics (p. 11). All of this is consistent with their overall vision of what constitutes and characterizes evidence-based decision making. The best possible science is drawn upon, while problem solving is multidisciplinary, drawing upon the expertise of a diverse team. A variety of planning frameworks and behavioral science theories are applied, such as ecological or systems models that consider how changes in the social environment will produce changes in individuals; and environmental changes may be brought about by supporting individuals. Meanwhile, problems need to be addressed at multiple levels with attention paid to interaction and integration of factors within and across all levels—“individual, interpersonal, community, organizational, and governmental” (p. 12). Also, the goal is embraced of moving toward healthy community environments where health-promoting information and social support is provided so people achieve a healthier way of living and being (p. 12). All of this suggests a role for community members as key stakeholders, helping to determine how to best accomplish such goals.

Transdisciplinary teams with community stakeholders at the table also follow sound evaluation principles. This includes systematic evaluation—both formative and outcome evaluation, permitting that which emerges as lacking effectiveness to be discontinued; that lacking effectiveness will not be continued merely because of “historical or political considerations” (Brownson et al., 2003, p. 12). Such historical or political considerations tend to prevail when one perspective, group, or discipline dominates. In addition, results are disseminated to others who need to know, allowing them to “enhance their own use of evidence in decision making”—sharing the news via publications, media, or meetings and hearings with policy makers (p. 12). Once again, community members as key stakeholders have an essential role to play in determining the format, shape, and content of what is disseminated, along with diverse transdisciplinary or multidisciplinary team members.

Moreover, such practices, consistent with community-based participatory research, effectively serve to “ensure that all voices are considered in the evaluation and that all will benefit” from it (Brownson, et al., 2003, p. 196). Results may include staff developing “skills and abilities in evaluation design and interpretation” (p. 196). Moreover, Brownson et al. note the following:

There are also other evaluation designs (participatory, collaborative, or empowerment evaluation) where stakeholders are seen as equal partners in all evaluation decisions from questions asked to types of data collected and participate in analysis and

interpretation of results. Some of these designs emphasize stakeholder participation as a means of ensuring that the evaluation is responsive to stakeholder needs while other designs involve stakeholders to increase the control and ownership. . . . (p. 197)

The work of Airhihenbuwa (2006) further reinforces why transdisciplinary teams and key stakeholders who are community members from the cultural context play such a vital role. The approach that is needed should draw upon “the experiences of scholars from multiple fields of specialization in ways that render a single disciplinary focus inadequate” (Airhihenbuwa, p. 32). By bringing stakeholders, community members, and members of transdisciplinary teams to the table in conceptualizing the approach to research, there is hope for averting critical errors of misrepresenting the reality of a group of people (Airhihenbuwa; also, see Airhihenbuwa & Okoror, chapter 3).

A drive for transdisciplinary teams and community-based participatory research must be at the core of the field of equity in health. This is essential in order to function effectively in our global community where diverse cultures abound.

(6) The Drive for Globalization and Global Collaboration

There is also a drive for globalization and global collaboration. The Internet and new technologies serve to bind us together as a global community (see Adams & Leath, chapter 17; Moretti & Witte, chapter 16).

The Internet is not the only force that binds us as a global community (Carr-Chellman, 2006), nor is the reality of our interdependence (Ayebofo, 2005). As a global community, we are bound by the forces of globalization, including the multidimensional integration of the world economy, politics, culture, and human affairs—all of which are fundamentally changing world health dynamics (Chen & Berlinger, 2001, p. 35). Kawachi and Wamala (2007a) cover the challenges and opportunities that come with globalization, the resulting health threats, and various approaches that can be taken in contemporary times, given the global organizations in existence and reality of globalization; most importantly, they note how globalization is “breaking down economic, political, cultural, social, demographic, and symbolic barriers across the world at a pace hitherto unseen in the history of civilization” (p. 3).

This globalization is an inescapable reality, corresponding to our current phase of historical development, while having the power to fulfill many human wants (Chen and Berlinger, 2001). Kawachi and Wamala (2007b) summarize the key aspects of contemporary globalization that make it unique historically. This includes how more than \$2 billion is exchanged in the world’s currency markets, the presence of new actors (e.g., the World Trade Organization [WTO] with authority over national governments, multinational corporations with more economic power than many states, as well as the global networks of nongovernmental organizations), and new rules of governance (e.g., multilateral agreements on trade and intellectual property). Moreover, there are also “new forms of communication (e.g., the Internet, satellite television), and the global movements of populations (whether as economic migrants, refugees, or trafficked individuals)” (pp. 3–4).

Consistent with the multiple influences of globalization, others have offered global approaches. For example, Merson, Black, and Mills (2006) compile the voices of many to articulate the full scope and dimensions of international and global health, shedding light on what nations around the globe are doing, including the challenges being faced, and how health systems are emerging in response to these issues, including their connection with the economic development of countries—providing many case studies for purposes of illustration.

The physical space that separates us is bridged by the rapidity with which technology can disperse information across time, linking those who share this planet in ways that suggest it is now a rather intimately shared space. Images and news of what is happening in one corner of the world can rapidly reach us, while we can just as quickly travel to another continent around the globe—potentially taking our infections and rapidly spreading them to others.

Kawachi and Wamala (2007b, p. 4) point out how “both travel and migration have helped to spread contagious diseases such as HIV/AIDS and SARS, while the Internet has provided a convenient vehicle for the global illicit traffic in laundered money, drugs, women, and weapons.” Given the impact of globalization, Kawachi and Wamala (2007a) put forth strategies (i.e., tools) for monitoring and evaluating these impacts, including health impact assessment techniques, the kind of global solutions needed, the role of global organizations (i.e., World Bank, IMF, WTO, WHO, the G8, other national governments), while stressing the opportunities that globalization also presents (e.g., globally coordinated efforts to combat the SARS outbreak, applications of technology) via health dividends (pp. 13–14).

Given the inescapable reality of globalization and the forces that will ensure it continues, we can maximize the potential for good through global collaboration on problems. If weapons and armed forces can be rapidly deployed, so can resources to ensure equity in health for all. Meanwhile, global warming is yet another phenomenon that speaks to how what one country does or sanctions affects other countries, if not all members in the global community. The emergent reality is that “what affects one, affects all” in our global community, suggesting our interdependence (Ayebofo, 2005).

A New Definition of Globalization

This suggests a new definition of *globalization* as an awareness of how “what affects one affects all,” or a consciousness of our fundamental interdependence as a global community, as well as the resulting process of learning to work collaboratively and share and disperse resources within our global community to ensure social justice, equity, the protection of human rights, and the sustainability of the planet.

Such a consciousness and process can also guide the weeding out of the destructive forces to which Ayebofo (2005) also refers. We should collaborate to fully actualize that which is constructive.

The drive for globalization, as newly defined, and global collaboration is at the center of the field of equity in health. The reality of our interdependence necessitates constructive collaboration.

(7) The Drive for Cultural Competence and Cultural Appropriateness

There is also a drive for cultural competence and cultural appropriateness. Scholarship and recognition are growing with regard to what constitutes cultural competence and its impact, underscoring the importance of obtaining training in cultural competence (Núñez & Robertson, 2006). Núñez and Robertson (p. 371) explain cultural competence as the “ability of health-care providers to interact with patients who are different from themselves,” encompassing “knowledge, attitudes, and skills (educational perspective) about health-related beliefs and cultural values (socioeconomic perspective), disease incidence and prevalence (epidemiologic perspective), and treatment efficacy (outcomes perspective).” In addition, cultural competence has been defined as “a set of behaviors, knowledge, attitudes and policies that come together in a system, organization, or among health professionals that enables effective work in cross-cultural situations” (p. 371).

However, cultural competence may also be discussed in the context of training not only practitioners or interventionists, but also researchers, teachers, trainers, policy-makers, administrators, and organizational leaders. Both individuals and organizations can be assessed for their level of organizational cultural or multicultural competence (Wallace, 2000).

Also, consider how some within the field of psychology have provided tremendous leadership, allowing us to amass a critical body of knowledge on how to foster, train, and educate for multicultural competence, cultural competence, and the overcoming of racial prejudice, discrimination, and hate; this body of knowledge also covers how to identify, respond to and redress unintentional and covert forms of racism and oppression, as well as pursue social justice—having implications for the training of counselors, psychologists, teachers, those working in various other disciplines/fields, as well as ordinary community members (Carter, 2005; Constantine & Sue, 2005, 2006; Pedersen, 2006; Pedersen, Draguns, Conner, & Trimble, 2002; Sue, 2003; Sue & Sue, 2003; Sue & Torino, 2005; Vera, Buhin, & Shin, 2006; Wallace, 2003, 2005a, 2005b).

While the field of psychology has provided critical leadership with regard to the fostering of cultural competence, more recently the field of medicine and training of medical professionals has also made great strides. There has been recognition of the role of cultural sensitivity, cultural appropriateness, and cultural competence as factors related to good quality health care (IOM, 2001). Indeed, there is now widespread recognition of the importance of cultural competence (Betancourt, Green, Carrillo, & Park, 2005). Cultural competence emerges as a core strategy for eliminating health disparities.

Betancourt et al. (2005, p. 499) explain cultural competence as “a strategy to improve quality and eliminate racial/ethnic disparities in health care;” in addition, it can lead to the creation of a health care system and adequately trained workforce—one capable of delivering “the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency” (p. 499). Reporting on the results of interviews with experts on cultural competence from a variety of fields, Betancourt et al. found evidence of a widely perceived link between cultural competence and health disparities; however, also found was a consensus that cultural competence alone would not reduce disparities—as they are rooted in multiple factors/causes; and, cultural competence alone was viewed as insufficient to address the problem of disparities.

Betancourt et al. (2005) also recognize the role of the Liaison Committee on Medical Education (LCME) in fostering progressive change, given their cultural competence accreditation standard; specifically, the LCME has established the requirement for all medical schools to integrate cultural competence into their curricula. Also fostering change is the Association of American Medical College's (AAMC) newly developed tool, specifically designed for the assessment of cultural competence training (Tool for Assessing Cultural Competence Training, TACCT) within medical schools; the goal is to assist medical schools in meeting the new standards. Furthermore, residency programs have responded to the Accreditation Council of Graduate Medical Education's (ACGME's) cultural competence standards; and cultural competence training has substantially increased in recent years due, in part, to both the increasing diversity of the patient population, and pressure from the ACGME. Meanwhile, the Institute of Medicine has also recommended that cross-cultural curricula be part of the training of clinicians from the undergraduate level through continuing medical education (CME). Collectively, these developments provide hope that the new drive for cultural competence is "evolving from a marginal to a mainstream health care policy issue and as a potential strategy to improve quality and address disparities" (Betancourt et al., p. 503).

There is also contemporary discussion about what is culturally appropriate with regard to research, prevention, interventions, training, and treatment (Wallace, 2000). Engaging in that which is deemed culturally appropriate when interacting with diverse patients is also of vital importance (LaVeist, 2005). Underlying mechanisms may be at play (see Ogedegbe et al., chapter 7). For example, LaVeist provides a summary of key findings in this regard: Black and Hispanic patients are less likely to be treated by providers from the same culture, while Whites enjoy the highest rates of race concordance with their physicians; and patients who were race concordant with their physicians rated their visits with physicians as more participatory compared to those who were race discordant; and, that African American patients who were race concordant with their physicians rated them as excellent and reported receiving needed medical care and preventive care; and, those patients reporting the highest level of satisfaction were race concordant with their health care provider (pp. 121–124).

Hence, discussions of cultural competence and what is culturally appropriate inevitably need to include calls for more training for researchers, practitioners, and interventionists (see Franklin et al., chapter 11; Walker, chapter 2). Meanwhile, the field of equity in health incorporates as its core the drive for cultural competence and cultural appropriateness.

(8) The Drive for Health Literacy and Linguistic Appropriateness

There is also a drive for health literacy and linguistic appropriateness at the core of the field of equity in health. For example, the Association of American Medical Colleges (AAMC) seeks to ensure training that produces both cultural and linguistic competence (Betancourt et al., 2005).

Health literacy and linguistic appropriateness are vital considerations, particularly with regard to delivering health information—as a task distinct to medical practitioners

and health education/disease prevention specialists (see Perez-Rivera & Langston-Davis, chapter 30). Interventions must be tailored in light of language and culture—as the two critical dimensions of cultural tailoring (LaVeist, 2005).

Zarcadoolas, Pleasant, and Greer (2006) bridge health education, health promotion, and health literacy through the model they advance from a public health perspective, including standards for how to develop and evaluate health communications materials. They offer definitions of three terms often used interchangeably: *health promotion* is a process of enabling people to increase control over their health, thereby also improving it; *health education* involves a multiplicity of activities where the communication of vital health information to people is at the core of all activities, while seeking to bridge the gap between what people know and what they do; and *health communication* involves the use of “human and mass or multimedia and other communication skills and technologies to educate or inform an individual or public about a health issue and to keep that issue on the public agenda” (in an era when consumers want more and better health information) (p. 5). Also of note, *social marketing* involves the “merging of traditional marketing and advertising strategies to persuade people to act in specific ways on social issues such as health and the environment” (p. 5); *consumer decision making* involves the “cognitive and emotional roles individuals play in attending to, evaluating, and acting on health information” (p. 5); and *health literacy* “is the wide range of skills and competencies that people develop to seek out, comprehend, evaluate, and use health information and concepts to make informed choices, reduce health risks, and increase quality of life (pp. 5–6).

Furthermore, Zarcadoolas et al. (2006) explain how health and literacy are linked, as low levels of literacy are strongly linked with poor health and early death both nationally and globally; and the greater the health literacy the greater the level of health (p. 21). At our current historical juncture in time, “there is an urgency to identify relevant characteristics of individual and groups in order to design effective health messages and campaigns” (Zarcadoolas et al., p. 42). Culture, language, and level of health literacy are key characteristics being given due consideration.

Zarcadoolas et al. (2006) explain how health literacy involves “people’s abilities to understand and use health information, most often in print (p. 46). Also, a person can have “high fundamental literacy but have low or insufficient health literacy and vice versa” (p. 46). Zarcadoolas et al. (p. 260) also note how language “is clearly not the sum total of culture, but at times the two are inseparable.” Zarcadoolas et al. advocate for “efforts at communication” at “the appropriate level of linguistic difficulty” with all materials “crafted with the appropriate cultural characteristics” of individuals and group being kept in mind (p. 260). “Culture, and by extension cultural literacy as a component of health literacy, is clearly part of a successful equation to improve health care, promote healthy decisions, and prevent unhealthy behaviors” (p. 260). Most importantly, it is vital that medicine and health care “consistently include culture as a component in the design of health care, health promotion, and health communication efforts” (p. 261). In order to do this effectively, knowledge and understanding of the language and literacy needs of an audience should be acquired through a “combination of quantitative and qualitative research” (p. 290). Many sources of health information currently available, including that available on the Internet is “poorly designed in terms of the ability to help people with low literacy and health literacy skills” (p. 309).

Hence, the drive for health literacy and linguistic appropriateness emerge as vital to ensure equity in health—lying at the core of the field of equity in health.

(9) The Drive to Ensure the Right to Health

The drive to ensure the right to health is also at the core of the field of equity in health. Closely aligned with the right to health is the right to determine what constitutes health, health standards/outcomes, and way of life, while we accept and respect members of diverse cultures and their right to self-determination—as an overarching ever-present principle.

As evidence of a drive to ensure the right to health, Braveman (2006, p. 183) explains how the foundations for addressing health disparities and pursuing health equity “come not only from ethics but also from the field of international human rights.” Elaborating further, human rights are described as “that set of rights or entitlements that all people in the world have, regardless of who they are or where they live” (p. 183). Even if we tend to think of certain civil and political rights (e.g., freedoms of assembly and speech and freedom from torture and cruel or arbitrary punishment), the reality is that these “human rights also encompass economic, social, and cultural rights”; this encompasses things such as the right to a decent standard of living, adequate food, water, shelter, and clothing—indeed, all requisite for health, “as well as the right to health itself” (p. 183).

Bambas and Casas (2003) cite the Universal Declaration of Human Rights, asserting that it established “a benchmark of standards against which to assess equity in health” (p. 321). Bambas and Casas (p. 321) focus on the assertion in article 25 that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” Equally important for Bambas and Casas (p. 321) is what is set forth in article 2: “Everyone is entitled to all rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

Bambas and Casas (p. 333) acknowledge how “the pursuit of equity is necessarily linked to issues of governance, which includes accountability, transparency, decision-making procedures, and the ability of the political sphere to allow for broad representation and the effective exercise of choice by all” in that society. Bambas and Casas conclude as follows: “Once a society embraces a political foundation of egalitarianism, whereby all citizens of a country are due equal regard under the law and have equal political voices, societies themselves become the ultimate arbitrators of equity in health or any other sphere” (p. 333).

Levy and Sidel (2006b) also acknowledge the value of an approach rooted in “the Universal Declaration of Human Rights and the International Declaration of Health Rights, as these provide a foundation for “reducing, and ultimately eliminating, social injustice” (p. 13). In this regard, Satcher (2006) notes the following: “From the founding of the United States to the present day, the right to good health and well-being has been a basic tenet the nation holds dear” (p. 547). Despite this, it is also true that currently, “the United States stands alone among industrialized countries in not providing universal access to health care”—as just one dimension of a rather poor ranking, overall (Satcher, p. 554).

Thus, we need more than guiding ideals. We need concrete actions that reflect the drive to ensure the right to health.

(10) The Drive for Social Justice and Acknowledgment of Forces in the Social Context

The drive for social justice and acknowledgment of forces in the social context is also key within the field of equity in health. Any discourse on equity goes hand in hand with that on not only the “right to health,” but also “social justice,” while drawing necessary attention to the social context. Social justice also goes hand in hand with training that inculcates the development of a professional and personal identity that encompasses the taking of social action for social justice (Wallace et al., 2003).

Levy and Sidel (2006b) define social injustice as “the denial or violation of economic, sociocultural, political, civil, or human rights of specific populations or groups in the society based on the perception of their inferiority by those with more power or influence” (p. 6). In all cases and with all types of social injustice, the hallmarks involve “a lack of fairness or equity, often resulting from the way that society is structured or from discrimination by groups or individuals within the society” (Drucker, 2006, p. 6).

Peter and Evans (2001) discuss the ethical dimensions of health equity, placing emphasis on the link between the pursuit of health and the pursuit of social justice; they view health equity as embedded in the more general pursuit of social justice, while efforts to ensure social and economic justice are key. Also, Hofrichter (2006, p. xviii) compiles a chorus of voices in his book on health and social justice in order to support a core argument that forging “health equity requires a coherent strategy that addresses social and economic inequality, as well as the ideologies that support and sustain it.” Also worthy of acknowledgment are the many “imbalances in political power and the institutions that maintain those power relations,” as these should be seen as “primarily responsible for producing inequities, apart from other uncertainties and immeasurable factors” (p. xviii). In essence, the resulting task of eliminating health inequities becomes “a matter of social justice” (p. xviii). Attention to matters of social justice remains essential, as merely implementing “enhanced social services or other interventions aimed primarily at effects cannot eliminate the sources of health inequities” (p. xviii). As a consequence, it emerges as vitally important to rethink “how we might create health equity or at least overcome barriers to achieving it” (p. xviii). Toward this goal, it emerges as equally important “to identify the social determinants of health—social and economic conditions that improve community health; to examine the political implications of differing paradigms and perspectives used to explain health inequities; and to explore alternative strategies for eliminating health inequities” (p. xxi). Thus, an emphasis on social justice forces us to pay attention to the social context and the social determinants of health, leading to potential points of entry for their remedy, reduction, and elimination.

Kunitz (2007, p. 183) points out how understanding and predicting health is “much more likely to result from stitching together all that one can know about the context—institutional, cultural, political, epidemiological—in which particular populations live and work”; even if such a view is “disquieting for those who equate doing science with

having a theory that makes possible accurate predictions” (p. 183); (also, see Walker, chapter 2). What is needed is an acceptance of how all “generalizations about the social determinants of health and disease begin in the lived reality of particular people and places” (Kunitz, 2007, p. 185). This may include the impact and legacy of injustice embodied in the social context. For example, Williams and Jackson (2005) emphasize the social sources of disparities in health, noting how factors in the social environment initiate and sustain racial disparities in health.

The link between inequity in health and social injustice has also been discussed in terms of the fundamental social basis of disparities in health. Diderichsen et al. (2001) elaborate on the relationship between the social context and how individuals are sorted into certain social positions, asserting this is central to the issue of social differentials in health. It emerges as crucial to articulate effective actions to redress health inequities; this is contingent on elucidating the pathways through which social context and position are linked to health outcomes, as well as being linked to the social consequences of disease. Diderichsen et al. (2001) identify four mechanisms they view as playing a role in generating inequities: factors affecting social stratification; differential exposure to health damaging factors; differential vulnerabilities/susceptibility that lead to unequal health outcomes; and differential consequences of illness.

In a similar vein, LaVeist (2005) discusses the role and function of social risk factors. LaVeist identifies variables such as “racism, sexism, socioeconomic status, social support, population density, housing quality, racial segregation, stress, or residence in a neighborhood with a high crime rate” as having all been “demonstrated to be associated with health” (p. 27). Within the model of LaVeist, also recognized as impacting health, illness behaviors, and overall health status is “the culture of an ethnic group” (p. 27). Also included in the model are societal factors impacting health, illness behavior, and health status, given how these “place constraints on an individual’s ability to engage in health or illness behaviors that are protective of health” (p. 27). For example, societal factors may include how “race may lead to lower socioeconomic status, which may lead to underutilization of health services,” even as “one might inaccurately ascribe such a finding to a person’s race when it is really an effect of social class” (p. 27). The real danger that LaVeist’s (2005) model seeks to correct is erroneous thinking that might “lead to the assumption that there is something about a person’s skin color that makes the person engage in risky behavior” (p. 27). What is really at issue is the effects of a social category.

Edelman (2006) similarly notes how the current gaps in health “thrive in a climate of economic and social inequities,” which includes an adverse impact on “the health of individuals and communities by denying individuals and groups the equal opportunity to meet their basic human needs” (p. vii). Levy and Sidel (2006b) also note how social injustice has a negative impact on both individuals and communities, while also constituting a violation of fundamental human rights. In order to substantiate this claim, Levy and Sidel (2006a, p. ix) compile the voices of many in their edited volume; they do so in order to offer a “comprehensive approach to understanding social injustice and its impact on public health,” given how “social injustice underlies many public health problems throughout the world.” Moreover, Levy and Sidel (2006b) note how the origin of social injustice is often rooted in how “those who control access to opportunities and resources block the poor, the powerless, and those otherwise deprived from gaining fair and equitable access” to vital opportunities and resources; meanwhile, “those in the upper class receive a disproportionate share” (p. 11). Allen and Easley (2006) assert

that the equitable provision of health care is the “most important immediate action in response to social injustice against racial and ethnic minorities that leads to disparate health outcomes” (p. 63).

The new field of equity in health must incorporate the drive for social justice and acknowledgment of forces in the social context.

(11) The Drive to Protect and Support the Most Vulnerable

The drive to protect and support the most vulnerable is also at the core of the field of equity in health. The characteristics (e.g., the poor, powerless) of those who tend to experience social injustice emerge as meaningful and key.

According to Levy and Sidel (2006b, p. 6), the most vulnerable tend to be populations of groups “defined by racial or ethnic status, socioeconomic position, age, gender, sexual orientation, or other perceived population or group characteristics.” Moreover, these groups tend to be negatively stereotyped and stigmatized, as well as “targets of hate and violence” (p. 6). Thus, groups with certain key characteristics emerge as among the most vulnerable to forces of domination, oppression and discrimination.

Those oppressed because of their race emerge as among the most vulnerable (see Constantine, Kindaichi, Graham, & Watkins, chapter 9; Franklin et al., chapter 11). Allen and Easley (2006, p. 62) emphasize the importance of addressing institutionalized racism such that institutionalized structures “no longer support racism.”

House and Williams (2003) also analyze how racism affects disparities in health: the impact of racism in the larger society is such that it can lead to “systematic differences in exposure to personal experiences of discrimination” which “may be an important part of subjectively experiences stress that can adversely affect” physical and mental health for a broad range of racial/ethnic minority populations, as also reflected in self-reported measures of health (p. 107); racism and related systematic discrimination “can also affect the quantity and quality” of medical care and health services received (p. 107); “the prevalence of negative stereotypes and cultural images of stigmatized groups can adversely affect health status” (p. 107); “racism restricts and truncates socioeconomic attainment” (p. 106); the impact of economic discrimination produced by large-scale societal structures are reflected in racial differences in SES and poorer health; racial segregation and residential segregation create and reinforce racial inequality, and operate to determine access to educational and employment opportunities—which leads to “truncated socioeconomic mobility for blacks and American Indians” (p. 106); next, living in segregated neighborhoods “can lead to exposure to environmental toxins, poor-quality housing, and other pathogenic living conditions, including inadequate access to a broad range of services provided by municipal authorities” (p. 106); moreover, these living conditions “importantly account for the large racial difference in homicide,” together with the “combination of concentrated poverty, male joblessness, and residential instability” that account for variation in violent crime levels (p. 106); research is also impacted, insofar as racism has an influence on SES indicators such that they are “not commensurate across racial groups, which makes it difficult to truly adjust racial differences in health for SES”; as a result, it is vital to recognize “racial differences in the quality of education, income returns for a given level of education or occupational

status, wealth or assets associated with a given level of income, the purchasing power of income, the stability of employment, and the health risks associated with occupational status” (p. 107).

People with disabilities are another vulnerable group (see Keller & King, chapter 25). Thus, the most vulnerable are also sometimes referred to as special populations, possessing special needs, necessitating extra protection and support.

All working in public health should work to ensure that “disability issues are included in all phases of public health education and practice” (Groce, 2006, p. 158). Making an analogy to women, Groce recalls how 30 years ago there was little being done in public health with regard to women—beyond maternal and child health, while, today, the considerations of women are routine. Groce anticipates the day that such considerations people with disabilities will be just as routine. What must be transformed is the “denial of human rights to people with disabilities, their lack of equitable access to public health and social service resources, and their disproportionate rates of poverty”—which are all socially determined “threats to social justice” which can be “socially redefined” (p. 158).

Mutaner and Geiger-Brown (2006) also discuss how the LGBT population is another vulnerable group, being at risk for unjust treatment, given how they suffer from homophobia and heterosexuality (see Greene et al., chapter 23; Nanin et al., chapter 22; Rosario et al., chapter 24). Lombardi and Bettcher (2006) similarly discuss the impact of social injustice on the health of the LGBT population, given the stigmatization and marginalization that they face; they indicate a need for legislative and other policies explicitly prohibiting discrimination and violence against the LGBT population; and, the transgender/transsexual also need legislation and policies that legitimize their lives and identities, while covering practical matters such as changing legal documents, and access to affordable medical care for procedures related to their identity.

Another vulnerable population suffering great social injustice includes those who are incarcerated around the globe (see Bahl, chapter 20), and especially in the United States. Drucker (2006, p. 161) acknowledges how among those factors damaging community cohesion is mass incarceration, while also detailing the damage done to opportunities for “work, education, housing, and a stable family life, undermining many of the foundations of personal health and well-being.” Contemporary U.S. incarceration policies and practices are appropriately likened to being “the modern heir to our long legacy of state mechanisms that perpetuate social and racial injustice” (p. 161). These include slavery, segregation, discriminatory immigration, trade union, and social welfare policies. Moreover, incarceration is likened to a plague because of the “striking economic, ethnic, and racial disparity in its application,” disproportionately impacting African American males, in particular. And, the incarcerated population suffers from health disparities common to low-income populations (e.g., sexually transmitted diseases, viral hepatitis, HIV/AIDS), as well as from trauma and abuse while incarcerated.

The incarcerated emerge as more than worthy of protection and support (e.g., Mauer & Chesney-Lind, 2002; Restum, 2005). The over-representation of Black males in prisons suggests their vulnerability, in particular, within the socio-cultural-political context of the United States. This serves to justify early interventions that begin as early as possible, such as in elementary school, and focus upon the most at-risk, such those experiencing the largest gaps in academic achievement, lagging behind. In this regard, attempts to close the gaps in academic achievement are now increasingly focusing on Black males; these efforts include culturally tailored components and mentoring designed to meet the

needs of Black males and reduce their risk for a range of negative outcomes—from special education placements, to school dropout, and incarceration (Hu, 2007). Interventions that effectively engage such at risk students show promise for closing the education gap between Whites and Blacks (see Ross & Smalls, chapter 26). Supplementary education (see Bridglall & Gordon, chapter 27) may target Black males, in particular, or utilize strategies that effectively this group in the learning process (see Campbell & Wallace, chapter 28). Other interventions that provide peer mentoring and tutoring may also benefit Black males more than any other group, consistent with how the needs of urban adolescent males at risk of school drop-out are also the most pronounced (see Chew & Wallace, chapter 29).

Global policies also create new vulnerable groups. Pertinent policies include those that lead to “war, violence, global warming, government corruption, lack of access to essential public health or medical services, erosion of civil liberties and freedoms, restriction of education/research/public discourse” as well as other “actions that adversely affect the societal conditions in which people can be healthy” (Drucker, 2006, p. 6). The resultant vulnerable groups who suffer the most include “the poor, the homeless, the ill or injured, the very young, and the very old” (p. 6).

Not to be forgotten are those displaced from their homes or homelands, those injured and maimed who end up disabled, refugees forced into camps, child soldiers who are traumatized, and victims of sexual violence/exploitation and rapes within the context of war. All emerge as especially vulnerable within the global social context.

A drive to support and protect the most vulnerable is essential to the field of equity in health.

(12) The Drive to Repair Damage, Restore Trust, and Take Responsibility

The drive to repair damage, restore trust, and take responsibility for what needs to be done in the aftermath of the damage done is also at the core of the field of equity in health. The damage done includes a host of negative consequences experienced by those subject to domination, oppression, and discrimination. Typically, it involves damage experienced most acutely by the most vulnerable populations.

For example, Levy and Sidel (2006b) point toward “adverse health consequences, as reflected in disparities in health status and access to health services within or between populations” (p. 7); there are also “increased rates of disease, injury, disability, and premature death because of increased risk factors and decreased medical care and preventive services,” as well as “poverty, inadequate education, and inadequate health insurance” (p. 10); and, poorer nutrition, greater exposure to unsafe water, increased contact with infectious disease agents, more exposure to occupational and environmental hazards, higher rates of complications of chronic diseases, more use of alcohol/tobacco/drugs, decreased social support, and increased physiological and immunological vulnerability to disease. Furthermore, there is less access to comprehensive diagnostic, therapeutic, and rehabilitative services and lower quality of health. And, there is less access to clinical preventive services (i.e., screening and counseling) and to community-based preventive measures (p. 10).

Regarding repairing the damage done, House and Williams (2003) identify numerous avenues: “socioeconomic policy and practice and racial/ethnic policy and practice are the most significant levers for reducing socioeconomic and racial/ethnic disparities and hence improving overall population health in our society, more importantly even than health care policy” (p. 111). They also note how “intervening in or changing one or a few major risk factors for health (including inadequate medical care) can have only a limited effect on socioeconomic and racial/ethnic disparities in health” (p. 122). However, they also indicate that this “effect is clearly enhanced if interventions or changes are attentive to the broader social forces that produce these disparities” (p. 122). Most important among the avenues for repair of the damage done there is the “potential for reducing socioeconomic and racial/ethnic disparities in health and improving overall population health” by improving socioeconomic status and “reducing invidious racial/ethnic distinctions themselves, especially among the more disadvantaged portions of the population” (p. 122). Thus, both “economic growth and development and progress toward greater racial/ethnic equality have had and can have dramatic effects on individual and population health” (p. 122). This is the case, “especially if these changes impact the more disadvantaged socioeconomic and racial/ethnic groups in our society” (p. 122).

Other avenues for repairing the damage done emerge through the work of LaVeist (2005, p. 285) who presents a model similar to that of Benzeval, Judge and Whitehead (1995), who presented a four-level framework for addressing health disparities: (1) improving the physical environment; (2) addressing social and economic conditions; (3) improving access to appropriate and effective health and social services; and, (4) reducing barriers to adopting healthy lifestyles. Hence, these are all avenues for repairing damage done.

There is also a need to restore trust, given the damage done (see Constantine et al., chapter 9; Franklin et al., chapter 11). In this regard, the research of LaVeist (2005) locates lower rates of health care use in issues of level of trust of health care institutions. For example, citing the research of van Ryn and Burke (2002), African Americans endorsed at twice the rate of Whites items indicating that hospitals often seek more personal information than needed, and that “hospitals have sometimes done harmful experiments on patients without their knowledge” (LaVeist, 2005, p. 117). Also, nearly three times as many African Americans perceived, when compared to Whites, that racial discrimination in a doctor’s office is common (p. 117). Meanwhile, other evidence reveals good reasons for distrust, given how physicians “consistently reported more negative attitudes toward African American patients than toward White patients” (p. 120). More specifically, this included perceptions that African Americans were more likely to abuse alcohol or drugs, be noncompliant with medications, while Whites were perceived as more likely to strongly desire a physically active lifestyle, had adequate social support; and, White patients were more likely to be the “kind of person” the physician could see being friends with (p. 120). Other negative perceptions of African Americans held by physicians included being less likely to see them as very intelligent, or at least somewhat educated; meanwhile, Whites were more likely to be viewed as very pleasant and very rational.

Others take a historical view in locating the roots of distrust. Randall (2006) locates the destruction of trust in the medical and health care system, as well as in medical personnel and researchers within the long history of medical experimentation in the United States on Blacks, prisoners, and members of the armed forces in America. As a consequence, Randall (2006, p. 124) asserts that such episodes of abuse are stored within

the collective Black consciousness. The result is a deep-seated distrust that currently influences Blacks' attitudes toward the health care system, contributing to disparities in health.

In the same vein, Washington (2007) details the practice of "medical apartheid" in the United States, meaning the history of medical experimentation on Blacks, dating back to colonial times and the abuse of enslaved African Americans; it continues up to the present via forced experimentation on prison inmates and soldiers in the armed forces, and the erosion of informed consent so experimental procedures are used in emergency rooms on non-consenting victims—many of whom end up dead. The result is not only a lack of trust, but even a deep seated fear "of medical professionals and institutions"—something Washington (p. 21) calls iatrophobia, being "coined from the Greek words *iatros* ("healer") and *phobia* ("fear"). Black iatrophobia is the fear of medicine" (p. 21).

Damage has been done, and trust destroyed through a more modern legacy of research with mostly African Americans, and some Hispanics that Washington (2007, p. 5) details: suspended research "at such revered universities as Alabama, Pennsylvania, Duke, Yale, and even Johns Hopkins"; and, "experimentation-related deaths at premier universities, from Columbia to California," and revelations of researchers lying through "falsified data or fictitious research agendas" involving scientists from "the University of South Carolina to MIT."

One theme running throughout Washington's (2007) analysis is that, while African Americans have either been specifically selected and targeted or suffered disproportionately because of their presence in prisons, the armed services, or urban emergency rooms, all of America has suffered and paid a high price, especially White middle class Americans paying for the health cost burden, creating an American tragedy. However, Washington's analysis goes beyond the borders of the United States to how Western researchers turn to the Third World or developing countries, and Africa in particular, and engage in unacceptable ethical practices that would not be allowed by Institutional Review Boards (IRBs) if the subjects were here in the United States. "American IRBs treat Africans as second-class subjects and employ different standards for evaluating study designs in Africa than those used in the United States (Washington, p. 394). Thus, there is a resultant global damage, including a profound distrust.

Avenues for rebuilding trust and repairing the damage done is also described by Washington (2007, p. 396). Despite the legacy of abuse, African Americans are strongly advised to "embrace new medical research—after judicious inquiries of their own into any study they are considering;" this is recommended, even as "there are still issues that must be addressed," requiring that they "embrace medical research warily" until these issues are "rectified" (p. 396). In particular, there is a vital need for "more and better research into black health care" (p. 399). There is also a need to do the following: ban the erosion of consent, specifically a ban on exceptions to informed consent, such that physicians face an imperative to treat patients as if the physician had no research protocol "to worry about"; this will leave physicians in a position where they must use the best-known treatment, not the one offered via a research protocol (p. 403); institute a coordinated system of mandatory subject education, covering the "ethical and practice conduct of biomedical research," just as the National Institutes of Health and Office of Research Integrity require of every practicing medical researcher (p. 403); embrace a single standard of research ethics, ending the practice of championing "human rights in medical research"

in the United States, but ignoring them abroad, while following “informed-consent strictures abroad that are as restrictive as those governing their research on American shores;” also, the “federal government should take advantage of its legal right either to force manufacturers to lower their prices [of lifesaving drugs] or to suspend patent enforcement” in poor countries (p. 403).

Offering yet other avenues for repair of the damage done, Washington (2007, p. 403) offers a vision of medical-research education. Within her vision, accessible lay education on medical research and assistance navigating clinical trials via “brochures, Web sites, and access to experts” is made readily available. There is also a role in this work for “church health fairs, social organizations, and community activism” (p. 403). This includes community members working to “bring medical-research education to the fore of the American health agenda,” as well as joining Institutional Review Boards and asking “the hard questions of physicians who are recruiting in your community, and to join appropriate clinical trials once you have satisfied yourself that they are worthwhile and relatively safe” (p. 403).

These recommendations begin to suggest how the taking of responsibility is also being advanced by Washington (2007)—even among those who were historically the most vulnerable and suffered the most damage. Further suggestive of what is involved in rebuilding trust and taking greater responsibility, African Americans are challenged to “effect a transformation of our attitudes toward medical research,” demanding “our place at the table to enjoy the rich bounty of the American medical system in the form of longer, healthier lives” (p. 403).

Others acknowledge the loss of trust, regardless of race, across America, and view the rebuilding of trust as a vital task, while also offering viable solutions. Shore (2007a), as Founding Director of the Trust Initiative at the Harvard School of Public Health, asserts that there is a lack of trust in health care (Shore, 2007b). The edited volumes goes on to discuss in detail both causes and consequence of declining trust in health care. In his opening chapter, Shore (2007b, p. 3) explains how trust “in the professionals and institutions that provide healthcare in America has been eroding over time,” being at “an all-time low.” Consequences include endangering “patients’ lives and well-being,” while stripping the health care system of what is vital to a “well-functioning system” (p. 3).

Whether the patient who takes a medication (that would be toxic if taken in large quantities), or the patient stripped naked and knocked unconscious for surgery, trust is essential (Shore, 2007b). Specifically, “trust entails two distinct but equally important elements. If I am to trust you, I must believe that you are competent to do what needs to be done,” having requisite skills and resources “to do what you say you will do, and that your actions are likely to help me rather than to hurt me” (p. 4). Second, “I also must believe that you have my best interests at heart and that your judgment and actions are not compromised by a financial (or any other) motive that would put me at risk” (p. 4). Most importantly, the lack of trust may mean that patients “don’t do what they are supposed to do and they don’t tell their caregivers the truth about what they actually do” (p. 4).

Shore (2007b) explores what steps might be taken by providers and the health care organizations in the process of rebuilding trust. First they would have to address service quality, having to establish and monitor high levels of quality, and provide consistent high quality—just like a “power brand” (pp. 14–15); this includes everything from a friendly receptionist to a clean environment, to the physician’s manner, to how billing is handled.

Secondly, “trust-seeking organizations must be learning organizations. They must learn from experience what builds trust and what destroys it”—such as rigid gatekeeping, or responses to crisis (e.g., the cover-up) (p. 15). In health care, a third factor is cultivating brand identity with the hospital corporation needing a brand “that means something to people,” since “perception is reality,” justifying “using all the tools and techniques of branding to build a power brand” (p. 16).

Blendon (2007) discusses how the dynamics of declining trust in health care “correspond very closely to the dynamics of declining trust in government”—citing three kinds of scandal: (1) the medical error where a “doctor or a hospital makes a mistake, and a patient dies”; (2) the impaired physician, whether by drugs, alcohol, or mental illness—doing “terrible things to patients”; and, (3) the “doctor or hospital found to be billing insurance companies or Medicare, fattening his or her own purse at the expense of premium payers or taxpayers” (p. 24).

Blendon (2007) explains that getting trust “back is not magic. It involves leadership that does not ignore problems, that reacts firmly and ethically to scandals the minute they break and does not try to cover them up, and that understands how the consequences of seemingly small decisions can loom large” (p. 30). Leaders need to take the “long view” and “take the steps necessary to build trust” (p. 31).

In concluding his analysis, Shore (2007b) asserts that health care is at a “tipping point” that is hoped to be a “turning point.” Shore (p. 16) asserts how everybody “has an interest in building trust: patients, clinicians, organizations, government,” while all will also benefit from increasing levels of trust. Most importantly, the problem “is being named and analyzed, and solutions are being offered. Providers and healthcare organizations can pick these up and run with them” (p. 16).

Levy and Sidel’s (2006b) view of what needs to be done further suggests how we have reached a tipping point or turning point. Also, striking a hopeful note, they observe how humanity has entered an era, perhaps “for the first time,” wherein we actually possess the requisite “technical capacity and the human and economic resources to address poverty, ill health, human rights violations, and the social injustice that helps spawn and promote these problems” (p. 13). Thus, if we take responsibility, we can restore trust and work to repair the damage done.

Although humanity now possesses “the way” to solve these problems, the “will” to do so is not a universal trait. Instead, those enjoying privilege may resist sharing their greater proportion of resources. In such cases, Levy and Sidel (2006b) see a role for “social or legal action for their prevention or correction” (p. 13). Even this requires the taking of personal responsibility by individuals and communities.

Elder (2001) also describes a new public health era—one in which societies and individuals have to take responsibility for health, rather than waiting for changes to be made for them. Also, suggesting the taking of responsibility, Washington (2007, p. 403) concludes by asserting that above and beyond all of her recommendations, most important “is the need for African Americans to set their own research agendas—as an ultimate avenue for taking responsibility.” This taking of responsibility is consistent with a final charge to “change,” given how survival goes to “the one most responsive to change”—with Washington (pp. 403–404) quoting Charles Darwin to underscore this point.

In this manner, there is a drive to repair damage, restore trust, and take responsibility—as a core and essential guiding principle for the field of equity in health.

(13) The Drive to Redistribute Wealth and Access to Opportunity

Finally, there is a drive to redistribute wealth and access to opportunity, as a guiding principle for the field of equity in health. In this regard, Kubzansky et al. (2001) underscore how the United States has the dubious distinction of ranking first among industrialized nations in inequalities in both income and wealth. There is a growing trend of growing socioeconomic inequalities in the United States that have widened considerably over the past two decades. There is a robust effect of income on health; it is evident in all age, racial/ethnic, gender, and income groups; moreover, it persists across two different markers of health status—premature mortality and disability. Those with less income—when compared to their counterparts with more income—consistently live more disabled and less healthy lives, while also dying at younger ages (Kubzansky et al., 2001, p. 116). Kubzansky et al. thereby underscore “both the relative unfairness and the burden of poor health in the United States” (p. 119). They view this type of documentation of “contingent inequalities in health” as being of the utmost importance, as it may lead to action to “reduce these inequalities and improve health equity” (p. 120).

In a similar vein, Kawachi, Daniels, and Robinson (2005) identify historical, political, and ideological obstacles that have prevailed in blocking adequate analyses of race and class as codeterminants of disparities in health. What they perceive as needed is a whole new second front and new approach to the elimination of health disparities by addressing class, in addition to race (Kawachi et al., p. 350). First, they reject an approach based in pseudoscience—one that views racial disparities in health as linked to innate biological inherited differences in susceptibility to disease—such as notions that Blacks were inferior and only suited to be slaves, justifying slavery; in rejecting this approach they advise others to consider how much skepticism is warranted with regarding to “pinning our hopes on the biological account of disparities in health” (p. 343). Secondly, they view the practice of viewing race as a proxy for class as unwarranted; it is race that influences class, and not vice versa. They support a third approach, a model that accounts for the “independent and interactive effects of both class and race” in producing disparities in health (p. 346). And, racial disparities in health should not be analyzed without simultaneously considering the contribution of class disparities. Meanwhile, the information infrastructure necessary to measure and monitor both race and class is currently lacking in the United States. Hence, they recommend health equity impact statements, following the British model, which could influence policy initiatives. This same call for a focus on race as a social construct and social class is also put forth in this volume (see David & Collins, chapter 10).

There is also a need to link efforts to address the “injuries of race and class simultaneously” (Kawachi et al., 2005, p. 351). We may also have to face certain consequences. For, political “struggle is unavoidable, and the contest involves questions of equity and reallocation, if not redistribution, of vital resources. So there are formidable obstacles to making class inequalities in health a focus of policy reform” (pp. 349–350). Nonetheless, Kawachi et al. (p. 350) hold fast to their assertion that “major progress against either form of health inequalities (by race or class) requires linking efforts to address them, not separating such efforts.” They even explain the possible motivations in keeping the focus on race, while eliminating class. For example, a function of racism in the United States is to “divide people with common class interests so that they are less able to struggle

politically in their common interest” (p. 347). There is also an attempt “to make race a highly visible feature of public policy while hiding or disguising anything that resembles class” (p. 347). Indeed, there is “a long-standing ideological effort to suppress any consciousness of class” (Kawaichi et al., p. 347).

A corresponding pattern of elevating whiteness and negatively stereotyping blackness in the United States has weakened support for “more redistributive policies,” historically undermining class solidarity (Kawaichi et al., p. 348). In sum, poor Whites and Blacks end up divided so they “fail to see their common interests” (p. 349), such as the benefits of a policy of wealth redistribution in the United States. A focus on racial inequalities allows them to be discussed as a “violation of basic human rights” as well as being seen within a “moral and legal framework of equal opportunity that many associate with U.S. culture;” this makes it “easy to point to racial disparities as unjust because the only explanation for them is unjust social policy” (p. 349). Different challenges emerge when it comes to class. For, “class inequalities either are not seen or understood, or are obscured by rationales that provide some apparent justification for them” (p. 349).

Braveman (2006) acknowledges disputes about the extent to which a given condition could be influenced by policies. “For example, some people might argue that it is impossible to enact policies in the United States that redistribute resources in favor of less advantaged groups, given this country’s deep-rooted ethos regarding individual responsibility and entrepreneurship” (p. 182). There is also recognition of a “relative lack of tradition of social solidarity in the United States” (p. 182).

Regardless, more and more contemporary data analyses lead to the conclusion that a response to health disparities needs to include policies that redistribute income, such as via equal access to educational or employment opportunities (see Lahiri & Pulungan, chapter 6). Such data analyses include explicit suggestions that even more studies need to link health outcomes to explicit social, economic and political processes; moreover, there is hope that social class unity—across racial lines—could develop over time, making possible deep political change (see David & Collins, chapter 10).

In this regard, there are even guiding ethical principles for policies of wealth redistribution or equalization of access to opportunity. For example, the following: a concept of “distributive justice,” meaning “the equitable allocation of resources in a society;” a guiding value wherein “the most disadvantaged in a society” have their needs attended to; and, the “egalitarian distribution of resources for the essentials of life (such as health) could be justified” (Braveman, 2006, p. 183).

In this manner, there is a drive to redistribute wealth and access to opportunity that is also at the core of the field of equity in health.

Conclusion

The thirteen guiding principles embodied as driving forces within the field of equity in health, as discussed in this introductory chapter, provide hope for a future global transformation in health, given how we are now in a new era. Since health disparities have been declared the civil rights issue of the twenty-first century, the global movement being driven by these thirteen contemporary forces constitutes a necessary response. The global transformation in health being sought requires the training and preparation

of global leaders within this movement. This volume seeks to be a milestone, in both launching the field of equity in health and seeking to prepare such global leaders. In effect, this introductory chapter has underscored the validity of seeking to change the discourse in the United States within a major paradigm shift so we now speak of and focus upon the manifestation of equity in health as a new global approach to health disparities.

This introductory chapter has also begun to identify and weed out those destructive forces that must be removed in order to make way for new growth within a new field of equity in health. What should grow and come forth includes everything from new theories, new perspectives, new modes of research, new procedures, new policies, to entire new models of medical care and public health. It even requires new personal identities among those working on issues of health.

The remainder of this volume serves as a clearing in which the new field of equity in health may be further established. Each chapter suggests the parameters of the new field, including the kinds of new theories, perspectives, research, procedures, policies, and models evolving within the field of equity in health. The paradigm in which this field is rooted demands that a non-hierarchical equality guide us in all that we do, providing the hope that we are entering a new era, indeed.

REFERENCES

- Airhihenbuwa, C. O. (2006). 2007 SOPHE presidential address: On being comfortable with being uncomfortable: Centering an Africanist vision in our gateway to global health. *Health Education and Behavior, 34*, 31–42. Retrieved December 15, 2006, from <http://heb.sagepub.com/cgi/content/abstract/34/1/31>
- Airhihenbuwa, C. O. (2007). *Healing our differences: The global crisis of health and politics of identity*. Lanham, MD: Rowman & Littlefield.
- Allen, C. E., & Easley, C. W. (2006). Racial and ethnic minorities. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Ayebofo, N. K. (2005). *Tigare speaks: Lessons for living in harmony*. Philadelphia: StarSpirit Press.
- Bambas, A., & Casas, J. A. (2003). Accessing equity in health: Conceptual criteria. In R. Hofrichter (Ed.), *Health and social justice: Politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey-Bass.
- Benzeval, M., Judge, K., & Whitehead, M. (1995). *Tackling inequalities in health*. London: King's Fund.
- Betancourt, J. R., Green, A. R., Carrillo, J. R., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspective and trends. *Health Affairs, 24*(2), 499–505.
- Blendon, R. J. (2007). Why Americans don't trust the government and don't trust healthcare. In D. A. Shore (Ed.), *The trust crisis in healthcare: Causes, consequences, and cures*. New York: Oxford University Press.
- Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health, 27*, 167–194.
- Brownson, R. C., Baker, E. A., Leet, T. L., & Gillespie, K. N. (Eds.). (2003). *Evidence-based public health*. New York: Oxford University Press.
- Carr-Chellman, A. A. (2006). *Global perspectives on e-learning: Rhetoric and reality*. Thousand Oaks, CA: Sage Publications.
- Carter, R. T. (Ed.). (2005). *Handbook of racial-cultural psychology and counseling: Training and practice*, Vol. 2. New York: John Wiley & Sons.
- Chen, L. C., & Berlinger, G. (2001). Health equity in a globalizing world. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 34–47). New York: Oxford University Press.
- Comas-Díaz, L., Lykes, M. B., & Alarcon, R. D. (1998). Ethnic conflict and the psychology of liberation in Guatemala, Peru, and Puerto Rico. *American Psychologist, 53*(7), 778–792.

- Constantine, M. G., & Sue, D. W. (Eds.). (2005). *Strategies for building multicultural competence in mental health and educational settings*. New York: John Wiley & Sons.
- Constantine, M. G., & Sue, D. W. (Eds.). (2006). *Addressing racism: Facilitating cultural competence in mental health and educational settings*. New York: John Wiley & Sons.
- Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action*. New York: Oxford University Press.
- Drucker, E. M. (2006). Incarcerated people. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Du Bois, W. E. B. (1899/1996). *The Philadelphia Negro, a social study*. Philadelphia: University of Pennsylvania Press.
- Edelman, M. W. (2006). Foreword. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Elder, J. P. (2001). *Behavior change and public health in the developing world*. Thousand Oaks, CA: Sage Publications.
- Fielding, J. (2003). Preface. In R. C. Brownson, W. A. Baker, T. L. Leet, & K. N. Gillespie (Eds.). *Evidence-based public health*. New York: Oxford University Press.
- Groce, N. E. (2006). People with disabilities. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Hester, R. K., & Miller, W. R. (Eds.). (2003). *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed.). Boston: Allyn and Bacon.
- Hofrichter, R. (Ed.). (2006). *Health and social justice: Politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey-Bass.
- House, J. S., & Williams, D. R. (2003). Understanding and reducing socioeconomic and racial/ethnic disparities in health. In R. Hofrichter (Ed.), *Health and social justice: Politics, ideology, and inequity in the distribution of disease*. San Francisco: Jossey-Bass.
- Hu, W. (2007, April 9). To close gaps, schools focus on black boys. *The New York Times*, pp. A1, B5.
- Institute of Medicine (IOM). (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.
- Kawachi, I., Daniels, N., & Robinson, D. E. (2005). Health disparities by race and class: Why both matter. *Health Affairs*, 24(2), 343–352.
- Kawachi, I., & Wamala, S. (Eds.). (2007a). *Globalization and health*. New York: Oxford University Press.
- Kawachi, I., & Wamala, S. (2007b). Globalization and health: Challenges and prospects. In I. Kawachi & S. Wamala (Eds.), *Globalization and health*. New York: Oxford University Press.
- Kubzansky, L. D., Krieger, N., Kawachi, I., Rockhill, B., Steel, G. K., & Berkman, L. F. (2001). United States: Social inequality and the burden of poor health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action*. New York: Oxford University Press.
- Kunitz, S. J. (2007). *The health of populations: General theories and particular realities*. New York: Oxford University Press.
- LaVeist, T. A. (2005). *Minority populations and health: An introduction to health disparities in the United States*. San Francisco: Jossey-Bass.
- Levine, R. S., Foster, J. E., Fullilove, R. E., Fullilove, M. T., Briggs, N. C., Hull, P. C., et al. (2001). Black-white inequalities in mortality and life expectancy, 1933–1999: Implications for Healthy People 2010. *Public Health Reports*, 116, 474–483.
- Levy, B. S., & Sidel, V. W. (Eds.). (2006a). *Social injustice and public health*. New York: Oxford University Press.
- Levy, B. S., & Sidel, V. W. (2006b). The nature of social injustice and its impact on public health. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Lombardi, E., & Bettcher, T. (2006). Lesbian, gay, bisexual, and transgender/transsexual individuals. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Mauer, M., & Chesney-Lind, M. (Eds.). (2002). *Invisible punishment: The collateral consequences of mass imprisonment*. New York: The New Press.
- Merson, M. H., Black, R. E., & Mills, A. J. (Eds.). (2006). *International public health: Disease, programs, systems, and policies* (2nd ed.). Boston: Jones and Bartlett Publishers.
- Miller, W. R., & Rollnick, S. (Eds.). (1991). *Motivational interviewing: Preparing people to change addictive behaviors* (1st ed.). New York: Guilford.

- Miller, W. R., & Rollnick, S. (Eds.). (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.
- Mutaner, C., & Geiger-Brown, J. (2006). Mental health. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health*. New York: Oxford University Press.
- Nairn, R., Pega, F., McCreanor, T., Rankine, J., & Barnes, A. (2006). Media, racism, and public health psychology. *Journal of Health Psychology, 11*(2), 183–196.
- Núñez, A., & Robertson, C. (2006). Cultural competency. In D. Satcher & R. J. Parnes (Eds.), *Multicultural medicine and health disparities*. New York: McGraw-Hill.
- Pedersen, P. (2006). Five antiracism strategies. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings*. New York: John Wiley & Sons.
- Pedersen, P. B., Draguns, J. G., Conner, W. S., & Trimble, J. E. (2002). *Counseling across cultures* (5th ed.). Thousand Oaks, CA: Sage Publications.
- Peter, F., & Evans, T. (2001). Ethical dimensions of health equity. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 24–33). New York: Oxford University Press.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of cigarette smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*, 390–395.
- Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Progress in Behavior Modification, 28*, 183–218.
- Randall, V. R. (2006). *Dying while Black: An in-depth look at the crisis in the American healthcare system*. Dayton, OH: Seven Principles Press, Inc.
- Restum, Z. G. (2005). Public health implications of substandard correctional care. *American Journal of Public Health, 95*(10), 1689–1691.
- Sammons, M. T. (2001). Combined treatments for mental disorders: Clinical dilemmas. In M. T. Sammons & N. B. Schmidt (Eds.), *Combined treatments for mental disorders: A guide to psychological and pharmacological interventions* (pp. 11–32). Washington, DC: American Psychological Association.
- Satcher, D. (2006). The role of government in minority health: A surgeon general's perspective. In D. Satcher & R. J. Parnes (Eds.), *Multicultural medicine and health disparities*. New York: McGraw-Hill.
- Satcher, D., & Parnes, R. J. (2006). Preface. In D. Satcher & R. J. Parnes, (Eds.), *Multicultural medicine and health disparities*. New York: McGraw-Hill.
- Shore, D. A. (Ed.). (2007a). *The trust crisis in healthcare: Causes, consequences, and cures*. New York: Oxford University Press.
- Shore, D. A. (2007b). The (sorry) state of trust in the American healthcare enterprise. In D. A. Shore (Ed.), *The trust crisis in healthcare: Causes, consequences, and cures*. New York: Oxford University Press.
- Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. New York: John Wiley & Sons.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse* (4th ed.). New York: John Wiley & Sons.
- Sue, D. W., & Torino, G. C. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling*, Vol. II (pp. 3–18). New York: John Wiley & Sons.
- Taylor, C. (1994). The politics of recognition. In A. Gutman (Ed.), *Multiculturalism: Examining the politics of recognition*. Princeton, NJ: Princeton University Press.
- van Ryn, M., & Burke, J. (2002). The effect of patient race and socioeconomic status on physicians' perceptions of patients. In T. A. LaVeist (Ed.), *Race, ethnicity, and health: A public health reader*. San Francisco: Jossey-Bass.
- Vera, E. M., Buhin, L., & Shin, R. Q. (2006). The pursuit of social justice and the elimination of racism. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings*. New York: John Wiley & Sons.
- Wallace, B. C. (1996). *Adult children of dysfunctional families: Prevention, intervention, and treatment for community mental health promotion*. Westport, CT: Praeger.
- Wallace, B. C. (2000). A call for change in multicultural training at graduate schools of education: Educating to end oppression and for social justice. *Teachers College Record, 102*(6), 1086–1111.
- Wallace, B. C. (2003). A multicultural approach to violence: Toward a psychology of oppression, liberation, and identity development. In B. C. Wallace & R. T. Carter (Eds.), *Understanding and dealing with violence: A multicultural approach* (pp. 3–39). Thousand Oaks, CA: Sage Publications.

- Wallace, B. C. (2005a). A practical coping skills approach for racial-cultural training. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling*, Vol. II. (pp. 97–119). New York: John Wiley & Sons.
- Wallace, B. C. (2005b). *Making mandated addiction treatment work*. Lanham, MD: Jason Aronson/Rowman & Littlefield.
- Wallace, B. C., Carter, R. T., Nanín, J. E., Keller, R., & Alleyne, V. (2003). Identity development for “diverse and different others”: Integrating stages of change, motivational interviewing, and identity theories for race, people of color, sexual orientation, and disability. In B. C. Wallace & R. T. Carter (Eds.), *Understanding and dealing with violence: A multicultural approach* (pp. 41–91). Thousand Oaks, CA: Sage Publications.
- Washington, H. A. (2007). *Medical apartheid: The dark history of medical experimentation on black Americans from colonial times*. New York: Random House.
- Williams, D., & Jackson, P. B. (2005). Social sources of disparities in health. *Health Affairs*, 24(2), 325–334.
- Zarcadoolas, C., Pleasant, A. F., & Greer, D. S. (2006). *Advancing health literacy: A framework for understanding and action*. San Francisco: Jossey-Bass.