

# THE POWER OF A BELIEF

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Program officers at the W.K. Kellogg Foundation (WKKF) come together each month to share insights from their grantmaking experiences. One memorable story came from an education program officer working primarily in the state of Mississippi. She shared a story about trying to get local civic and business leaders to match philanthropic investments in a proven charter school model. The business leaders refused and indicated unanimously that it would be a “waste of money” because those children could not learn. The community turned to other sources to raise the needed dollars, and two years later when these same civic and business leaders saw the test scores and improved educational outcomes, they were “flabbergasted” and voiced shock. They simply had to admit that their “beliefs” about the innate abilities of these children were wrong.

When a new superintendent of a chronically failing public school district boldly altered the curriculum to emphasize literacy, and, as a result, significantly improved student performance and teacher morale, stress was reduced and the life trajectory from diseases caused by stress was altered for these students. Their risks for failure and even incarceration were reduced.

The message from these stories is twofold: children can achieve academically when given a chance and the right tools, and in the process they can reduce their vulnerability to illness and disease.

There is a growing body of evidence that explains how our experiences become our biology. Nancy Krieger of the Harvard School of Public Health was one of the early researchers who advanced the theory of how diverse aspects of people’s social location within their societies are “embodied” and related to disease susceptibility. Bruce McEwen added more to this idea by developing the concept of allostatic load, which elucidates the biochemical and hormonal pathways through which experiences have a cumulative effect. As recently as December 2011, the American Academy of Pediatrics issued the policy statement *Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health*. Andrew Garner was the lead author of this report.

When the brain perceives an experience as stressful,

physiologic and biochemical responses are initiated such as blood pressure elevation and hormonal secretions. Over time, with repeated exposure, biochemical stress mediators can have adverse effects on the function of body organ systems. This can lead to chronic diseases such as hypertension and atherosclerosis in adults. Early stress exposures in infancy and childhood can negatively affect brain development.

Public health workers, parents, educators, economic and community developers, land use planners, elected officials, law enforcement officers, and care givers make decisions and take actions every day that may cause increased or decreased allostatic load consequences for our nation’s most vulnerable populations. Grantmakers’ decisions may have similar consequences.

Archived at WKKF is the original resolution document with 55 signatures from the April 2000 foundation-funded Salzburg Seminar (#437) *The Social and Economic Determinants of the Public’s Health*. This groundbreaking gathering of health and policy leaders from around the world served as a backdrop for subsequent WKKF social determinants of health funding strategies. Efforts to accelerate the application of knowledge about the social determinants of health became the hallmark of WKKF health funding through the decade of 2000-2010, and continues today. At the Salzburg Seminar, there was considerable tension between calls for what was then termed “scientific problem solving” as opposed to “calls for complex, caring creative relationships.” As is often the case when paradigms are shifting and deeply held beliefs are challenged, false dichotomies were created and used to distract or impede progress. One such dichotomy that persists in the minds of many health funders yet today is the belief that access to quality, affordable health care is somehow juxtaposed to social determinants of health. This dichotomy is clearly wrong-headed. Timely access to quality, affordable care is one of many social (or contextually based) determinants of health and well-being. The Affordable Care Act, with its primary prevention, health promotion, and “health in all policies” sections can serve as an unprecedented resource for propelling the nation toward more equitable health outcomes and greater health equity. Its inherent opportunities must be leveraged,

however. That will require “the will and the skill” of an energized public. The Salzburg convening heralded a shift in thinking for the attendees who collectively asserted that “community involvement must be underpinned by a value system of social justice, fairness, and equality” (WKKF 2000). They called for efforts to transcend the limits of the biomedical model for defining and resolving public health threats.

Fast forward to 2012. A global movement for health equity exists. The principles of this movement are embodied in the final report of the World Health Organization’s (WHO) Commission on the Social Determinants of Health entitled, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinates of Health*. The commission was created in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The commission’s final report boldly asserts:

Social justice is a matter of life and death...Inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness...The conditions in which people live and die are in turn, shaped by political, social, and economic forces.

I would add that, as the Mississippi school story reveals, the conditions are also shaped by the force of beliefs.

Several countries and agencies have become partners with WHO and the commission by working to frame policies and programs across the whole of society that influence the social determinants of health and improve health equity. The United States is not one of the partnering nations. However, when the framework for our nation’s public health goals, Healthy People 2020, was announced in 2011, it included a focus on understanding and addressing the social determinants of health. This marked a sea of change in U.S. government health policy and can be attributed (in part) to persistent, yet innovative work by many philanthropies such as the MacArthur Foundation, the Robert Wood Johnson Foundation, and WKKF, and to bold leadership by many city and county health officials in the National Association of City and County Health Officials (NACCHO).

It was not easy to slice through the broad list of social indicators in the social determinants of health paradigm and select the “one” for inclusion as a Healthy People 2020 goal. Some in the field were disappointed that only one indicator was selected. This one had to be measurable and have data systems in place in states and counties across the country that could be compared over time. The data would have to be aggregated and disaggregated. Issues of correlation versus

cause would need to be clarified and supported. The committee honed in on education as *the* social determinants of health indicator for 2020. Specifically they chose on-time graduation or high school completion within four years. In so doing, they have challenged health grantmakers to show the way and cross our own boundaries in related understanding and action. Of course our primary action as funders is “grantmaking.” What is our role, if any, in helping realize this pivotal social determinants of health Healthy People 2020 goal? In the comments that follow, I will share some insights gleaned during WKKF’s decades-long journey into the complex world of social determinants of health and health equity.

WKKF is not an exclusively “health or health care” foundation. Our other focus areas are education and family economic security, both “social determinants of health.” Two overarching approaches guide all of the program areas at the foundation: community/civic engagement and racial equity. We recognize that geographic boundaries are determinants of social, economic, and policy forces that converge within local communities where people live, work, and develop. We have supported “place-based” initiatives over the years and recently identified several priority places – “geographic areas for long-term focused funding and investments to improve lives of vulnerable children.” These are New Mexico, Mississippi, Michigan, and New Orleans in the United States. The foundation continues to carry an international portfolio, as well.

Perhaps I should pause here to assert a core principle that since 2007 has undergirded the funding approach of WKKF. This principle is that our funder’s mandate and our subsequent mission of helping communities create the conditions that “propel vulnerable children to success,” cannot be fully realized without an explicit focus on achieving racial equity through racial healing and addressing structural racism. It follows that our work on health inequities (often framed as health disparities) necessitates addressing the effects of our nation’s deeply held unconscious biases. Our country’s collective unconscious and implicit biases were wrought through more than three centuries of building and sustaining stratified social, economic, legal, medical, governance, and religious institutions to protect the mythological belief in racial hierarchy.

While great strides were made to abolish slavery, to legislate freedom, and to end discrimination through the civil war and the era of reconstruction, as well as in the civil rights movement of the 1960s, neither the former nor the latter dealt with the fundamental *belief* in racial differences and racial hierarchy. These beliefs shaped and defined the social order and dictated behaviors and resource distribution

for a time period that exceeds the life of this nation as a “nation.” Indeed, the denial of the humanity of millions of enslaved and free Africans and native people in the Americas and much of the world (coupled with annihilation, exploitation, and exclusion of brown, yellow, red, or black races) was an institutionalized government and church-sanctioned way of believing and behaving for more than four centuries. As of 2012, the United States is only 236 years old.

In short, the preformative, formative, developmental, and most recent history of this young nation was shaped by the belief in superiority based on physical characteristics and inferiority (actually less than human status) based on skin color, hair texture, and the contour of facial features. To view persistent inequality in wealth, education, health, and social indicators without dealing with this fact is to practice and reinforce our national malaise of “denial” about our racialized history and its consequences.

In my years of clinical practice as a licensed holistic health provider, naprapath (a healer specializing in connective tissue, pain relief, and wellness), naturopath, and nutritionist, I learned that getting people to embrace new ideas and subsequently to change their actions or behaviors often requires overcoming denial. I observed that denial, as a psychological tool, has four stages. The most obvious is denial of the facts of a situation (some patients deny smoking for example). Once the facts are accepted, the next level of resistance is denial of consequences. When consequences are finally acknowledged, then the mind or psyche may refuse to see the myriad implications of a difficult or painful truth that threatens it. But the ultimate level of denial that must be overcome is the most difficult. We must face the “feelings” that are uncovered when denial is no longer blinding us. I learned that people will release denial when (and only when) at some level *they* believe *they have the resources* for coping with the threat or *loss*. When it comes to facing and addressing this nation’s racialized culture and structured realities of racialized exclusion and hierarchy, the facts have yet to be widely asserted or understood, the consequences are euphemistically disguised as disparities or intractable social dislocations at best, and the implications are far too complicated for most beneficiaries or subjects of the hierarchy to acknowledge. Finally, emotions – the raw feelings that range from fear, shame, guilt, anger, rage, and hate to love – constitute the seemingly insurmountable mountain that has to be scaled before we can hope to achieve racial healing.

America must come to grips with the meaning and effects of its racialized societal structure. Some ask how it is possible to address these issues and the legacy in their communities. At WKKF we were surprised and inspired when we were

overrun with responses to our modest request for proposals from communities that were willing to apply innovative approaches to healing the legacy of racism and its consequences in their communities. Our scan of the nascent field in 2008 showed that most racial healing work was either voluntary or minimally funded. While we have committed \$75 million to the first phase of the work, our resources only scratch the surface of need and, we believe, good will that is latent within communities across America.

In response to a clear mandate by the WKKF board of directors, we designed and are implementing a comprehensive strategy to “jump start” a long overdue healing process in this country. The goal is to uproot the remnants of the most pervasive set of beliefs that gave rise to existing systems of privilege and stratification of opportunity. Racial bias, particularly unconscious or implicit bias, is a social determinant of health. And since residential segregation, school funding, access to quality medical care, job opportunity, and even air quality are driven by these patterns of belief, racial bias is perhaps the most fundamental social determinants of health in the United States.

Did those civic and business leaders in Mississippi really change their core beliefs about the innate capacity of innocent black and Latino preschoolers to learn? A realistic response is that their assumptions were challenged. And some of them actually changed their decision about funding the charter school. But real healing would require engaging these same “leaders” in experiential processes designed to help them peel back years of layers of denial. They would need to participate, voluntarily, in experiences that brought them into a set of facts, historical and contemporary. We have found that “story is a powerful tool” in this work. They would need to be guided through experiences that generate a deeper understanding of consequences and implications. Finally, with the help of skilled facilitators, they might connect with and diffuse the emotional barriers to expand their conscious circle of human concern and empathy. This is the work of racial healing for individuals.

These leaders are often quite powerful and have lived their lives at the top of the extant racial hierarchy. In his 2010 book, *Fire in the Heart: How White Activists Embrace Social Justice*, author Mark R. Warren documents the stories of white activists who became aware of the dynamics of racial inequality and injustice and were no longer willing to participate in the passive acceptance of this as part of the American social fabric. Warren quotes one of the more than 50 white activists he interviewed:

Oh hell, I’ve been working at this stuff for a long, long time. I’m clear that I benefit from notions of white

superiority that have been inculcated in this culture from the founding of the nation, and I don't feel good about that. But I don't think hand wringing and feeling guilt personally about that is very helpful. What I have to do is to be real clear about that and then say, "What can I do in a day-to-day way that allows people to cross racial barriers in ways that are meaningful at a personal level and that are meaningful at a communal and political level?"

What can we as health grantmakers do in a day-to-day way that allows people to cross racial barriers in ways that are meaningful in achieving health equity?

The journey at WKKF continues after having begun more than 20 years ago. We can offer some lessons:

- An engaged and committed board of directors emerged after it was diversified and involved in shared experiences of racial healing. External facilitators helped in this process.
- Decisions and actions to diversify staff required coaching to help individuals understand and cope with subsequent conscious and unconscious biases that began to play out more openly in the work place.
- Objective data tracking systems are both required and useful in sustaining the work. Implementing them requires redesigning data systems for soliciting and processing applications, contracts, reports.
- Once the "ism" of racism is lifted, calls for addressing all "isms" are made. We were clear that, while we understood and respected the injustice of sexism, homophobia, and classism, our mission to help vulnerable children compelled us, at this time, to prioritize the longstanding issue of racism. The rapidly changing demographics of the country revealed that most children born today and in the foreseeable future are children of color. Most of these children are being born into low-income or impoverished communities. Failure to address the racial divide portends only widening gaps of inequality in America and limited opportunity for the majority of our children, as well as increased exposure to chronic stress, high allostatic loads, and disease susceptibility.

Health grantmakers can help communities achieve the Healthy People 2020 social determinants of health goal related to education success in many creative ways. Funding local collaborations working to address issues such as school funding inequities, residential segregation, housing discrimination, environmental justice, or food justice is one possibility. Foundations may also support local coalitions

working on living wage campaigns or employment opportunities. Funders may partner with private and public sector leaders to help reframe the debate about health and health care to include a focus on social determinants. NACCHO has developed a related web-based curriculum and toolkit (with support from the National Institutes of Health), available at [www.naccho.org](http://www.naccho.org).

It is our contention at WKKF that while all such efforts are warranted and may be effective in the short run, they will not have long-term impact until the underlying issues of racial bias and the racialized opportunity structures of this nation are exposed and healed. These residual beliefs along with the confusion, anxiety, and paralysis that they produce are barriers to true community coalescing for the greater good of humanity and this nation.

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