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Effective Elimination of Structural Racism

Edited by Erick Guerrero



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Meet the editor



Dr. Erick Guerrero completed his doctoral degree at the University of Chicago in 2009 and received tenure as Associate Professor at the University of Southern California in 2016. Dr. Guerrero has a background in clinical psychology and organizational behavior. As a clinician, he has provided counseling for the past 23 years. As an organizational researcher, Dr. Guerrero has published more than seventy-five peer-reviewed manuscripts and three books on racial/ethnic and gender disparities and the implementation of evidence-based practices in healthcare in the United States and Mexico. Funded by the U.S. National Institutes of Health, he is currently co-leading four research studies to respond to the COVID-19 and opioid overdose public health crises. Dr. Guerrero is a fellow at Yale University's Innovation to Impact program, and director of the I-LEAD Institute, a research and consulting firm operating in the United States and Mexico.

Contents

Preface	XIII
Section 1 Healthcare	1
Chapter 1 Perspective Chapter: Centering Race, Stigma and Discrimination - Structural Racism and Disparities in HIV among Black Sexual Minority Men <i>by Paul A. Burns</i>	3
Chapter 2 Addressing Systemic Factors Related to Racial and Ethnic Disparities among Older Adults in Long-Term Care Facilities <i>by Rebecca L. Mauldin, Shellye L. Sledge, Ebonie K. Kinney, Sarah Herrera and Kathy Lee</i>	25
Chapter 3 Cultural Competence as a Response to Structural Racism in Latino Substance Use and Access to Care in the United States <i>by Erick Guerrero, Tenie Khachikian, Richard C. Cervantes, Charles Kaplan, Rene D. Olate and Jennifer B. Unger</i>	47
Section 2 Culture and Politics	67
Chapter 4 Gender Differences in Coping with Racism: African American Experience and Empowerment <i>by Grace Jacob, Monnica T. Williams, Naomi S. Faber and Sonya Faber</i>	69
Chapter 5 Perspective Chapter: Cultivating Environments of Belonging in Psychiatry, Clinical Psychology and the Allied Mental Health Fields <i>by Felicia Lazaridou and Andreas Heinz</i>	87
Chapter 6 Discrimination against Women in Mexico's Three Main Population Groups Integrating Mexican Society <i>by Alicia Puyana Mutis and Cinthia Márquez Moranchel</i>	113

Chapter 7	131
Perspective Chapter: Black Lives Matter and the Anti-Woke Campaign in the UK <i>by Andrew Pilkington</i>	
Section 3	151
Education	
Chapter 8	153
Perspective Chapter: Behind the Exceptional Educational Pathways of Canadian Youth from Immigrant Background - Between Equality and Ethnic Hierarchy <i>by Pierre Canisius Kamanzi and Tya Collins</i>	
Chapter 9	165
Ethnic Minority Students in the UK: Addressing Inequalities in Access, Support, and Wellbeing in Higher Education <i>by Julie Botticello and Titilayo Olufunmilyo West</i>	

Preface

Discrimination of vulnerable groups by communities, organizations and governments has been a common practice for centuries. Yet, identifying, understanding, and eliminating the discrimination embedded in policies, practices, and structures of public systems are gaining global attention. In this book, a group of international researchers define structural racism and propose ways in which its deleterious effect on vulnerable populations (women, racial, ethnic and gender minorities) can be abated. As structural racism is represented by policies, structures, and practices that disempower culturally diverse groups, authors highlight how the effect of structural racism is observed in different systems across the world, and how evidence-based strategies may dismantle those structures and promote equity and fairness.

This volume provides unique, comprehensive, and science-based approaches to eliminate structural racism in different public systems. Nine chapters describe the identification, understanding, and elimination of the macro, mezzo, and micro factors contributing to racism and discrimination. Chapters focus on the healthcare, political, and education systems that reproduce discrimination and disempower vulnerable groups in particular nations. For instance, in the healthcare system in the United States, authors provide a description of the theoretical underpinnings of the link between structural racism and HIV and propose a culturally appropriate, trauma-informed agenda to reduce HIV vulnerability for racial/ethnic and sexual/gender minorities. Two other chapters in healthcare examine how structural racism affects minority older adults in long-term care facilities, and how the role of cultural competence may abate structural racism in Latino substance use and access to care. Overall, authors offer a series of policies and responsive organizational practices that may dissolve the structural factors that promote racism in healthcare.

Culture researchers also highlight how Black people tend to cope with racism through social support, religion, avoidance, and problem-focused coping, with some gender differences in coping approaches. Politically, researchers present work on the notion of belonging as a “feeling of mattering” in contemporary politics. Authors propose “belonging” as a strategy to eliminate structural racism in mental health, whereas economists research how structural racism affects indigenous and afro-descendant women’s political and economic participation in Mexico fueling inequality. In the United Kingdom, authors examine the Black Lives Matter and anti-woke campaign and discuss the role of structural racism in enabling or detracting political participation.

The volume concludes with two chapters on education systems in two countries. Authors highlight the forces of structural racism that promote inequalities in access, support, and wellbeing of minority students in higher education in Canada. In the United Kingdom, researchers identify the social determinants and factors contributing to structural racism in the higher education system that limit opportunities for ethnic minority students.

Overall, nine chapters offer a comprehensive view of science-based approaches to identify, understand, and effectively eliminate structural racism within healthcare, political, and education systems originally designed to empower people regardless of their background. The group of committed authors/scientists offer the public as well as scholars and policy makers a series of evidence-based practices that may ensure equity across public systems.

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Section 1

Healthcare

Perspective Chapter: Centering Race, Stigma and Discrimination - Structural Racism and Disparities in HIV among Black Sexual Minority Men

Paul A. Burns

Abstract

Structural racism is a fundamental cause of health disparities in the United States among racial/ethnic and sexual/gender minorities. Although there are well-documented disparities in the access of HIV prevention, care, and treatment services, the impact of structural racism on HIV/AIDS remains not well understood. The purpose of this chapter is to provide a detailed description of (1) the theoretical underpinnings of the link between structural racism and HIV, (2) a review of the evidence of these associations, and (3) a culturally appropriate, trauma-informed agenda that addresses intersectional, multi-level structural racism and its myriad manifestations to reduce HIV vulnerability for racial/ethnic and sexual/gender minorities, particularly Black sexual minority men.

Keywords: structural racism, structural discrimination, Black MSM, men who have sex with men, MSM, Black sexual minority men, pre-exposure prophylaxis (PrEP), human immunodeficiency virus (HIV), sexual and gender minorities, racial and ethnic minorities, stigma and discrimination

1. Introduction

After 40 years of the discovery of the human immunodeficiency virus (HIV) that causes autoimmune deficiency disease syndrome (AIDS), HIV remains a critical public health concern, particularly among racial/ethnic and sexual/gender minority populations. During the intervening years, there have been enormous advances in biomedical prevention strategies (e.g., pre-exposure prophylaxis (PrEP) and treatment therapies antiretroviral therapy (ART) that have transformed HIV from a death sentence to a chronic condition. Yet, despite these lifesaving treatments and therapies, the benefits have not been equally shared. There are still alarming numbers of new infections disproportionately impacting racial/ethnic and sexual/gender minorities, particularly Black gay and bisexual men in the United States. Notably, Blacks represent less than 13% of the population, but Black MSM accounts for 42% of all new HIV infections [1]. There are marked racial/ethnic disparities in health in the US, with Blacks or African-Americans faring substantially

worse compared to their white counterparts, including diabetes prevalence, colorectal cancer incidence and death, and mortality due to coronary heart disease and stroke [2–4]. These disparities are particularly acute in HIV, particularly for Black men who have sex with men (Black MSM). It is estimated half of Black MSM in the U.S. can be expected to become HIV positive in their lifetime [5]. Current surveillance data show that most of the HIV cases are clustered in the Southern U.S., a region marked by racial and structural inequalities as a result of racialized chattel slavery and Jim Crow segregation, where a large majority of the Black population continues to live in neighborhoods, that are divided and unequal reflecting previously codified racial divisions in housing, employment, education, healthcare, public utilities, and infrastructure [6].

While studies have shown African Americans do not have higher rates of sexual risk behaviors than their white counterparts and biomedical advances are effective at prevention and transmission of HIV/AIDS, at issue is accounting for the enormous racial/ethnic disparities in HIV-related outcomes [7]. In this perspective chapter, we explore the evidence underpinning the relationship between structural racism and high rates of HIV among racial and sexual minority populations in the U.S., particularly Black men who have sex with men (MSM). We examine the social, economic, and political policies and practices that engender a social and structural, and built environment that may increase or reduce an individual's HIV vulnerability to exposure to HIV. An examination of structural racism and HIV is timely given the ongoing debates around race and Covid-19, the Black lives matter movement and the ending the HIV epidemic initiative [8–10]. This work builds on previous work on race and HIV by incorporating emerging research employing an intersectional lens to understand the role of multiple identities and interlocking oppressions in explaining differential outcomes around HIV [11–13]. First we will review the origins of HIV using a social-ecological lens to better understand the influence of structural factors on increasing barriers to HIV prevention, care, and treatment services among racial/ethnic and sexual/gender minorities. Next, we provide an overview of the types of structural racism followed by a description of the intersectional stigma framework that underpins our conceptualization of how structural racism operates to increase HIV vulnerability. Then we embark on a review of the literature providing evidence linking structural racism and HIV-related disparities. Finally, we end with conclusions, key policy recommendations, and future directions of research to address the unique needs and structural barriers that create the conditions ripe for HIV to flourish among racial and sexual minority populations. While this chapter focuses primarily on the experience of Black sexual minority men in the U.S., it is our hope this information will have broader relevance to other populations and settings to inform the development and implementation of structural level programs and interventions to reduce the number of new infections among racial/ethnic and sexual/gender minority populations, both in the U.S. and beyond.

2. Understanding the structural origins of the HIV epidemic

Significant success in the prevention of HIV infection in the United States has been achieved. However, those successes were hard-won with significant opposition from hostile government officials, religious groups, and the public at large. In the early days of the AIDS epidemic, there was widespread misinformation about AIDS with many believing it was a disease that affected only homosexuals and was a punishment from God for their turning away from the teachings of the Bible. Alongside these common misinterpretations, longstanding homophobia and anti-gay stigma and discrimination were the norm. It was within this socio-political

context of government inaction and societal scapegoating where HIV went undiagnosed and untreated and allowed to flourish within the Black community, particularly among Black MSMs.

Much of the initial response was largely limited to activities organized by LGBT community-based organizations and the gay community focusing primarily on behavioral change and lifestyle factors including harm reduction (e.g., drug and substance use, sexual risk behavior) or uptake of biomedical therapies (e.g., condoms). The first community-led activities were launched in San Francisco and New York City where the first cases of HIV occurred [14]. These early activities were designed to increase awareness and to educate the gay community about how the virus is transmitted and risk reduction strategies to prevent HIV.

As time progressed, the government stepped in launching HIV prevention programs to reduce the spread of the disease. These early government initiatives led by the CDC continued the focus on individual-level programming around behavioral change including: (1) the development of the National AIDS Information Line (1983), (2) National AIDS Clearinghouse (1987), (3) America Responds to AIDS, a national public information campaign (1987), and (4) the development and dissemination of Understanding AIDS (1988). Understanding AIDS was groundbreaking, being the first public education campaign utilizing the U.S. postal service to deliver health literacy information to every home in the United States [15]. However, early approaches in delivering basic HIV education and awareness, changing attitudes, and harm reduction among most-at-risk populations often did not address the unique needs and realities of racial/ethnic communities. These programs targeted priority populations deemed at elevated risk including high-school and college-aged persons, pregnant women, and healthcare workers [16]. While important advances were made in the gay community benefitting the white gay community, however, they did not substantially reduce HIV risk for African American and LatinX communities. In the late 1980s, we start to see the development of more targeted evidence-based interventions such as the five-city CDC AIDS Community Demonstration Projects (1989), CDC HIV Prevention Research Synthesis Project, and the CDC Diffusion of Effective Behavioral Interventions (DEBI) project [17, 18]. While these studies and interventions were more tailored for marginalized populations such as injection drug users, sex workers, and racial/ethnic minorities, they were primarily individual-level behavioral change initiatives with only a few structural interventions.

3. A conceptual framework for the association between structural racism and HIV

Researchers in the area of public health, sociology, geography, and urban planning have shown macro-level factors at the structural level can influence health on a number of health-related outcomes including mental health, cardiovascular disease, maternal health, diabetes, and HIV [19–26]. According to Link and Phelan in their theory of fundamental causes they argue that structural factors, that is, socioeconomic status (SES) contribute to inequalities in health [27]. Extrapolating from this premise and building on socio-ecological frameworks, we posit that the broader dynamic and interactive macro-level social, political, and economic processes structure access to societal resources and opportunity structures which are mediated through the built environment has profound consequences influencing sexual risk behavior and access to HIV prevention, care and treatment services. Our model draws inspiration from the following structural frameworks: Structural violence, social determinants of health, neighborhood effects, weathering and intersectionality [13, 28–30]. Each of these theories and frameworks center upstream, macro-level

factors as foundational to health disparities and provides a useful conceptual lens to understand the spatial legacies of chattel slavery and contemporary effects of racial capitalism and structural racism. Farmer's theory of structural violence emerged from Paul Farmer's groundbreaking work in HIV in Haiti and argues that structural consequences, for example, slavery, colonialism, Jim Crow, and other forms of oppression have profound material consequences for individuals and populations, particularly racial and ethnic minorities. Next, social determinants of health argues that unequal access to basic needs and resources (i.e., employment, education, housing, and healthcare) disadvantages certain individuals and groups affecting their health outcomes [28]. Diex Roux's neighborhood effects framework highlights the importance of spatial and geographical variations in health arguing the larger structural environment shapes neighborhood/community conditions and features that may influence health outcomes [29]. Finally, we include Geronimus' Theory of weathering which helps us to better understand how effects of structural racism (e.g., residential segregation, poor-quality schools, environmental racism) 'gets under the skin' creating stress in the form of allostatic load which has been shown to affect health outcomes [30]. These active and ongoing adjustments necessary to manage these multiple interacting structural forces and stressors can create wear and tear on the body leading to poor health outcomes, particularly increasing HIV vulnerability for historically marginalized and stigmatized groups such as Black MSM. Moreover, we employ an intersectional approach to emphasize the intersections of multiple and intersecting identities (e.g., race, gender, and sexual orientation) and interlocking systems of oppression (e.g., racism, homophobia, and classism) that may influence an individual's behavior and access to resources and opportunities that impact their health and well-being [11–13]. By utilizing an intersectional perspective, it allows us to center the multiple stigmatized identifies and contend with the insidious and harmful direct effects of intentional and unintentional state-sanctioned race-based, structural factors and processes that distribute resources and opportunities that increase HIV vulnerability for Black sexual minority men. Our conceptual model presented in **Figure 1** is informed by the aforementioned socio-ecological frameworks and divided into three levels: (1) structural level, (2) neighborhood level, and (3) individual level, representing the multilevel and multivalent nature of structural racism. The structural level is defined as macro-level forces (e.g., social, political, economic, and legal policies) developed by governments and powerful institutions that govern the organization and structure of society. The structural racism interpretation of HIV proposes that macro-level structural level forces are paramount in understanding HIV-related health disparities and as such foundational to explaining differential HIV-related outcomes. Neighborhood level refers to the community environment including both social and built environment aspects of neighborhoods. The construct of the neighborhood is derived from the neighborhood effects framework which explicitly acknowledges that relative deprivation in the form of neighborhood structural disadvantage (e.g., access to employment, housing, public transportation, etc.) may influence health-seeking behavior and limit access to HIV prevention, care, and treatment services. Finally, the individual level includes both sociodemographic characteristics (e.g., race, gender, age, and education) and risk factors (e.g., condom use, number of sexual partners) that are derived out of an unequal distribution of resources and exposure that create barriers to healthy behaviors and access to healthcare. Illustrated in **Figure 1** are pathways that are represented by arrows in the diagram modeling key risk factors theorized as having a significant impact on HIV vulnerability and explaining differential HIV-related outcomes, particularly among Black MSM. The arrows indicate the dynamic and interactive nature of structural racism which has both direct and moderating effects that either reduce or increase an individual's exposure to HIV.

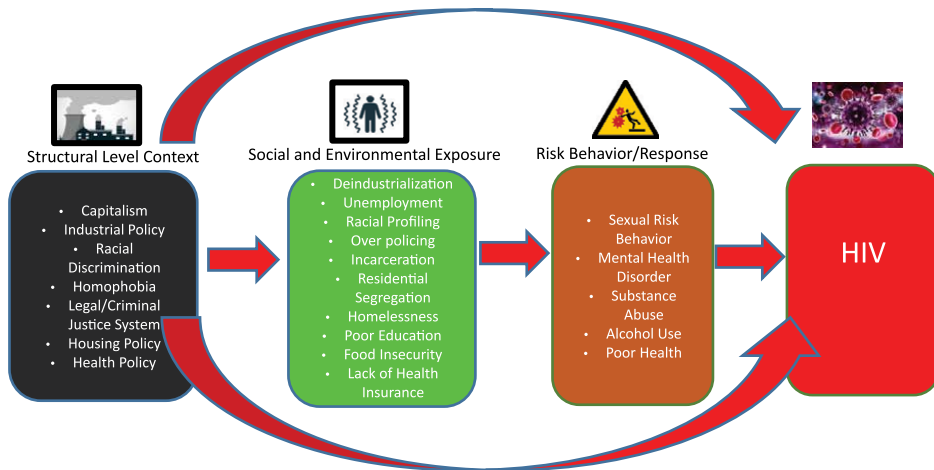


Figure 1.
 Structural racism and HIV vulnerability conceptual framework.

4. Evidence linking structural racism and HIV

While there is growing recognition of structural racism and its impact on health, yet there is limited research examining the relationship between structural level factors impact on health HIV-related outcomes. A full accounting of structural racism and HIV disparities among sexual and racial minorities is beyond the scope of this chapter; rather instead we will provide an overview of the research focusing on the role of structural racism in fostering conditions that increase HIV vulnerability for Black MSM. We also acknowledge there is significant diversity within the Black MSM rubric (e.g., gay, bisexual, transgender, gender non-conforming; and same-gender-loving) with each subgroup experiencing varying levels of structural racism at the intersection of race, class, sexual, and gender identity, gender expression and HIV. Several researchers have critiqued the use of the term MSM because of who it includes and excludes, however again due to the limited scope of this chapter, we use the more traditional definition of Black MSM—an individual who identifies as Black or African American, assigned male at birth (MAB) and gay, bisexual and other men who have sex with other men [31–33]. In this section, we divide structural racism into five key domains: (1) Neighborhood Effects, (2) Social Determinants of Health, (3) Access to HIV Prevention Care and Treatment Services, (4) Incarceration, Criminal Justice System and HIV, and (5) Stigma, Cultural Competency, and Medical Mistrust. We will attempt to address each in turn.

5. Neighborhood effects and HIV

Research has shown characteristics of the neighborhood can shape HIV risk environments with differential impacts, particularly among sexual and racial/ethnic minority populations [34–40]. Segregated residential patterns concentrate high rates of HIV and community viral load in a small geographical region increasing a person’s likelihood of having a sex partner who is HIV-positive and not virally suppressed [41–43]. A study of Black MSM in Chicago found that an additional infected person into your sexual network increases the odds of seroconversion by a factor of thirteen [43]. The Chicago Metropolitan Statistical Area is ranked 5th in the nation with a dissimilarity score of 83.6. The index of dissimilarity is a

measure of residential segregation that measures how one racial group is distributed across census tracts in the metropolitan area compared to the other group. Scores ranging from 0 to 100 with a value of 60 or above is considered very high. In Chicago, a score of 76.9 indicates a high level of segregation which aligns with low viral suppression rates, thereby increasing HIV vulnerability for Black MSM [44]. Residential segregation has also been shown to affect the choice of sexual partner's by limiting their social network contributing to increased levels of HIV transmission and susceptibility among the Black MSM population. A study of the effect of partner characteristics on HIV infection in Los Angeles found Black MSM are more likely to have Black sexual partners than other groups, thus increasing their potential of encountering an HIV-positive sexual partner [45]. In this study, Black MSM were 4.4 times more likely to be HIV positive than their white counterparts. Moreover, data suggest an association with neighborhood conditions and HIV-related outcomes. Another study of Black MSM residing in New York City found a measure of neighborhood physical disorder (e.g., boarded up and vacant housing) was associated with lower odds of serodiscordant condom less intercourse (AOR = 0.43; 95% CI 0.19, 0.95) among Black MSM suggesting the physical environment foster conditions and situations that influence sexual risk behavior [46].

6. Social determinants of health

Poverty-related factors (e.g., low-income, unstable housing, incarceration, etc.) have been shown to be a driver of the HIV epidemic creating significant barriers to access to HIV prevention services and poorer HIV-related outcomes [47–49]. Housing instability has been shown to be negatively associated with risk of HIV infection; viral suppression and uptake and retention of PrEP and ART [50–52]. One study of Black MSM in Massachusetts found those with unstable housing were four times more likely to report engaging in unprotected sex. A systematic review of housing status and HIV-related outcomes found lack of stable, secure, adequate housing is a significant barrier to consistent and appropriate HIV medical care, access and adherence to antiretroviral medications, sustained viral suppression, and risk of forward transmission [53]. In a recent six-city study of Black MSM, 12.1% had experienced homelessness in the last 12 months and reported difficulty in maintaining adherence to ART compared to stably housed respondents [54]. Millet et al. found housing instability, income, and marijuana use explained higher rates of HIV among Blacks compared to whites [44]. In another study of Black MSM in Atlanta, one-third of respondents reported experiencing unstable housing with the majority of those being homeless [55]. Being unstably housed was associated with declines in viral suppression. In addition to housing, the study found living below the federal poverty level, and being incarcerated in the last 12 months was also associated with statistical differences in viral suppression between Black and White MSM [55]. For many racial/ethnic and sexual gender minorities maintaining health-promoting behaviors and/or medication regimens such as PrEP compete with other survival needs, such as securing stable housing.

7. Access to HIV prevention care and treatment services

Historically, African Americans have faced significant challenges obtaining affordable, quality healthcare and often delaying seeking healthcare resulting in an expensive emergency room visit and increased morbidity and mortality [56]. Due to their stigmatized and marginalized status as Black, gay and poor, Black MSM in

particular face a myriad number of challenges to accessing affordable culturally competent, quality healthcare across the HIV continuum. Access and uptake of HIV prevention biomedical therapies (e.g., HIV testing, pre-exposure prophylaxis (PrEP), and antiretroviral therapy (ART)) is essential to improving HIV-related outcomes for people living with HIV (PLWH) and as an effective HIV prevention strategy to eliminate transmission of HIV [57]. However studies show Black men are less likely to use ART and have low rates of adherence. In 2017, a study found Black MSM were less likely to secure ART, after controlling for less education, lower-income and access to healthcare [58]. Pre-exposure prophylaxis (PrEP), which has been found to be highly effective at reducing the transmission of HIV, remains alarmingly low among Black MSM [59]. A recent study found approximately 500,000 African Americans could benefit from PrEP, but only 7000 prescriptions (0.014%) were filled [60]. Several studies have found Black MSM are less likely to use PrEP than their White counterparts [61, 62]. For example, a study utilizing the National HIV Behavioral Surveillance survey conducted in San Francisco among MSM showed only 7.7% of Blacks used PrEP compared to 22.9% of their White counterparts.

There is growing evidence that suggests structural racism-related access to social and economic resources affects access to HIV prevention, care, and treatment programs among Black MSM. Numerous studies have shown Black MSM face significant barriers to accessing health insurance. In a meta-analysis of risk factors associated with disparities in HIV infection among MSM in Canada, UK, and the USA, Millet et al. found Black MSM were less likely to have health insurance compared to their white counterparts [63]. In this same study, the authors found pronounced disparities across a number of structural barriers that increase HIV vulnerability for Black MSM. Black MSM was more likely to be unemployed, have low educational attainment, have lower income, and ever been incarcerated which exacerbate efforts to obtain healthcare. A study examining access to healthcare found expansion of Medicaid was associated with a decline in new HIV diagnoses [64]. A recent study of Black MSM found 31% had no access to health insurance [65]. Another study found an association between having health insurance and being unaware of one's HIV status demonstrating the importance of having a primary healthcare provider [66].

8. Incarceration, criminal justice system and HIV

There is growing recognition that incarceration is a major structural factor in increasing HIV vulnerability among Black MSM. Structural inequities in the criminal justice system (e.g., stop and frisk, race-based sentencing, bail bonds) have led to disparities in incarceration rates for racial/ethnic minorities, for both Black men and Black MSM [67–70]. Research has shown correctional facilities are hotspots of HIV infection where HIV prevalence rates are 5 times that of the general population, yet only 20 states conduct HIV testing at the point of admission [71]. A study conducted in North Carolina showed only 31% of male inmates received a voluntary HIV test [72]. While some facilities provide HIV prevention education, it is often inconsistent [73–75]. Also, despite high rates of unprotected sex and HIV infection within the prison system, the provision of condoms is not routine. Only two state prison systems and five county jails make condoms available to their male inmates [76]. Among Black MSM inmates who reported engaging in anal sex, 90% indicated they did not use a condom [77]. Furthermore, a prior history of incarceration is associated with non-adherence to HIV treatment [78]. Over incarceration of African American men and lack of access to HIV

prevention, care and treatment create conditions that drive the transmission of HIV among racial/ethnic minority populations, particularly Black MSM [79].

9. Stigma, cultural competency and medical mistrust

While having insurance and a primary healthcare provider are important in increasing access to needed HIV prevention, care, and treatment services, it does not always guarantee access. For HIV prevention therapies to be prescribed both patients and healthcare providers must be ready and willing to discuss sexual health. Institutional cultural competency and subsequent patient-provider communication have been shown to influence uptake and use of PrEP. Cultural competency and the healthcare provider at the institutional level play a critical role in creating access to HIV prevention care and treatment for Black MSM. Despite advancements in LGBT inclusion and rights, many healthcare providers lack awareness and sensitivity in relation to sexual and gender minorities, particularly Black MSM. Evidence has shown healthcare providers often fail to discuss sexual health as a part of routine medical care which can lead to missed opportunities for critical HIV prevention education, testing, and counseling [66].

Additionally, stigma and discrimination in healthcare settings have been shown to create barriers to care among Black MSM [80–82]. Black MSM who experience institutional racism or health care provider stigma and discrimination are less likely to engage in health-seeking behavior [83, 84]. Research has shown stigma is not only a deterrent to accessing care, but it can lead to longer lapses in care among those who experience it [85–91].

10. Conclusions

There is a growing recognition that structural racism contributes to HIV-related outcomes, particularly for Black MSM [92]. This year CDC declared structural racism a public health concern [93]. Several initiatives to advance our understanding of structural racism and its effect on health have been implemented including NIH Unite Initiative whose primary goal is to address structural racism and promote racial equity and inclusion at NIH and within the larger biomedical research enterprise [94]. In the area of HIV, NIH has recently convened an HIV-Related Intersectional Stigma Research Advances and Opportunities Working Group to develop measures and resources that better help to identify and measure HIV-related stigma and discrimination at multiple levels that pose a critical barrier to the prevention, care, and treatment of HIV; and negatively affect the quality of life in those living with HIV [95].

In an effort to build on these initiatives, we call on national, state, and local governments, policymakers, and community-based organizations to implement the following structural HIV prevention interventions to reduce the number of new infections among Black MSM, marginalized and highly stigmatized population:

10.1 Development and implementation of structural competency training and policy

While there is a growing recognition of structural factors (i.e., structural racism) in shaping HIV-related outcomes, there is an urgent need for training and implementation of structural-based programs and interventions that complement biomedical therapies that address social determinants of health to improve

HIV-related outcomes among Black MSM. The importance of a culturally competent healthcare professional in providing quality health care is well established [96]. Cultural competency is an evidence-based framework utilized by healthcare care systems, agencies, and organizations that establishes a set of behaviors, attitudes, and policies that enables effective cross-cultural communication between healthcare professionals and vulnerable populations leading to improved health outcomes [97]. Similarly, there is a need for the development and implementation of structural competency training including a theoretical framework setting out a set of constructs, measures, and strategies on establishing and maintaining structural competency for health care systems and healthcare professionals.

10.2 Increase and expand HIV patient navigation services

We call for the development and implementation of patient navigation services that are culturally and structurally tailored to meet the unique needs of Black MSM who are disproportionately impacted by HIV. Evidence has shown patient navigation services increase patient engagement and patient linkage to needed HIV prevention, care, and treatment services [98–100]. Structurally-appropriate HIV services might include provision of non-clinical services, for example, transportation, clothing, food, rental assistance, housing, and workforce development. Additional research and investments in addressing social determinants of health are critical if we are to reach our goals of ending the HIV epidemic by 2030.

10.3 Implementation of innovative HIV structural interventions

There is growing evidence that structural-level interventions reduce HIV vulnerability and improve HIV-related outcomes. There are a number of HIV structural interventions that have been shown to be effective including comprehensive sex education, access to healthcare, and housing assistance. However, there are other examples that may not be widely known, we list a few here to provide you examples of novel and innovative programs that can be scaled up and/or adapted for Black MSM. The Max Clinic in Seattle, WA and Open Arms Healthcare Center (OAHCC) in Jackson, MS are two examples of health centers that have been designed to meet the needs of racial/ethnic and sexual/gender minority populations by providing culturally competent, quality healthcare across the HIV Continuum [101, 102]. Both clinics offer a range of clinical and non-clinical services. OAHCC utilizes an integrated HIV care model consisting of five care components: (1) case management, (2) HIV health care (including primary health care), (3) behavioral health care (i.e., mental and substance abuse screening and treatment), (4) adherence counseling (a pharmacist-led intervention), and (5) social support services (transportation, emergency food assistance, housing, and legal assistance). The Max clinic is based on high intensity, low threshold incentivized care model including walk-in service (no appointment necessary), primary care services, food vouchers, cash incentives, no-cost bus passes, cell phones, as well as intensive case management with cross-agency coordinated care.

10.4 Expand youth friendly HIV Services (YFHS)

Both in the U.S. and globally, adolescents and young people represent a growing share of the newly infected. In the U.S., Black youth make up one-third of the newly diagnosed [103]. There is a large body of evidence supporting the effectiveness of providing youth friendly services that improve the delivery of sexual and reproductive health services. Given youth, particularly young Black gay and bisexual men,

are at elevated risk of HIV, there is an urgent need to implement HIV prevention programs targeting Black MSM early in their pre-teen years. Delivery of quality services that are tailored to young Black MSM may reduce sexual risk behavior and improve adherence to HIV prevention methods such as condoms, PrEP and ART. The WHO has implemented guidelines recommending YFHS should be accessible, acceptable, equitable, appropriate, and effective [104].

10.5 Implementation of multi-level, intersectional, trauma-informed HIV prevention, care and treatment programs and services

Due to structural racism, discrimination, and stigma, Black MSM face a myriad of traumas (e.g., poverty, early childhood adverse events, that is, sexual and/or child abuse, mental health disorder, substance disorder, environmental hazard, poor educational system, lack of healthcare, and substandard housing) which have been shown to have negative effects on an individual's mental, physical, social, emotional, or spiritual well-being and consequently has shown to be associated with HIV vulnerability [105]. There is an urgent need for evidence-based, structural-level trauma-informed interventions to address structural racism and its effects on sexual risk behavior that increase the risk of HIV transmission. Sub-Saharan Africa has been at the forefront of the implementation of structural level, trauma-informed interventions including addressing gender norms and HIV, intimate partner violence, and the use of microfinance to reduce HIV risk among young women [106–111].

If we are to meet the goal of ending the HIV Epidemic [112] by 2030, then we must radically shift how HIV prevention services are designed and implemented. Evidence supports the rapid roll-out and scale-up of structural-level HIV prevention programs: including comprehensive sex education, stigma reduction, universal condom availability, expanded syringe access for drug users, mental health counseling, and free access to PrEP and PEP. We call for increased investments in programs and policies that address social and structural determinants of health and fundamentally shift political and policy priorities, rethink social norms, and empower and transform historically marginalized communities. A number of structural approaches have been used or may be adapted to address racial/ethnic disparities in HIV including, free healthcare, affordable housing, a living wage, guaranteed income, reforming of the criminal justice system, early childhood education, and free tuition to college. These programs and policies from a wide range of fields and disciplines, including, education, economics, and public health could be used and adapted to address racial/ethnic disparities in HIV [113]. **Figure 2** presents a conceptual model for an integrated, trauma-informed HIV service delivery system. Using an ecological framework, we construct a multilevel, intersectional trauma-informed HIV service delivery model. The fundamental premise of the model is that broader, dynamic, and interlocking oppressions derived out of a distorted, racially-determined political economy, mediated through structural level processes, increase HIV vulnerability by creating barriers to access to HIV prevention, care, and treatment. We have divided the framework into three major constructs (i.e., structural, community and individual). To date, the majority of interventions have been focused on the individual level and to lesser extent community-level interventions. We propose policymakers, researchers and public health officials increase investments in the development and implementation of structural level interventions that will complement HIV prevention efforts. The effects of structural racism are foundational to our understanding of racial/ethnic and sexual gender disparities in HIV and as such it requires a structural level, systems approach to address the underlying structural,

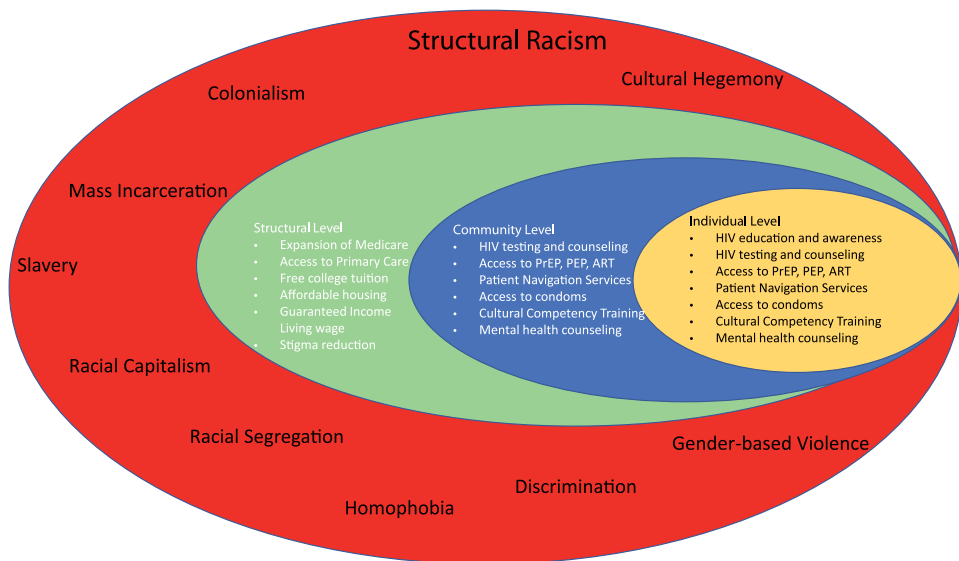


Figure 2.
A multilevel, intersectional trama-informed HIV service delivery model.

political, and economic processes that structure HIV vulnerability for Black, sexual minority men.

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PB has no conflict of interests.

Availability of data and material

Any datasets generated during and/or analyzed during the current study are not publicly available due to confidentiality concerns but are available from the corresponding author on reasonable request.

Code availability

N/A


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Addressing Systemic Factors Related to Racial and Ethnic Disparities among Older Adults in Long-Term Care Facilities

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Abstract

Disparities in older adults' care and experiences in long-term care facilities (LTCFs) such as nursing homes and assisted living/residential care communities reflect disparities in the broader society. Various policies and institutional practices related to economic opportunity, education, housing, health care, and retirement financing have created and maintain inequitable social structures in the United States. This chapter describes racial and ethnic disparities among older adults in LTCFs in the United States and the systemic factors associated with those disparities. It presents a conceptual framework for understanding the role of structural racism in the racial and ethnic inequities experienced by LTCF residents. In the framework, structural racism directly contributes to racial and ethnic inequities among LTCF residents through LTCF-related policies and practices. Structural racism also indirectly causes disparities among LTCF residents through health and economic disparities. The chapter describes current efforts that address the effects of structural racism within LTCFs and concludes with practice and policy recommendations to redress racial and ethnic disparities among LTCF residents.

Keywords: long-term care facilities, nursing homes, assisted living communities, health disparities, racial and ethnic inequities, Medicaid policy, Long-Term Care Ombudsman Program

1. Introduction

Structural racism affects individuals and communities across the life course. For older Americans, inequities in health access, quality, and outcomes caused by racism and systemic barriers in the United States can be exacerbated in later life in a variety of domains including physical and cognitive health, mortality rates, and quality of care. Systems for care in later life include long-term care facilities (LTCFs) such as nursing homes and assisted living/residential care communities. Paired with the demographic trend of increasing proportions of older adults from historically minority racial and ethnic groups [1] is a growing utilization of LTCFs by people of color [2]. Unfortunately, older adults of color in the United States experience disparities in access to quality nursing homes; access to care in assisted

living communities; quality of care and quality of life in LTCFs; health outcomes as LTCF residents; and social engagement within LTCFs. These disparities are associated with a variety of structural factors (e.g., federal and state policy related to LTCF funding and oversight, housing policies that have created racially segregated communities, and workforce practices that lead to income and wealth disparities). The growing number of people of color in LTCFs and persistent disparities within them creates an urgency to address racial and ethnic inequities in quality of care and quality of life for older adults of color living in LTCFs.

1.1 Long-term care facilities (LTCFs)

Older adults who experience chronic limitations in physical and cognitive functioning may need long-term services and supports. Long-term care encompasses a range of services and supports that assists individuals in completing activities such as dressing, preparing meals, medication management, and housework [3]. Most long-term care is provided at home by family caregivers [4]; however, long-term care is also available in long-term care facilities (LTCFs). The need for long-term services and supports increases as individuals age, as does the likelihood of not having the assistance of a spouse who can provide informal care. For this reason, and due to the aging of the population in the United States, a growing number of older adults are utilizing LTCFs [3, 5].

In the United States, the majority of the funding for long-term services and supports comes from public sources, but many people privately pay or use private long-term care insurance [6, 7]. Medicaid, a means-tested program, is the primary funder of care in LTCFs. The federal and state governments jointly fund Medicaid, but it is administered by the states. Each state sets its own eligibility requirements for Medicaid, which include income and resource limits. In contrast, Medicare is administered at the federal level, and eligibility requirements are tied to eligibility for Social Security or Railroad Retirement benefits [8].

1.1.1 Nursing homes

Nursing homes are residential communities that provide a higher level of care than can often be provided at home or through other community-based services. Nursing homes may also provide health care services such as physical or occupational therapy to help patients recover from illnesses or injuries. The median monthly U.S. nursing home cost in 2020 was \$8,821 for a private room and \$7,756 for a semi-private room [9]. Most nursing home residents pay for long-term nursing home care with Medicaid, with Medicare paying for more short-term post-acute nursing care in skilled nursing facilities [10].

Private nursing homes became common in the United States beginning in the late 1930s, after the Social Security Act of 1935 prohibited older adults who lived in public almshouses from receiving Old Age Assistance [11]. Wealthier White older adults were able to afford private nursing home care; however, this option was financially inaccessible for poorer White people and poorer people of color [12]. Public funding for nursing home care was not available until the 1950s [13]. These policy decisions created financial barriers for people of color, particularly African Americans, to access nursing home care.

In contrast to the past, today older adults of color are overrepresented in the nursing home population, representing approximately 25% of nursing home residents [2, 10]. The trend for increasing portions of residents of color in nursing homes seems to be driven in part by White older adults disproportionately accessing more appealing alternatives to nursing homes that are funded by Medicaid waivers for Home and

Community-Based Services [2] and privately paying for care in assisted living communities [14]. At the same time that an increasing percentage of people of color are using nursing homes, there have been increased closures of nursing homes across the country, with closures concentrated in disadvantaged communities of color [2].

Nursing homes tend to be quite segregated by race and ethnicity [15], a phenomenon related to past structural racism. Policies such as the 1946 Hill-Burton Act (which funded construction of “separate but equal” nursing homes) and southern Jim Crow laws combined with discriminatory practices in hospital discharge planning and nursing home admissions to create and maintain segregated nursing home systems [12, 16, 17]. In the 1960s, the Johnson administration failed to use provisions of the Civil Rights Act to desegregate nursing homes and prohibit discrimination in nursing home practices [12, 17, 18]. Housing policies such as redlining created and perpetuated racial segregation of neighborhoods which in turn supported racial segregation of nursing homes, as nursing home residents tend to come from their surrounding communities [15].

1.1.2 Assisted living/residential care communities

Assisted living or similar residential care communities are another type of LTCF. They serve older adults who cannot live alone safely, but do not need the level of care provided at nursing homes. They offer personal care and household assistance to residents in a homelike environment. Assisted living and residential care communities can range from small homes with a few residents to large communities of private apartments in large residential settings, which tend to be chain-affiliated and owned by for-profit companies. These communities generally provide communal meals and opportunities for socialization and physical activities in addition to personal care services. Assisted living communities tend to be in urban/suburban areas and communities characterized by high levels of education, income, and financial resources [2]. Licensing of assisted living/residential care communities is at the state level, with variations across the states.

Many Americans have a more favorable impression of assisted living than of nursing homes, and it the fastest growing model of residential long-term care [19]. The 2020 median monthly cost of assisted living care was \$4,300 – substantially less than care in a nursing home [9] – but prohibitive for many to pay out of pocket. Medicaid only covers assisted living in states that have Medicaid waivers for Home and Community-Based Services that fund assisted living [20]. Although most states have these waivers, the coverage is low, and smaller and poorer states are less likely to adopt Medicaid waivers [21]. Furthermore, Medicaid eligibility, benefits, cost sharing requirements, and reimbursement rates vary by state [22], and evidence suggests that racial bias within a state is related to lower levels of Medicaid spending [23]. A few states do not provide any Medicaid funding for assisted living/residential care and in others, Medicaid covers personal care, but not room and board. In states that do fund assisted living with Medicaid, low reimbursement rates and the costs of administering Medicaid deter many assisted living providers from becoming Medicaid certified [24]. Indeed, less than half of the assisted living/residential care communities in the United States accept Medicaid [10]. As might be suggested by these systemic barriers, older adults of color are underrepresented in assisted living communities [10, 25].

2. Racial and ethnic disparities in U.S. long-term care facilities

The almost half-million older adults of color who currently live in U.S. LTCFs [3] face disparities along a variety of dimensions including health outcomes, quality

of care, quality of life, and social integration compared to non-Hispanic White residents. Much of the evidence of racial and ethnic disparities in long-term care comes from nursing homes, which are federally mandated to provide detailed health outcome and demographic data for their residents. This evidence points to racial and ethnic disparities in health and quality of life outcomes, engagement with health services, and access to quality care.

In nursing homes, health outcome disparities are evidenced by findings that Black residents have a higher risk for developing pressure ulcers [26, 27] which can lead to serious medical complications, and are less likely to recover from pressure ulcers present when they are admitted [28]. There are ample examples of racial and ethnic disparities in engagement with health services and health care quality within LTCFs. Black residents have received less pain management [29], have been subject to more use of physical restraints [30], and are less likely to receive a flu vaccine [31] compared to White residents. Black residents and those categorized on medical records as coming from “other” racial groups (e.g., American Indian/Alaska Native; Native Hawaiian/Pacific Islander) were found to be less likely to have toileting plans for incontinence than White residents [29]. Depressive symptoms – which can have severe mental health consequences if depression is left untreated – seem to be underreported for Black, Latinx, and Asian nursing home residents [32].

Racial and ethnic disparities in quality of life outcomes such as cultural fit and social engagement have also been reported. For example, higher proportions of minority residents in nursing homes are associated with more quality of life deficiencies reported in the facility [33]. Chinese residents have reported a lack of culturally appropriate food, which related not only to their feelings of belonging and being valued, but also to receiving enough nutrition [34]. Compared to White residents, Black, Latinx, and other nursing home residents of color have scored lower on social engagement measures that include interacting with others, accepting invitations to group activities, being at ease in group/structured activities, and establishing their own social goals [35]. Indeed, nursing home residents of color have reported lower quality of life indicators than White residents across multiple domains, including personal attention, food, engagement within the facility and with staff, and mood [36].

Data regarding complaints received by the U.S. Long-Term Care Ombudsman Program extends our understanding of racial and ethnic disparities in LTCFs to include assisted living communities. The Long-Term Care Ombudsman Program is a federally mandated program administered at the state level that advocates for LTCF residents in both nursing homes and assisted living communities. Local ombudsmen conduct site visits, make referrals as needed, provide resident and public education, engage in policy advocacy, and receive and resolve complaints on behalf of residents. In their role as resident advocate, state Ombudsman Programs are well positioned to enhance our understanding of racial and ethnic disparities among LTCF residents. However, State Ombudsman Programs are not required to collect and report data about the race and ethnicity of the residents for whom they receive complaints; they are only required to report aggregate-level race and ethnicity data for the facilities under their purview.

A recent study of ombudsman complaints in the Dallas, TX, area collected race/ethnicity data associated with resident complaints in an examination of racial and ethnic differences in complaint types and resolution rates [37]. Residents of color were more likely than White residents to file complaints related to residents’ rights (i.e., abuse, access to information, autonomy, financial rights). Interestingly, complaints more likely to be resolved in nursing homes and assisted living communities with higher percentages of minority residents; however, this finding was related to the resolution of complaints from or on behalf of White residents living

in those communities [37]. In focus groups, ombudsmen noted they had witnessed residents of color who refrained from making complaints about care compared to complaints about rights for fears of retaliation or being branded as a problem in the community. The ombudsmen also described ways in which LTCFs did not provide culturally appropriate environments for all residents (e.g., staff who could not communicate with residents in their language). Finally, the ombudsmen provided additional information about staffing ratios at Medicaid-certified facilities noting at times that only one aid would be available to care for a dozen residents needing aid.

2.1 Between- and within-facility sources of racial and ethnic disparities in LTCFs

As described earlier in this chapter, LTCFs tended to be racially segregated which relates to disparities in access to quality LTCF care. Many of the racial and ethnic disparities LTCF residents experience arise from differences between LTCFs that serve higher percentages of residents of color, particularly Black residents, and those that serve lower percentages [27, 33, 36]. LTCFs that serve higher percentages of residents of color tend to have fewer financial and community resources and insufficient staffing, with a correspondingly high number of care deficiencies, inadequate direct care, and low quality of care ratings [33, 38–40]. Economic factors play a major role in these differences. In general, LTCFs with higher concentrations of residents of color rely more on Medicaid funding than LTCFs serving predominantly White residents and are therefore more constrained by Medicaid's lower reimbursement rates [33, 38, 39]. Indeed, the more Medicaid-reliant a nursing home is, the fewer resources it has to devote to resident-directed care and activities, improving the home environment, and other quality of life and quality of care related pursuits [41].

Although facility-level differences account for many of the racial and ethnic disparities among nursing home residents, disparities still exist within individual facilities such as in vaccination rates and quality of care [31, 42]. This can be attributed in part to an unconscious provider bias, which can lead to health care providers limiting the amount of information they share with residents of color and result in less patient-centered communication [43]. It can also be related to the fact that people of color tend to be admitted to nursing homes with worse health and greater care needs [44].

2.2 COVID-19 and racial and ethnic disparities in long-term care facilities

The COVID-19 pandemic ushered in a heightened awareness of structural racism and discrimination related to the provision of health care to older adults. Communities of color were disproportionately affected by COVID-19 infections, severe illness, and deaths [45]. The Centers for Disease Control and Prevention [46] reported that approximately 22% of the COVID-19 deaths in the United States in 2020 occurred in LTCFs. Prior to the pandemic about 63 percent of nursing homes had infection-control deficiencies [47]. Because older people of color were overrepresented in nursing home populations in general – and specifically more likely to reside in lower-quality nursing homes – this put them at an increased risk for contracting infectious diseases like COVID-19. Indeed, facility-level disparities quickly became apparent. In the early months of the pandemic in the United States, *The New York Times* [48] reported that nursing homes with higher percentages of Black or Latinx residents were twice as likely to report COVID-19 infections than those with predominantly White residents. A subsequent analysis of Centers for Medicare & Medicaid Services data through May 2020 had similar findings [49].

Nursing homes with higher portions of residents of color tended to be in areas with higher levels of COVID-19 cases and deaths. It also found that LTCFs with higher proportions of residents of color were more likely than those with low proportions of residents of color to experience COVID-19 infections and deaths and report a shortage of aids during the pandemic [49].

3. Conceptual framework for understanding role of structural racism in inequities among long-term care facility residents

To understand and address the effects of structural racism for LTCF residents, this chapter proposes a conceptual framework with elements from critical race theory, social determinants of health, and life course perspectives of inequity. **Figure 1** presents a graphical image of this conceptual model for understanding the role of structural racism in racial and ethnic disparities among LTCF residents. In this framework, structural racism directly contributes to increased racial and ethnic inequities among LTCF residents through LTCF-related policies and practices. It is also the root cause of economic and health disparities, which in turn cause racial and ethnic disparities among LTCF residents.

3.1 Direct effects of structural racism

The first tenet in our conceptual framework is that structural racism – the reinforcement of a racial hierarchy privileging “whiteness” and disadvantaging “color” through policy, systems, and institutional practices – is a direct cause of racial and ethnic inequities among LTCF residents. It is important to recognize that racism is so deeply embedded in the very fabric of U.S. society that the nation has, in a sense, become desensitized to it. Critical race theory responds to this need by shining a light on the role of race and structural racism in contemporary inequities [50].

To understand racial and ethnic disparities among LTCF residents, it is necessary to identify how structural racism directly affects their experiences. For example, the societal decisions to restrict public financing of LTCFs to Medicaid and to provide low levels of Medicaid reimbursement have created racial and ethnic disparities in access to quality LTCF care. Black, Latinx, American Indian/Alaska

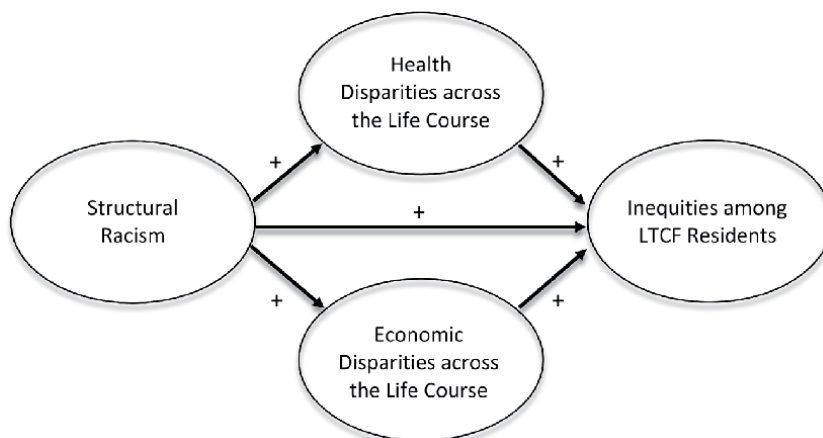


Figure 1. Conceptual framework for understanding and addressing racial and ethnic inequities among long-term care facility residents.

Native, and multiracial people are more likely to have Medicaid coverage or be dual eligible for Medicare and Medicaid [51]. As a result, LTCFs that rely on Medicaid funding tend to have higher portions of residents of color [52]. These more Medicaid-dependent LTCFs tend to provide poorer quality of care than those with more generous funding streams [27, 33, 36]. Policy decisions restricting Medicaid reimbursement rates are not color blind; low rates of Medicaid reimbursement are correlated with higher levels of racism within a state [23]. Another example of structural factors associated with inequities in health services engagement and health outcomes for LTCF residents is federal regulations that fail to specify racial equity in their oversight of residents' quality of care and quality of life [53], in essence whitewashing the unique experiences and challenges of residents of color.

3.2 Health disparities

The second component of our conceptual framework relies on the Social Determinants of Health Framework. This framework recognizes that health is a social phenomenon across the life course, determined in part by social contexts and stratification [54]. When new residents are admitted into nursing homes, those from historically minority ethnic and racial groups tend to be younger, in poorer physical health with greater physical dependency, and have higher levels of cognitive impairment and care needs than newly admitted White residents [44]. These racial and ethnic disparities in health outcomes influence the level of care needs residents have once admitted and the quality of life they can experience.

Experiencing racism at the individual or personal level leads to worse physical and mental health outcomes for people of color [55]. However, the influence of racism systemically in the United States also leads to poorer health through its impact on economic stability, education, health care systems, and social and neighborhood environments [56]. The Social Determinants of Health Framework acknowledges that structural forces such as social policies, education and public health systems, social safety nets, politics, and societal values all affect health outcomes and health equity. Intermediary social determinants of health such as housing and neighborhood physical environment, financial resources, psychosocial stressors, and behavioral factors are caused by these structural factors.

There are abundant and interrelated examples of structural factors associated with the social determinants of health and racial and ethnic health disparities [56]. Access to quality health care in the United States requires insurance coverage or the financial means to pay for services. However, discriminatory hiring practices have disproportionately excluded people of color from higher paying jobs and jobs that provide health insurance. Furthermore, a confluence of policies and discriminatory practices from Jim Crow laws to the intentional exclusion of Black Americans from Social Security coverage in passage of the Social Security Act of 1935, as well as discriminatory hiring practices have resulted in economic inequities that span decades of unjust outcomes affecting generations of families [11, 56, 57]. Discriminatory practices in the criminal justice system and the War on Drugs have disproportionately targeted and incarcerated Black men [56], removing them from the paid workforce and economic opportunity. Income and wealth are important social determinants of health on their own and as factors associated with access to health care and healthy environments. Historical policies such as redlining and current discriminatory practices in rental and housing markets combined with economic disparities lead to racially segregated neighborhoods with communities of color being more likely to be placed near environmental health hazards or contain substandard housing [56, 58]. This also reduces opportunities for people of color to generate wealth through real estate [56]. The placement of health care services

in predominantly White communities has made geographic access to health care difficult for people of color. Within health care systems, people of color experience both interpersonal and institutional racism resulting in worse care and disparities in engagement with health services [56].

The original model of Social Determinants of Health took pains to distinguish the social causes of health from unjust societal factors [54]. More recently, scholars have acknowledged the prominent role of structural racism in health outcomes [12, 56, 57]. Yearby [12] has reconfigured the original model to remove this distinction and place structural racism as a prominent root cause of racial health disparities [12]. In her reconfiguration, structural discrimination is the force that shapes aspects of social policy and systems of public health, neighborhood environments, education, and the economy. Our model for understanding and addressing racial and ethnic inequities among LTCF residents incorporates this perspective placing structural racism as an indirect effect on disparities in LTCFs by creating the conditions that result in poorer health for LTCF residents.

3.3 Economic disparities

The third feature of our conceptual model relates to the economic inequities experienced by people of color across the life course [59, 60]. It has long been acknowledged that nursing homes that serve higher proportions of Medicaid-paying residents are more likely to serve Black residents and have poorer staffing ratios and more care deficiencies [38]. This is relevant to racial and ethnic disparities because, as discussed in Section 3.2, due to economic disparities in the United States, Black and Latinx residents are more likely than White residents to have limited financial means [59, 60]. Inequality in wealth and income makes people of color more likely to rely on Medicaid for LTCF funding. This inequality is caused by systemic barriers to higher paying jobs, professional networks, educational opportunities and ownership of valuable real estate. Economic inequities can also explain why White LTCF residents compared to residents of color are disproportionately opting out of care in nursing homes in favor of receiving care in assisting living [14]. Although the homelike setting of assisted living makes it appealing [61], the cost of assisted living and the need for private pay in many assisted living communities exclude people of color with limited savings.

3.4 Life course perspective of disparities among LTCF residents

The vast majority of LTCF residents are older adults. In nursing homes, most residents are age 75 or older and in assisted living/residential care communities, over half are at least 85 years old [10]. These older residents carry with them a lifetime of experiences, opportunities, and injustices. American-born residents who are 85 years old today grew up in the United States when racial discrimination was legal and codified in many state laws. Lynchings by White people targeted Black citizens in the south and Mexican nationals along the Texas-Mexico border [62]. Many older LTCF residents were in their 20s and 30s when the Civil Rights Act of 1964 was passed. Unequal opportunities and oppression of people of color continued throughout their lifetimes and persist today.

Taking a life course perspective on the accumulated effects of inequities adds perspective to disparities among LTCF residents. The Matthew effect explains that inequalities, once they occur, become a perpetual cycle, and in the absence of advocacy, widen the gap between the advantaged and disadvantaged [63]. The Matthew effect framework closely aligns with the theory of cumulative (dis) advantage/dis-advantage [64], which has been used to examine inequities in a variety of domains

including health, well-being, and aging [65, 66]. One approach to distinguishing the two frameworks is to consider the Matthew effect (or *mechanism*) as the macro-level process of increasing societal inequality while thinking of cumulative advantage or disadvantage as the accumulated effect of positive or negative circumstances on an individual [64]. Through life course perspectives of inequality, it becomes evident that by the time older adults enter LTCFs, their financial and health status has accrued over decades. Intervention to address structural racism and its effect on economic, education, and health care systems early in life is necessary. Nonetheless, it is never too late to redress inequities, and LTCF residents deserve interventions aimed at eliminating the racial and ethnic disparities they experience.

Individuals who have experienced an accumulation of advantages early in life may find the concept of Matthew effects unsettling [63]. These very people may be overrepresented in positions of power such as policy-makers and LTCF chief executive officers as a result of their early advantages. In spite of this, it is necessary for individuals in the position to make meaningful change in LTCF disparities to recognize the accumulating effects of structural racism across the life course. Without policies or interventions in place to address the vicious cycle of compounding advantage and disadvantage, social inequities will widen [63].

4. Policies to address racial and ethnic health disparities in long-term care facilities

There are myriad federal, state, and local policies that affect racial equity in LTCFs because the long-term care system is integrally connected to systems of – and structural racism within – housing, economic opportunity, and health care. In this section, we present federal and state policies directly related to LTCFs. Federal policy applies across all states and territories and is the prevailing law in terms of citizen rights when there are discrepancies between federal and state law. State laws can vary widely, and while state law can provide additional rights and protections to citizens beyond what is provided by federal law, it cannot reduce those rights.

4.1 Existing federal policy

There are broad prohibitions against racial discrimination within federal law and regulations. Regulations of the U.S. Department of Health and Human Services (DHHS) prohibit health care providers who receive federal funding from discriminating against people of color [67]. The federal Fair Housing Act prohibits discrimination based on race, color, or national origin in assisted living/residential care communities [68].

Federal policy also works to eliminate health disparities. The Patient Protection and Affordable Care Act of 2010 mandates and funds efforts to redress racial and ethnic health disparities. The Office of Minority Health reports directly to the Secretary of Health and Human Services and works to improve the health and quality of care of people from racial and ethnic minority groups and eliminate racial and ethnic health disparities [69]. There are also separate Offices of Minority Health within six DHHS agencies and the National Institute on Minority Health and Health Disparities within the National Institutes of Health that seek to eliminate health disparities.

4.1.1 Centers for Medicare & Medicaid Services regulations

Because approximately 72% of the funding for long-term care in the United States comes from federally funded programs [10], the Centers for Medicare &

Medicaid Services is a major regulator of LTCFs. This includes regulations and guidance for Medicare- and Medicaid-participating LTCFs [70] and assisted living/residential care communities that receive funding through Medicaid waivers for Home and Community-Based Services [71]. It is important to note, however, that over 14,000 assisted living/residential care communities in the United States do not accept Medicaid funding and are therefore not subject to any regulations by the Centers for Medicare & Medicaid Services [10].

Many of the Centers for Medicare & Medicaid Services regulations specifically for LTCF operations pertain to the quality of care and quality of life of residents [53]. Overall, these regulations do not mention race and ethnicity (apart from including “insults based on race” in the definition of abuse). Rather, they speak more broadly to concerns such as residents’ rights to “a dignified existence” and freedom from discrimination in exercising rights [53]. In fact, in crafting the 2014 regulations for Medicaid waivers for Home and Community-Based Services, the Centers for Medicare & Medicaid Services noted they had received several public comments recommending specific non-discrimination protections in the policy but chose not to include them because more general provisions existed elsewhere in Medicaid policy [71]. Additionally, although the Centers for Medicare & Medicaid Services provides detailed guidelines for state surveyors of Medicare- and Medicaid-certified nursing homes and training for nursing home staff, the regulations do not specify assessments or training related to racial and ethnic disparities in LTCFs [53].

4.1.2 Long-term care ombudsman program policies

As described in Section 2, the federally mandated mission of the Long-Term Care Ombudsman Program is to advocate for LTCF residents. The federal government provides detailed regulations for state Long-Term Care Ombudsman Programs and their local-level designees, including the types of policies they must have, required qualifications for staff, and the need to submit a publicly available annual report of their activities to the U.S. Administration on Aging and their state’s government [53]. Like the provisions of the Centers for Medicare & Medicaid Services, the regulations of the Long-Term Care Ombudsman Program do not identify racial and ethnic equity as an explicit concern in their guidelines. For example, the required qualifications for Ombudsman Program staff do not include any skills or knowledge of racial health equity [53]. Another omission is in the reporting requirements which do not mandate disaggregation of complaint data by race and ethnicity which would allow the program, public, and lawmakers to evaluate racial and ethnic disparities related to residents’ complaints [53].

4.2 Existing state policy

States can create policies to license, inspect, and regulate LTCFs. In fact, they are responsible for the bulk of oversight of assisted living/residential care communities. States cannot create regulations for nursing homes that are less stringent than federal policy, but for assisted living, each state has the latitude to set its own standards. These vary widely across domains of building and occupancy requirements, training, staffing requirements, and resident assessments [72]. States differ in the ways they distinguish and treat board-and-care homes for older adults – which tend to serve older adults of color – and assisted living communities [73]. The variation of state regulations for assisted living is related to the liberal/conservative leaning of state legislatures, the states’ bureaucratic capacities (e.g., capacity of the state Long-Term Care Ombudsman Program), and even the salaries of the legislators [68].

The lack of consistency in LTCF oversight and commitment to addressing racial health disparities across the states (see for example [74]) highlights the importance of a federal response to address inequities among LTCF residents.

5. Examples of policies and practices with the potential to address racial and ethnic disparities in LTCFs

The root causes of inequities among LTCF residents lie in structural racism and ultimately need to be addressed across multiple domains of economic opportunity, housing, and health care systems. Nonetheless, there are responses at the LTCF-level that demonstrate promise to reduce the consequences of structural racism. This section presents efforts with the potential to address structural racism and reduce inequities among LTCF residents.

5.1 Universal long-term care coverage

Across the globe, some high-income countries like the United States provide universal access to LTCF benefits through social long-term care insurance (i.e., Germany, Japan, Luxembourg, the Netherlands, and South Korea) or taxpayer funded long-term care (i.e., Denmark, Finland, Norway, and Sweden) [75]. By making coverage universal, these countries avoid the inequities that arise from relegating long-term care coverage to means-tested programs such as Medicaid in the United States. Universal long-term care helps ensure that all citizens have access to long-term care regardless of their financial circumstances and removes potential stigma associated with receiving public assistance. The countries with universal long-term care coverage do not have the unique social circumstances related to race and structural racism as the United States. However, it is reasonable to expect that the equalizing effects of universal long-term care exhibited elsewhere would include reducing racial and ethnic disparities among U.S. LTCF residents.

Within the United States, the State of Washington is implementing universal social insurance for long-term care within its borders [76]. In 2019, the state legislature passed the Washington Long-Term Services and Supports Act, which funds the Washington Cares Fund. Beginning January 1, 2022, Washington employers will be required to collect 0.58% of an employee's wages as premiums for long-term care insurance. Beneficiaries of the fund can receive up to \$36,500 for a variety of long-term care services and supports including care in assisted living/residential care communities and nursing homes [76]. This program is the first of its kind in the United States and can serve as an example for other states or ultimately for a federal program of universal long-term care benefits.

5.2 Medicaid

Because older adults of color are more likely to live in LTCFs that are funded predominantly through Medicaid, the states have an opportunity to address racial and ethnic LTCF disparities through their Medicaid programs. Limited Medicaid funding results in residents of color disproportionately living in LTCFs that are under resourced and poorly staffed. However, some states' Medicaid policies have improved the quality of care or life for residents of color. One solution is as straightforward as increasing Medicaid's per diem reimbursement rates LTCFs. In a longitudinal study of nursing home citations for care deficiencies from 2006 to 2011, Li et al. [77] found evidence that increased reimbursement rates reduce disparities between nursing homes with high- and low-percentages of minority residents.

In another example, Hernandez [24] found in 2012 that the state of Oregon provided Medicaid reimbursement for apartment-style assisted living. Compared to states like Florida which, at the time, reimbursed for assisted living units with as many as two to four roommates in a room, the practice in Oregon could provide better quality of life for assisted living residents. A state-by-state comparison of policies for state funding for assisted living/residential care (see, for example, compilations like [78]) can provide additional insights into how state policy can affect older adults in LTCFs.

5.3 Private sector initiatives

Within the private sector there are also examples of initiatives aimed at awareness, education, and elimination of racial and ethnic disparities in LTCFs. In Canada, the Ontario Centres for Learning, Research & Innovation in Long-Term Care have created resources for LTCFs including a toolkit for embracing diversity; a diversity and inclusion calendar; diversity, equity, and inclusion (DEI) posters for use within LTCFs; and publications, reports, and toolkits related to indigenous culture and care for indigenous residents [79]. The toolkit for embracing diversity includes an instrument LTCFs can use to assess their LTCF and plan DEI efforts [80]. It contains detailed assessment items for DEI in seven domains: planning and policy, organizational culture, education and training, human resources, community capacity building, resident and family engagement, and service provision. It also provides a template for LTCFs to create SMART goals (i.e., specific, measurable, assignable, realistic, and time-bound) related to DEI in their homes. In the United States, the Oregon Health Care Association, the largest long-term care trade association in the state of Oregon, helps connect its member LTCFs to resources related to race and racism, including information on cultural trauma; Black, Indigenous, and other People of Color (BIPOC) mental health; bystander intervention, and racial justice [81]. While these efforts may not dismantle structural racism itself, they can affect change in individual LTCFs or LTCF chains resulting in reduced disparities for residents of color.

6. Recommendations

The process of eliminating the effects of structural racism among LTCF residents is seemingly impossible without first acknowledging the history and plight of persons of color in the United States. Inequities in access to quality LTCFs have existed since the rise of private nursing homes in the late 1930s. In the U.S. society, systems of economic opportunity, education, housing, health care, and retirement financing have created and perpetuated racial disparities in health outcomes, engagement in health care services, and quality of care. The effects of structural racism accumulate over the life course, resulting in heightened disparities by the time older adults enter LTCFs. Immediate action at the LTCF policy- and practice-level is needed to reduce the inequities to which thousands of LTCF residents of color are subjected. This section focuses on actionable policy and practice recommendations geared toward the residents and systems directly connected to LTCFs. However, as our conceptual model for understanding and addressing racial and ethnic disparities among LTCF residents suggests, structural racism is a force across the life course. To ensure future cohorts of older adults experience racial equity and justice in LTCF-settings and systems, we must conquer structural racism and its resulting health and economic disparities across the life span.

The process of effectively eliminating structural racism can seem like a daunting task. However, the examples in the preceding section demonstrate the potential for tangible results that improve the LTCF experience for residents. Because structural racism is directly and indirectly associated with racial and ethnic disparities experienced by LTCF residents, policymakers and practitioners need to employ a critical lens to understand and rectify its effects for LTCF residents. This critical approach includes four domains: awareness, acceptance, advocacy, and action related to structural racism and its effects. **Table 1** presents these domains with LTCF-related examples. In terms of *awareness*, policymakers and practitioners can increase their own and others' awareness of historical and current racial injustices related to LTCF inequities (e.g., inequitable distribution of wealth and economic opportunity, neighborhood segregation, social insurance, and health care funding). *Acceptance* of the existence of inequities and systemic barriers to affordable and quality LTCF care for people of color is also necessary. Additionally, *advocacy* on behalf of residents and vulnerable resident populations becomes a crucial tool for engaging in a participatory process to create change in systems that perpetuate racial and ethnic inequities in LTCFs. Lastly, if there is to be a reduction and elimination of policies and practices associated with structural racism, there must be *action*.

This chapter concludes with policy and practice recommendations. With diligent advocacy and action, change aimed at equity and racial justice for all LTCF residents is possible.

6.1 Policy recommendations

Several policy changes have the potential to reduce racial and ethnic disparities among LTCF residents. This section focuses on the action of implementing these policies. However, as described above, awareness, acceptance, and advocacy are preliminary and important steps for enacting these recommendations.

Domain	Examples
Awareness	Make staff and shareholders aware of the existence structural racism and its impact on residents of color through diversity training and other educational activities
Acceptance	Collect and analyze data related to racial and ethnic disparities within LTCFs and across LTCFs Internal and external dissemination of statistical reports that include statements of how historical, social, and economic factors contribute to the perpetuation of discriminatory practices
Advocacy	Advocate with and for residents of color experiencing inequitable care or quality of life Testify at state legislative hearings about the need for increased Medicaid reimbursement rates for long-term care facilities Lobby Department of Health and Human Services Officials to include requirements that state surveyors and LTCFs assess and address racial disparities
Action	Facilitate focused efforts that result in tangible outcomes including: <ul style="list-style-type: none"> • developing a mission statement that promotes racial justice and takes a stand against actions that perpetuate racism. • implementing state regulations that require state surveyors to consider racial-ethnic disparities when conducting assessments and report writing • delivering programming within LTCFs that acknowledges and responds to the discrimination and life course challenges experienced by persons of color

Table 1.
Components of efforts to eliminate the effects of structural racism among LTCF residents.

An ambitious but powerful tool for reversing structural racism in long-term care funding is implementing a universal social insurance for long-term care. In 2018, 70% of Americans over the age of 40 supported this proposal [82]. Although universal long-term care coverage would not eliminate the root causes of current racial and ethnic disparities in LTCFs, it would increase access to care in LTCFs and reduce reliance on Medicaid and its low reimbursement rates for disadvantaged older adults, including many people of color.

Increased Medicaid reimbursement rates for LTCFs are another way to reduce racial and ethnic disparities among LTCF residents [77]. The percentage of Medicaid funding that was spent on long-term care dropped from almost 50% in 1985 to only 30% in 2015 [83], during a time when the percentage of older adults in the United States was increasing. This trend could be reversed and funding priorities could reflect a greater emphasis on supporting LTCFs. To overcome fiscal objections to increasing Medicaid reimbursements for LTCFs, Chisolm et al. [39] suggest increased reimbursement rates could be targeted to LTCFs with high percentages of residents paying for care with Medicaid. Both approaches merit serious consideration, particularly when backed with federal funding as opposed to state funding, which would help LTCFs in states with low levels of income and resources.

Reforms such as a new social insurance program or increased federal funding from Medicaid would require legislative action, but many other policy changes could be made within the executive branches of government (e.g., within the U.S. Department of Health and Human Services). Because the Centers for Medicare & Medicare Services regulates Medicare- and Medicaid-certified nursing homes (as well as some aspects of Medicaid-certified assisted living/residential care communities), it has the ability to transform LTCF practices. For example, regulations could add training in racial and ethnic disparities in LTCFs to the mandatory staff training requirements staff. Similarly, The Centers for Medicare & Medicare Services should add to their current guidance for state surveyors of nursing homes to include information about identifying and reducing racial and ethnic disparities. At the state level, state health departments could bolster regulations for state inspectors of LTCFs to include considerations of racial and ethnic disparities in assessments and reporting.

The Long-Term Care Ombudsman Program has long advocated for LTCF residents [84]. However, reporting practices vary by state and some state programs do not collect and report race and ethnicity data related to the complaints they receive and resolve [53]. The Patient Protection and Affordable Care Act of 2010 requires programs that receive federal funding to collect and analyze data related to their participants' race and ethnicity. We recommend extending the spirit of the Affordable Care Act to regulations for the Long-Term Care Ombudsman Program's reporting responsibilities. If the ombudsman programs were mandated to collect, analyze, and report race and ethnicity data related to the individual complaints they receive, it would facilitate tracking, understanding, and addressing potential racial and ethnic disparities in LTCFs, including assisted living communities, across the United States.

6.2 Practice recommendations

Organizations and individuals should take steps to increase awareness, acceptance, advocacy, and action related to structural racism and racial and ethnic disparities among LTCF residents. Organizations such as local Long-Term Care Ombudsman Programs, LTCF trade organizations, and LTCF companies can help increase awareness of staff, residents, and the public by including racial justice in their mission statements. They can not only hire staff from more diverse

backgrounds or bilingual staff members, but also ensure their staff receive diversity training, including training on the disparities across and within LTCFs and the systemic factor associated with the disparities. As part of acceptance of disparities, LTCF administrators can ensure their organizations analyze and report data related to racial and ethnic disparities among their own residents. Organizations and individuals can advocate for policy reform to their state and federal legislators, officials at their state department of human services, or the U.S. Department of Health and Human Services. It is also potentially empowering for teams across organizations and agencies to form partnerships to address racial and ethnic disparities within LTCF systems. For example, LTCF social workers and Long-Term Care Ombudsman staff and volunteers could work together to reduce disparities and bring cultural inclusiveness to LTCF residents and staff [53]. Finally, within individual LTCFs or LTCF chains, administrators can ensure that their services and group activities are appealing to and affirming of minority residents, that food options and building design are culturally appropriate; and that minority residents are empowered to raise concerns about their care and quality of life [85]. Some of these recommended efforts at the LTCF-level will require careful interrogation of assumptions of what is considered normative in LTCFs (e.g., book collections with only White authors) and could be supported by diversity, equity, and inclusion equity tools such as the toolkit from the Ontario Centres for Learning, Research & Innovation in Long-Term Care [79].

Conflict of interest


The authors declare no conflict of interest.

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Cultural Competence as a Response to Structural Racism in Latino Substance Use and Access to Care in the United States

Erick Guerrero, Tenie Khachikian, Richard C. Cervantes, Charles Kaplan, Rene D. Olate and Jennifer B. Unger

Abstract

Disparities in substance use disorders (SUD) and access to treatment among individuals identified as Latino/Hispanic have become a significant public health issue in the United States. National efforts to identify, understand, and eliminate such disparities have highlighted the role of structural racism in Latino health. In this chapter, we offer a critical review of how Latino substance use and access to care may be impacted by discrimination, acculturation stress, and other mechanisms of structural racism. As structural racism is represented by policies, systems, structures, and norms that deny and/or minimize cultural strengths and disempower culturally diverse groups and their attempts to invest in their wellness, we highlight how cultural competence may reduce the risk of SUD and may enhance access to treatment among Latinos. We conclude by highlighting policies and responsive organizational practices that may improve Latino health.

Keywords: structural racism, cultural competence, substance use, Latino, disparities

1. Introduction

According to the U.S. Census Bureau [1], 62.1 million Americans identified as Hispanic, Latino, or Latinx (hereafter Latino) in 2020, comprising approximately 19% of the total population [2]. More than half (51.1%) of the total U.S. population growth during the last decade came from growth in the Latino population [3]. Latinos, people with a historical origin in Latin American countries where Spanish language is spoken, have become the largest ethnic minority group in the United States [1]. The Latino population in the United States is diverse in national origin and acculturation status. The U.S. Latino population is largely urban and has been concentrated in large metro areas, although the population of Latinos in smaller cities and rural areas is increasing as well [4]. In 2020, the poverty rate for Latinos was 17.0 percent accounting for 10.4 million individuals [3]. Latinos constitute a young population, with 40% under the age of 20 [5]. Two-thirds of U.S. Latinos are first- or second-generation immigrants [5].

Many of the risk factors for Latino substance use are associated with rejection from their environment and associated stressors. This may be construed as bias,

discrimination, and/or racism in social, educational, and government institutions. There may be an indirect relationship between structural racism in the United States and Latino substance use. As such, we explore in this chapter, substance use patterns among individuals identified as Latino and how services and practices that consider the cultural and linguistic backgrounds of Latinos may combat the influence of structural racism on Latino substance use and access to needed treatment.

2. Prevalence of substance use and substance use disorders among Latinos

Among U.S. adults, the rate of illicit drug use during the prior month among persons aged 12 or older was 9.7% among Latinos compared to a national average of 11.7% [6]. Although Latinos have a lower drug use prevalence compared to other racial and ethnic groups in the United States, this level of drug use still has serious consequences for morbidity and mortality among Latinos. Particularly concerning is that the use of illicit drugs continues to increase among Latinos [7]. Regional patterns are also noticeable; in the Southwest, Latinos report more amphetamine use [8], whereas in the Midwest and East, Latinos report increased use of heroin [9].

U.S. Latinos are significantly less likely than Whites to have been diagnosed with a drug use disorder during their lifetime or the prior year [10]. However, during the last 40 years, reported substance use disorders (SUD) among Latinos have continued to increase in the United States [11, 12]. About 20.8 million people aged 12 or older had a SUD during the prior year [13]. SUD among U.S.-born Latinos (18.9%) are more prevalent than among all Latinos (11.3%, [14]). Among U.S. adolescents, Latinos have historically reported similar levels of substance use to those of Whites. In the last few years, however, Latinos have reported the highest rates of use of any illicit drug in 8th, 10th, and 12th grades, primarily due to their increase in marijuana use. Among 12th graders, Latinos have the highest prevalence of use of several substances, including marijuana, synthetic marijuana, inhalants, hallucinogens, LSD, cocaine, crack, methamphetamine, and crystal methamphetamine. Among 8th graders, Latinos report more use of nearly all classes of drugs compared to Whites and African Americans. However, Latino adolescents have a lower prevalence of misusing prescription drugs compared to Whites [15]. Experimenting with any use of substance during early adolescence has been related to a greater likelihood of SUD in adulthood [16–18].

3. Historical contexts

Throughout history, people of various cultures have used substances for reasons, such as altering or healing the mind [19–21]. Cultural beliefs have influenced SUD across many racial and ethnic minority groups, including Latinos living in the United States [19, 21]. Substance use behavior is defined as a human behavior motivated by sociocultural beliefs, peer and family influence, and environmental exposure [20]. The general notion is that culture shapes beliefs that lead to behavior and social norms, hence certain cultural beliefs may influence an individual's motivation to engage in substance use [19]. Cultural beliefs are also embedded in the history of Latinos in North America.

The history of drug use among Latinos has been strongly influenced by the U.S. indigenous nations that have relied on substances to heal several ailments, including abuse of other substances [22]. For example, cannabis has had a long history as both a folk medicine and as an intoxicant. This complex history includes the

system of legal control that has been instituted in both the U.S. and Latin American countries to regulate the substance. Another cogent example is a substance derived from peyote, a small spineless cactus, that has been used as a psychoactive drug in Northern Mexico to treat chronic alcohol addiction [23]. Native American churches have also used this substance for the spiritual treatment of chronic alcohol addiction [24]. Many indigenous cultures have used tobacco medicinally and spiritually for thousands of years, whereas in the mainstream U.S. culture, tobacco is considered a recreational and addictive substance [25]. These are important contextual conditions to consider when exploring substance use risk factors among Latino populations.

4. Risk and protective factors for substance use

Many of the risk and protective factors associated with substance use among Latinos are the same factors associated with substance use across multiple racial and ethnic groups, yet acculturation stress, in particular, plays a critical role in the risk of SUD among Latinos. Overall risk factors include substance use by friends or family members, perceived social norms about substance use, access to drugs, psychological comorbidities, impulsive or risk-taking personality traits, and coping skills [26]. Protective factors include antidrug social norms, parental monitoring, and bonding with prosocial mentors and institutions [27]. However, because of their ethnic minority status, immigration histories, and socioeconomic disparities, Latinos also might face additional risk factors for substance use [28]. Especially significant among Latinos is acculturation stress that stems from the circumstances of adapting to the dominant American culture. This persists and is compounded in stressors tied to tensions between the first and succeeding generations within Latino communities. Acculturation stress, which is related to immigrants' perceptions of discrimination by mainstream Americans, increases the risk of SUD among Latinos [29].

The prevalence of SUD in the Latino population is affected by other psychosocial and emotional factors associated with unemployment, immigration, limited access to education, living in disadvantaged communities, family conflict, and racial and income discrimination [8, 11, 12]. Empirical evidence has revealed interesting relationships with substance use. For instance, Latinos are more likely to use illicit drugs and develop SUD if they do not have a strong connection with their ethnic and cultural background [12, 30, 31]. The importance of family connectedness and living in safe neighborhoods have been emphasized that may contribute to acculturation stress and play a role in Latinos' substance use [30, 31].

5. Acculturation: U.S. orientation and Latino orientation

Because of the recognition of the centrality of acculturation stress as a risk factor for Latino SUD, a deeper understanding of acculturation is warranted. Most Latinos, even those born in the United States, have some degree of contact or identification with their Latino culture of origin, although this can vary widely across individuals. Latinos living in the United States also have some degree of contact and identification with U.S. culture. The extent to which their practices, values, and identification align with one or both cultures defines their acculturation status [32]. Early theories of acculturation assumed that immigrants replace their heritage culture with a new culture [33]. Later acculturation theories [32] propose that individuals can adopt aspects of the new culture but still identify strongly with the heritage culture. Several studies have concluded

that acquisition of U.S. culture is associated with an increased risk of substance use among Latino adolescents [34, 35].

More recent research has drawn a more nuanced conclusion—that the loss of protective aspects of Latino culture, rather than the acquisition of U.S. culture, increase the risk of substance use. Latino adolescents who assimilate into U.S. culture without maintaining a connection to Latino culture are at greater risk of substance use [36] than Latino adolescents who maintain their Latino cultural orientation, especially those who simultaneously participate in U.S. culture and maintain ties with Latino culture [27, 37]. As emphasized above, the role of acculturation stress and rejection from mainstream society plays a central and significant role in Latinos' higher risk of abusing alcohol and other substances. For example, higher acculturation is related to a higher risk of alcohol and illegal drug abuse as compared to less acculturated Latinos and Whites [38]. Acculturated Latinos reported a 7.2% increase in alcohol and illegal drug use during the previous month, compared to less than 1% of less acculturated Latinos and 6.4% of Whites [38]. Less acculturated Latinos had recently immigrated to the United States and therefore reported higher family values and lower rates of alcohol and drug use [29].

6. Acculturation discrepancies between parents and children

Acculturation occurs in a family system, with adolescents and their parents acculturating at different rates. Immigrant children typically learn and adopt a new culture more rapidly than their parents [33]. Children of immigrants grow up immersed in the receiving culture and are exposed to the heritage culture only secondhand. If families and communities do not maintain and support attributes of the heritage culture, adolescents might reject, forget, or never learn about their culture of origin, leading to acculturation discrepancies between adolescents and parents [33]. Acculturation discrepancies between parents and children can lead to family conflict, which can increase the likelihood that adolescents will experience emotional distress and turn to risky peer groups and risky behaviors in an attempt to cope with that stress [39, 40]. In addition, when parents are less acculturated to U.S. culture than their children, parents must rely on their children for help navigating U.S. culture [41]. This can undermine parental authority, place excessive stress on children, and boost youth's risk of involvement in problem behaviors, such as substance use [27, 33, 41].

7. Ethnic identity

Ethnic identity includes knowing about one's ethnic group, perceiving the value and emotional significance of that membership, and feeling a sense of belonging and commitment to the ethnic group [42]. Some studies have shown that a strong ethnic identity protects against substance use [43, 44]. However, this association has been inconsistent across studies, with some finding that a strong ethnic identity is a risk factor for substance use or that no association exists between ethnic identity and substance use [45, 46].

8. Cultural values

Cultural values are attitudes and priorities that are emphasized and encouraged by members of a culture. Endorsement of specific values varies widely across members

of a culture, but cultural values are those generally viewed as positive in the culture. For example, individualist cultures encourage and reward outstanding achievements by individuals, whereas collectivist cultures encourage and reward the well-being and prosperity of the group. Certain cultural values might protect against substance use (e.g., obedience to parents, not ingesting intoxicating substances, and regarding one's body as sacred), whereas other cultural values might increase the risk of substance use (e.g., glamorization of adolescent individualism and rebelliousness, expectations of intoxication in certain social contexts). The Latino cultural value of familism emphasizes the interdependence of family members [47]. This can involve a duty to take care of family members and serve as a resource and role model for family members—responsibilities that tend to be incompatible with substance use. However, *familismo* could be a risk factor for substance use if the family members are substance users and encourage other family members to use substances with them. *Respeto* emphasizes a child's duty to respect and obey parents and other authority figures [48]. Previous studies have found that familism and respeto protect against adolescent substance use [49, 50].

9. Discrimination

Ethnic discrimination is differential treatment based on membership in a minority or lower-status group. It includes overt acts such as violence, harassment by police, discourteous treatment by store clerks, and subtler aggressions such as condescending speech [51]. Ethnic discrimination can be understood as one of the core mechanisms of structural racism. It is through the policies, arrangements, practices, designs, spaces, narrative, and other mechanisms that structural racism gives way to separate, exclude, and ultimately discriminate individuals and/or groups [52]. Perceived discrimination can cause emotional distress, and repeated experiences with discrimination can deplete coping resources and increase the attractiveness of avoidant coping strategies, such as substance use [53]. Perceived discrimination by the dominant culture also can signal to minority group members that they will be blocked from opportunities, which may lead them to identify with oppositional subcultures featuring antisocial norms [54]. Perceptions of discrimination have been associated with the use of tobacco, alcohol, and other substances [55] and with depression [56].

10. Immigration and substance use

Substance abuse has been regarded as a complex phenomenon due to the biological, sociocultural, and historical concepts involved. Therefore, as highlighted above, understanding substance abuse in a target population requires considering its history and context that includes the experience of immigration. This critical factor contributes to substance abuse in Latinos' complex history that encompasses immigration, migration, or changes of state, such as among Mexicans living in territory acquired by the United States in the early 20th century. These individuals faced new socio-cultural values in their host country or new national context. This is most pertinent to Mexicans, who represent more than 65% of the total population of Latinos in the United States [19, 21]. Migration status and experiences are a proxy for the stress, trauma, and potential destitution or disenfranchisement associated with immigrants. Again, this stress has been associated with a higher risk of SUD behaviors.

Previous research indicated that Latinos who move to the United States are more likely to be at risk of illicit substance use compared to those who stay in their

home country [38, 57–59]. Mexican migrants residing in the United States are more likely to experience deficient health care and treatment compared to their U.S.-born Mexican counterparts, specifically women relative to access to treatment [60]. Mexico is one of the largest countries to experience return migration from 2009 to 2012 [61]. Mexicans who migrate to the United States and then return either voluntarily or by deportation for criminal activities to Mexico (i.e., transnational Mexicans) have reported an increased rate of substance use [30, 57, 58, 62, 63].

In addition, transnational Mexicans' family members (i.e., including relatives who did not migrate) are more likely to use substances (e.g., alcohol, marijuana, and other illicit substances) as compared to other Mexicans [62]. This population often does not seek treatment as readily as Mexicans who did not migrate to the United States [57, 58]. Furthermore, the high risk of substance abuse among transnational Mexicans has negative effects on the quality of life of residents in both countries [58, 64]. Although this may be the case, increasing concern is centered on alcohol and tobacco use among Mexicans living in Mexico [57, 58]. Similarly, compared to men, women reported particular increases in the use of marijuana and cocaine from 2008 to 2011 in Mexico [65].

Marijuana consumption is increasing among adolescents and adults living in Mexico [66]. In Mexico, frequent alcohol use and drinking in large quantities are most common [67]. It appears that this drinking behavior is passed on to adolescents, a substantial number of whom report becoming problem drinkers [68, 69]. Mexico's National Addictions Survey has shown an increasing proportion of the population needs to seek SUD treatment and learn how to moderate alcohol intake and avoid reoccurring patterns of binge drinking [67].

In Mexico, approximately 13 million Mexicans have reported using at least 100 cigarettes during their lifetime and more than 53,000 deaths occur each year due to tobacco-related diseases [67, 68, 70]. Older adults with higher education are more likely to use tobacco than older adults with a lower education level [71]. Youth are also affected by tobacco use in Mexico because initiation occurs at 13.7 years old on average [67]. This further contributes to the increase in public and social health concerns in Mexico, which have not started to shift away from cigarette use, potentially contributing to an increase in substance use among adolescents [71].

Increasing understanding of how migration affects SUD would help inform epidemiological efforts to reduce substance use behaviors and lead to better treatment outcomes [72]. It is also important to connect translational migrants with their networks and communities to bring about SUD behavior change in the Mexican population [62, 72]. Research has suggested that ecological factors are associated with substance use (e.g., marijuana, other illicit substances; [73]); however, these relationships need to be studied further, specifically in the context of migration [74], family networks, and substance use. Previous studies have recognized that Mexican migrants typically have additional risk factors for substance use, such as low socioeconomic status, immigration status, and social isolation [75, 76]. Therefore, it is still unclear whether substance use is a consequence of the stress of being a Mexican migrant or a manifestation of these other risk factors. This emerging evidence suggests the importance of continuing to explore substance use factors among Mexican transnationals [58] to inform public health efforts to reduce SUD in broad populations, including those in Mexico and the United States. Increasing efforts to understand SUD in other countries will help identify ecological factors and risk factors that affect multiple populations, informing the development and implementation of SUD treatment programs that help alleviate symptoms across a spectrum of populations and communities.

11. Cultural competence in SUD treatment

Latinos have become the fastest-growing population entering SUD treatment, reaching 12% of the total treatment population in the past 10 years [8, 77]. It is important to highlight the need for culturally competent practices and for providers to understand and use clients' cultural backgrounds, including immigration and acculturation experiences, to support their recovery from SUD. For instance, studies have suggested that among Mexican Americans in the United States, an extended period of residence contributes to a higher prevalence of SUD [78, 79]. Cultural competence may play a critical role in reducing the impact of structural racism in enhancing access to and engagement in the prevention and treatment of Latino substance use [19, 80, 81]. For instance, Latino clients are influenced by individual, program, and community characteristics when facing decisions about substance use and seeking help [7]. As is common with other cultural groups, it is important to establish trust and effective communication to foster positive health outcomes for Latino clients [7]. Engagement occurs through understanding and accepting cultural distinctions, speaking the client's language, and addressing sociocultural and economic issues related to the problem. In turn, structural racism creates policies, systems, structures, and norms to deny and/or minimize cultural strengths and disempower culturally diverse groups and their attempts to invest in their wellness.

Increasing cultural competence in prevention or treatment improves SUD problems among individuals from various cultural backgrounds [19]. Sociocultural beliefs can influence an individual's approach to substance use and abuse and further shape treatment options. For Latinos and other racial and ethnic minorities, language barriers and unavailability of bilingual interpreters can also add to long waiting periods to receive treatment [80–82]. Even further, Latinos and other racial and ethnic minorities experience more difficulties in navigating the health care system as compared to Whites [80]. These findings suggest that it is vital for SUD treatment programs to address the cultural and linguistic needs of their Latino and other minority clients by tailoring services and practices to help achieve better treatment outcomes. Specifically, with diverse populations continuing to increase in the United States, it becomes vital to assess an individual's substance use and abuse based on his or her racial and ethnic background.

12. Organizational cultural competence

Culturally responsive policies, institutions, communities, and programs can become an intervention to address, decrease and eliminate the creation and use of structural racism. The Office of Minority Health helped in developing standards for healthcare providers to abide by 14 standards (practices) to respond to the cultural and linguistic service needs of diverse populations [83]. Many of the culturally responsive practices have been associated with positive SUD prevention and treatment [80, 84, 85]. For instance, structural, policies, and practices that discriminate against certain groups may be a significant risk of dropout. For culturally and linguistically relevant service outcomes to improve, it is important to identify the methodological flaws of the practices [86]. Cultural competence has been correlated with improved communication, positive therapeutic alliance (e.g., provider-client trust), and higher client satisfaction [80, 87–89]. In particular, Latinos as well as other racial and ethnic minority clients are more likely to remain in treatment when the services they receive are responsive to their cultural and linguistic needs.

Considering the initial evidence suggesting cultural competence can increase the quality of care in SUD prevention and intervention, it is critical to developing nuanced, cost-effective interventions.

13. Training SUD treatment providers in cultural competence

Training staff members to practice cultural competence in SUD treatment is vital to dismantle mechanisms from structural racism that limit clients seeking treatment and improve outcomes. As recently noted in the *Diagnostic and Statistical Manual of Mental Disorders*, it is important for clinicians and staff members to be aware of the cultural differences of each client [90]. Staff composition is crucial to the implementation of treatment programs, specifically concerning access and retention [91]. In fact, appointing qualified staff members who share similar racial and ethnic backgrounds as clients dramatically increases the likelihood of patients entering treatment [91]. The central goal of the staff should be focused on making patients feel welcomed to help improve treatment outcomes [90]. Staff members can learn about the history of vulnerable groups that may be connected with stress and other factors associated with substance use, such as immigration and acculturation experiences. This is a clear outcome for training staff members that can increase the success of treatment programs and organizations by not only fostering an environment of acceptance but also making the patient feel capable of completing treatment [91].

It is equally important to instill cultural competence in the organization because this will influence policies and programs and integrate cultural empowerment values and beliefs in the system [92]. A culturally competent organization thrives on bringing diverse individuals together to alter their practices and make them more acceptable across various groups [93]. The organizational outcomes and benefits associated with increasing cultural competence in the organization include improving respect, increasing participation, improving trust and collaboration, and promoting equality [92, 93]. Organizations can become culturally competent by seeking collaboration with individuals from various racial and ethnic backgrounds and further identifying the needs of these groups [94]. Identifying those needs provides a space to better adapt and learn how organizations can meet the demands of their diverse clients.

14. Cultural competence applied to different treatment modalities

The importance of applying cultural competence to various settings and organizations is increasing. It is becoming the norm to request that professionals be culturally competent in the health care system [95]. Culturally competent environments are rapidly growing in organizations. For instance, culturally competent models are being applied to cognitive behavioral therapy as a means of improving outcomes in treatment among minority groups, such as Latinos [96]. This is achieved by providing bilingual translators and programs to Latino clients and training staff members to be respectful of their cultural backgrounds. This has led to the development of mutually respectful and cooperative relationships between clients and their providers.

Cultural competence has been applied to interventions that focus on individuals with depression to improve treatment outcomes among racial and ethnic minority groups [97]. In fact, culturally competent adaptations to psychotherapy have been found to be more effective in reducing symptoms of mental conditions (e.g., depression)

as compared to a wait-list control group [97, 98]. Professions that have focused on including cultural competence in their work environment include business, social work, psychology, public relations, education, and health care [99–102].

15. Cultural competence in the community

Aside from improving cultural competence in organizations, it is equally important to focus these efforts on refining communities. With minority populations migrating to different communities in the United States, there is an urgent need to make communities more inclusive (e.g., increase awareness of implicit bias and understanding of groups' needs through CLAS and other culturally responsive practices) toward diverse populations [103]. This diversity and inclusion may help mitigate some of the psychosocial stresses related to SUD among minority populations. Access to treatment for clients is usually available in their own neighborhoods and communities, and therefore it is critical for SUD treatment programs to adopt a community approach to cultural competence. Mounting evidence suggests that programs with greater knowledge and investment in minority communities are more likely to increase access to care [104]. Programs investing in communities of color may also benefit some of the most vulnerable members of society, such as homeless individuals [105].

Clients with SUD issues should feel comfortable accessing providers in their own communities that offer a safe and acceptable space for them to seek health care options. Efforts should be made to culturally integrate communities to develop programs and policies that are meaningful for diverse populations and to ensure cultural values are shared across the population [103, 106]. Cultural competence in the community setting could lead to the inclusion of community members and even increased participation and involvement in community issues [103]. Cultural competence could lead to numerous benefits from the individual to the communal level and lead to improved health outcomes by increasing understanding, acceptance, and respect for diverse clients and their communities [107].

16. Conclusion and future directions

The evidence provided in this chapter suggests that Latinos, as the largest ethnic minority group in the U.S., have a distinctive history of substance use and help-seeking behaviors. The socialization of substance use in their lives and the role of substances in their history of immigration, for instance, are important issues that may be impacted by structural racism. The prevalence of SUD in Latinos is affected by factors, such as unemployment, acculturation stress, and discrimination. Discrimination, in terms of exclusive prevention and treatment policies and practices by funders, regulators, and service providers, maybe one of the most critical factors contributing to SUD. A clear example is the bifurcated opioid treatment system, where low income and publicly insured Latinos are more likely to receive methadone, while mid- and high-income non-Latino Whites are more likely to receive buprenorphine, a medication with significant advantages to obtain, impact, and side effects.

Latinos have also distinctive prevalence rates regarding the use of specific substances. Some of these substances are more accessible in some regions of the United States. Latino adolescents also have unique primary substances of choice (e.g., marijuana and methamphetamine) compared to adults, and the prevalence of use among these youth reflects their developmental stage, with much higher

use during thrill-seeking ages that decreases as adolescents age. Overall, ecological factors, such as family, employment, migration, and discrimination, play an important role in Latino substance use and need to be studied further.

Cultural competence has become a critical approach to understand and respond to the substance use disorder issues experienced by groups vulnerable to discrimination and/or racism. In the past 30 years, research in the definition, operationalization, and assessment of this concept has slowly gained attention because of its potential to improve prevention and interventions to address SUD. But significant challenges remain to implement culturally responsive practices in social, educational, and government institutions to reduce acculturation stress related to Latino substance use and access to SUD treatment. Additional research is needed to establish the impact of key components of culturally responsive practices (e.g., inclusive policies, matching provider and clients based on language and cultural background) with different areas that support minorities achieving sobriety.

Future research is needed to understand the risk and protective factors for problematic substance use and treatment access among Latino migrants and future generations of Latinos living in the United States and intervene with structural factors, such as immigration and inclusive policies and responsive organizational practices to improve Latino health. If resilience factors can be identified and encouraged, addiction and its adverse medical and social consequences can be reduced. Latinos have become the fastest-growing population entering SUD treatment. The distinctive nature of Latinos' patterns of substance use, substance of choice, co-occurring mental and primary care issues, and barriers to access care highlights the importance of developing and implementing culturally informed interventions that consider clients' background, immigration experience, and linguistic service needs to help reduce substance abuse among Latinos. Policies and practices that are culturally responsive also referred to as antiracist may have the foundation and drive to have a significant impact on eliminating disparities and promoting the health equity that Latinos have long deserved.

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Section 2

Culture and Politics

Gender Differences in Coping with Racism: African American Experience and Empowerment

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Abstract

Black men and women encounter multiple forms of racism in American society and require numerous strategies to manage the stress associated with these experiences. This chapter reviews the current state of the literature regarding Black people and how they cope with racism. Findings demonstrate that Black people tend to cope with racism through social support, religion, avoidance, and problem-focused coping, with some gender differences in coping approaches. We also contrast functional versus dysfunctional coping approaches and underscore the importance of empowerment to promote well-being and social change. Limitations of this review include the predominance of American-based samples used in the literature, which often excludes other Black ethnic and national groups. Further, the experiences of other Black intersectional identities are not well represented in the literature and require more study as their experiences of coping with racism may differ.

Keywords: African Americans, racism, discrimination, emotion regulation, coping

1. Introduction

The mental and physical stakes for Black Americans facing racism are high. A Black individual who is regularly exposed to racial discrimination is forced to integrate coping mechanisms into their daily life to combat the many and ongoing adverse effects associated with race-based stress and trauma. Racial trauma (or race-based trauma) refers to the traumatization of racialized people caused by repeated racist experiences [1]. Racism can take many forms and occurs on many levels, including on an institutional, community, and individual/interpersonal basis [2–4]. Racism is an organized system of advantages and disadvantages, founded on the categorization and ranking of racial groups that devalues and disempowers groups considered inferior [5]. Studies have identified a high prevalence of racist incidents experienced by Black Americans; notably, Lee et al. [6] found that over two-thirds encounter racial discrimination from time to time or regularly. Another study found that Black adolescents in the United States must cope with incidences of racial discrimination an average of five times a day [7].

Without specific mechanisms in place to cope with this barrage of racism, Black individuals leave themselves open to significant stress and risk facing racial trauma, which can lead to psychologically taxing responses. Persistent experiences

of racism can lead to mental health problems and even chronic physical health problems [8–10].

The primary, although not exclusive, mechanisms for managing racialized stress includes processes termed “emotion regulation” and “coping”. Although these are distinct concepts, they share some characteristics. This chapter will first describe the role of emotion regulation and coping as protective responses to racism-based stress experienced by Black Americans. We explore gender differences in how Black Americans react to racist incidents and provide recommendations for functional and empowering responses to race-related stress.

1.1 Emotion regulation

Emotion regulation is a critical part of the human experience and daily life. Individuals are subjected to many types of stimuli that require them to regulate their emotions. Emotion regulation has generally been defined as the efforts a person makes to influence which emotions they experience in the moment, as well as the manner in which the emotions are experienced and expressed [11]. Emotion regulation may be conscious or unconscious, automatic or controlled, modified in terms of intensity, duration, amplitude and/or quality, or evaluated as positive or negative [11, 12]. There are many reasons people regulate their emotions. When a person evaluates a situation as being relevant to their goals, emotions emerge [13]. For example, when a person experiences a bad day at work, their goal might be to reduce their anger. To achieve this goal, an individual may resort to writing in a journal to express their emotions or even confide in a friend. Emotion regulation can be understood as the activation of a goal that will change an emotional response [14].

Individuals will typically cycle through different steps or phases when regulating their emotions. For example, when presented with a situation, people are required to evaluate it and create a response. The chronological sequence begins with a situation, followed by attention and evaluation of this event, ending with the emotional response [15]. People go through the steps of this cycle quickly and the responses to each sequence will influence the ones that follow. This is a part of the process model of emotion regulation which was initially described by Gross [16], who details five families of emotion regulation processes [17]: (1) situation selection, in which an individual influences the situation they will be faced with; (2) situation modification, in which one or multiple pertinent aspects of the situation are changed; (3) attentional deployment, which influences what parts of the situation are noticed; (4) cognitive change, in which there are changes in the way the situation is represented cognitively; and (5) response modulation, in which emotion-related actions are directly altered. When a person finds themselves in a situation, at each of these five points in the processing of the experience, emotions can be regulated with the use of specific strategies.

In addition, there are various strategies that individuals may employ to regulate their emotions. The most common strategies used are mindfulness, distraction, rumination, acceptance, problem-solving, worry, reappraisal, behavioral avoidance, experiential avoidance, and expressive suppression [12]. Each of these strategies fall under the umbrella of one of the five families of emotion regulation processes mentioned previously. Using these strategies, individuals are typically able to manage their emotions and respond appropriately to their environment.

1.2 Coping

Emotion regulation is strongly tied to coping. All emotion regulation is a form of coping and involves attempts to regulate one’s emotions specifically in response

to a stressful event [18]. Coping is commonly described as an individual's changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as taxing or that exceed the person's resources [19]. Coping is a process that happens in response to stress that can change over time and can vary depending on the context. Further, over 400 different ways of coping have been identified, but both emotion regulation and coping share the following elements: they are processes of regulation, they include controlled and purposeful efforts, and they are temporal processes [20, 21]. A distinction to be made, however, between emotion regulation and coping is that the latter refers uniquely to stress. Emotional regulation can occur in non-stressful situations, but coping involves dealing with stress. In this chapter, we examine how Black Americans use emotion regulation and other approaches to cope with race-related stress.

1.3 Emotion regulation, coping, and racism

Although stress reactions can vary from person to person, because of the history of Black-White relations in America, African Americans are subject to a unique set of stressors that may influence the way in which they engage in emotion regulation and the coping process. Clark et al. [22] investigated how racism acts as a stressor for African Americans and proposed a model that highlights the biopsychosocial effects; however, they also noted that existing research in this area is insufficient. Moreover, Brondolo et al. [23] conducted a selective review which consisted of identifying individual-level strategies utilized by individuals to cope with interpersonal racism. They also emphasized the lack of research focusing on strategies people can use to cope with racism.

Faced with a dearth of definitive findings on this topic, the main goal of this chapter is to provide a review of the empirical literature, summarize the various ways Black people regulate their emotions and cope when faced with racism, and show how the deployment of these coping mechanisms can vary between men and women, and make recommendations surrounding functional versus dysfunctional approaches inasmuch as they facilitate empowerment.

2. Methods

A wide search for peer-reviewed articles was conducted, based on a search of the following online databases: PubMed, MEDLINE, PsycInfo, Google Scholar, Scholars Portal and Microsoft Academic. A combination of the following search terms was used to obtain relevant articles: "racism", "racial discrimination", "emotion regulation", "coping response", "coping strategies", "Black people" and "Black". Article had to have been written in English or French, peer-reviewed, related to emotion regulation, coping, relevant to racism or discrimination, and the population as Black people (any ethnicity). Additional relevant articles were found through the references section of the articles initially identified. A total of 56 articles from 1996 to 2021 were found after the initial search. Following this, a full-text review was done, and articles that subsequently did not meet the inclusion criteria were removed from the final article count. These tasks were performed by one reviewer. Articles that focused on those under 18 years old were not included. Other reasons that articles were excluded from this review include that the topic was not about coping with racism, or emphasized biological functions such as heart rate. Following the abstract and full-text reviews, 25 articles remained and were utilized to develop the current review. The main themes were identified through analysis of each paper and their findings and afterwards, the coping methods were categorized.

3. Results

One purpose of this study was to identify techniques Black people in racialized environments most commonly use to cope with racism, as explored in the available published literature. In total, 25 relevant articles were identified [24–48]. Of these, 19 studies were quantitative and 6 were qualitative. Most studies reported more than one strategy, with a total yield of 58 coping strategies overall. All were about Black Americans, except one (Black Canadians), and as such the resulting findings most reliably relate to Black American approaches for racism in the US.

3.1 Different types of coping

Although social support and religion were mentioned most often, there is variability when it comes to the other coping mechanisms used. Strategies that were presented for Black Americans included disengagement [27, 35, 36], avoidance [28, 31, 34], rumination [30, 31], direct strategies [37, 43, 45], emotion-focused coping [28, 40], Africultural coping [33, 34], venting [24], and mindfulness [26]. The full list can be found in **Table 1**, which presents an overview of the coping strategies described in the articles reviewed.

We found that the choice of strategies varies depending on the type of racist experience that occurs. The three different types of racism that were recognized in the studies in this review are institutional, cultural, and interpersonal (or individual) as shown in **Figure 1**. Four of the 25 articles highlighted differences in the responses to one or all three of the types of racism. Relating to institutional racism, a combination of different strategies were used: problem-solving [33] and active strategies [47]. When facing cultural racism, collective coping, problem-solving and social support were utilized [46].

For interpersonal racism, spiritual-centered coping strategies were specifically emphasized. Moreover, a few articles identified gender differences within responses to different forms of racism. In regards to interpersonal or individual racism, African American women prefer using avoidance strategies [46]. Lewis-Coles and Constantine [34] found that for institutional racism, African American women tend to utilize cognitive-emotional debriefing, spiritual-centered strategies, and collective coping strategies. For cultural racism, African American men preferred collective coping strategies, which refer to social support from friends, family and community members [34].

Avoidance (3) <ul style="list-style-type: none"> • Disengagement (3), Not responding (1) Africultural coping (2) • Cognitive-emotional debriefing (2), Collective coping (1) Active coping (4) • Working harder (1), Active anger (1), Physical activity (1) Direct strategies (3) • Speaking out (1), Confrontation (1), Educating White people (2) 	Rumination (2) <ul style="list-style-type: none"> Problem-focused coping (4) • Social support (7), Problem-solving (1), Planning (2), Instrumental support (1) Emotion-focused coping (2) • Positive reframing (1), Mindfulness (1), Venting (1), Self-blame (1), Processing the event (1), Religion/ Spirituality (5), Acceptance (1) Substance Use (2) Humor (1)
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Note: Many of the coping strategies identified are a part of a larger coping category. These subcategories are found underneath the main coping mechanism. The numbers in parentheses represents the number of papers that mentioned the specific coping strategy.

Table 1.
List of coping strategies used by black people when responding to racism.

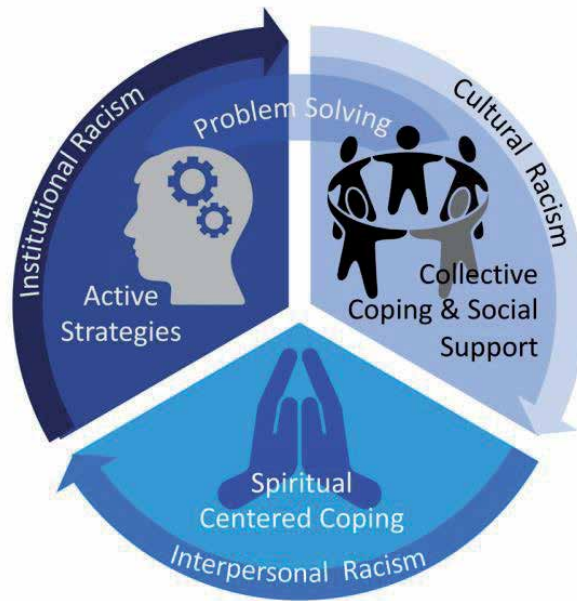


Figure 1.
Coping strategies model. The major categories of racism are depicted as a linked circle. Strategies used by black individuals are utilized preferentially in a specific way to cope with each of the three identified types of racism.

Although the identified articles demonstrate how universal many coping mechanisms are for Black Americans, there was little discussion on their efficacy as tools to combat racial stress and trauma. Understanding that different forms of coping are habitually used for specific types of stressors could be useful for designing experiments which can inform researchers about which of these types of responses are most efficacious in which situations. This knowledge can then be used to better support interventions to address racial trauma.

3.2 Similarities across genders

Many similarities were found when examining the literature on coping in Black people. Most researchers found that Black Americans use a variety of strategies to respond to racism [24, 25, 28, 31–34, 36, 37, 43, 44, 46, 47]. Although these papers do not mention the same list of strategies, it is important to consider trends that reoccur within the articles when they are examined in detail. Multiple studies show that Black Americans use social support, religion, and problem-focused coping to respond to experiences of racism. Seven studies described social support mechanisms [29, 33, 34, 36, 42, 46, 47], five studies discussed religion [24, 27, 33, 34, 36], and four described problem-focused coping [27, 28, 33, 40]. In addition, there were similar interpretations of the efficacy and utilizations of these strategies. For example, social support referred to talking with friends, family and/or support groups such as alcoholics anonymous. Religion involved prayer, going to church, and spirituality. Whereas problem-focused coping describes active efforts an individual will make to directly confront the stressor in order to reduce, eliminate or modify it [49].

3.3 Black women

Many of the studies that were relevant for this review had a focus on the strategies employed specifically by Black American women, and they show prominent

gender differences when examining the broader question of Black people’s responses to racism. For example, Black women were most likely to seek social support as a response to experiencing racism. There were seven articles that demonstrated this behavior [24, 34, 43–47]. The authors in these studies explain that Black women will rely on friends and family to discuss racist the incidents for validation and support [43].

The coping behavior that was next most frequently seen among Black American women was religion or spirituality, noted in five studies [24, 25, 34, 43, 44]. As mentioned above, this response can refer to praying or going to church. For participants in Spates’ (2019) study, for example, religion/spirituality helped Black women to be optimistic despite hardships.

Other types of strategies that were observed in Black women were “overt strategies”, mentioned in three studies [37, 43, 44]. This is an umbrella term that signifies observable behaviors or responses such as confronting or speaking out [50]. In Pittman [37], female faculty depended on assertive actions to respond to classroom racial stressors, for example one Black professor described speaking up for herself after a White student threw paper at her. Similarly, Black women in Spates et al.’s [44] study women used overt strategies such as calling out discriminatory behavior. A participant in Shorter-Gooden’s [43] study actively fought back by filing a complaint against the officer after an experience of police abuse.

Additionally, “covert strategies” were also observed, which are intrapersonal actions unobservable by others [51]. In Spates et al. [44], some of the Black women participants described making an effort to blend in and not stand out to avoid racism by attempting to assimilate. Black American women will often adjust their behaviors and roles to reduce the amount of racialized stress they face [52]. Additionally, avoidance strategies were identified among Black women in four studies [34, 43, 46, 48]. This includes avoiding stressors instead of becoming actively involved with them and also includes minimizing or denying these experiences [53]. The cognitive-emotional debriefing coping style is an avoidance strategy that was identified in one of the studies. This strategy entails forgetting about the situation, minimizing the negative aspects of the situation, or engaging in distracting activities [48]. This study further explains that when more gendered racism is experienced by a Black woman, it will lead to more distress and more engagement in cognitive-emotional debriefing coping [48].

In sum, Black women in America are most likely to use a variety of strategies to cope with racism, the most common being social support and faith-based strategies, which is similar to American Black people in general, along with a combination

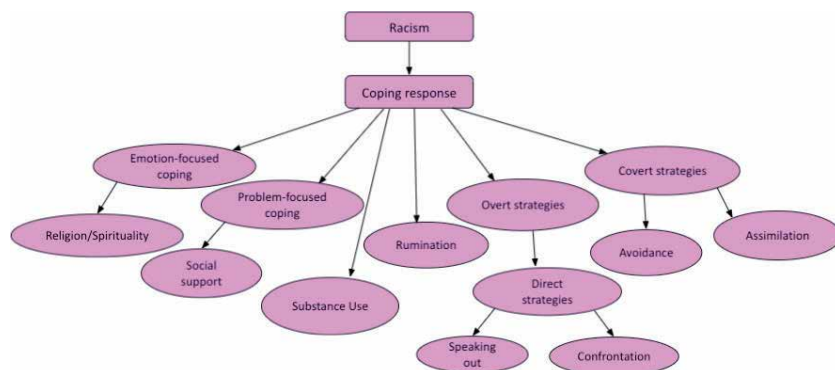


Figure 2. A model of American black Women’s coping responses to racism. Note: The main coping categories are found under ‘coping response’. The specific coping strategies (subcategories) are listed below these.

of overt and covert strategies. **Figure 2** displays all of the coping strategies that are used by Black women when responding to racism based on the findings of the articles in this review.

3.4 Black men

As opposed to the literature detailing the coping mechanisms for African American women, there are no similar tendencies one can draw in the responses to racism for African American men. The findings specific to men were much more diverse. These strategies included seeking social support [32], active anger [38], substance use for instance alcohol and drugs [25, 32], planning [24], religion [32, 34], not responding [45], active coping and acceptance [24]. Consistent with the overall category of African Americans, for Black men, there seems to be a lack of common consensus on the frequency or efficacy of which responses are most prevalent. Therefore, it is difficult to say with certainty the most common or effective strategy utilized by American Black men to cope with racist incidents. However, as with African American women, African American men will also use a variety of coping strategies when responding to racism. These coping strategies are captured in **Figure 3**.

3.5 Functional versus dysfunctional coping

Some methods of coping with racism are more functional than others. How to define functionality depends on if the goal is to end the distress caused by racist acts or if the goal is to stop more racism from occurring in the future, which may increase distress in the short term but result in greater well-being in the long run. Although stopping distress in the short term may have a more immediate impact on the victim's emotional state, behaviors that will be effective in stopping racism rather than simply coping with it, may also constitute a more altruistic means of coping and contribute to the ultimate goal of eradicating racism and facilitating anti-racist structures.

Coping strategies for racism can be divided into two distinct categories. Emotion-focused coping and problem-focused coping, both of which prove valuable in different ways. As exemplified in the study by Plummer and Slane [40], emotion-focused coping (as opposed to problem focused coping) refers to efforts an individual makes to reduce emotional consequences of stressful experiences [49]. Emotion-focused coping methods include mindfulness, positive reframing,

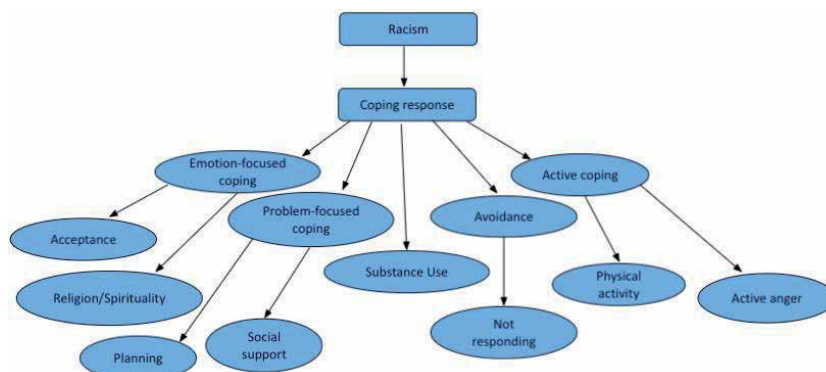


Figure 3. A model of American black Men's coping responses to racism. Note: The main coping categories are found under 'coping response'. The specific coping strategies (subcategories) are listed below these.

venting, acceptance and processing the event. Complementarily, problem-focused coping refers to active efforts an individual will make to directly confront the stressor in order to reduce, eliminate or modify it. Problem-focused coping methods can be harmful or helpful and can include actions as diverse as speaking-out, confrontation or self-blame and substance abuse.

3.5.1 Dysfunctional coping

Despite widespread use, numerous coping strategies, both problem-based and emotion-based, can prove to be harmful to individuals in terms of psychosocial functioning, resulting in further dysfunction in the given individual. Dysfunctional coping approaches include overworking which can cause physical ailments [54, 55], disengagement and rumination which leads to or is a product of depression [56, 57], avoidance strategies which increase anxiety in the long term [58], positive reframing and self-blame which only increases denial and can lead to internalized racism and depression [59] and substance use which can lead to health problems and dependence [22].

3.5.2 Ambiguous coping

Many coping strategies may be helpful or detrimental to individuals depending on how they are used. Positive humor can be an effective form of emotion regulation for negative emotions as it helps facilitate reappraisal. However, negative humor may create too much emotional distance from the experience, and lead to disillusionment and cynicism [60].

Non-responsiveness as another example of an ambiguous coping mechanism can be an essential survival mechanism for Black Americans. By not responding and thereby avoiding escalation, a person can evade negative and potentially dangerous confrontations that can often trigger or even traumatize (e.g., [61]). However, this type of coping can cause an individual's racial trauma to become internalized which can lead to depression, self-hatred, and repressed anger that may surface in unhealthy and even self-destructive ways.

Confrontation coping can help lead to good outcomes as it allows for agency and can be helpful in eradicating feelings of powerlessness [62]. However, it can become dangerous in cases where confrontation leads to an increased risk of persecution or retaliation from others [63, 64]. Anger is a natural response to being wronged, and it can motivate people to make important changes. But active anger can lead to impulsive actions or words which are violent or emotionally abusive.

Finally, while acceptance and mindfulness may at first glance seem to be positive strategies for coping, because they present a mechanism to accept the emotions elicited by a racist event and reduce distress [26, 65], they can be potentially unhelpful if they result in acceptance of repetitive racist mistreatment and facilitate continued exposure to racism, that can then lead to racial trauma [10, 66].

3.5.3 Functional coping

Several of the coping strategies identified in this review have been found to be beneficial for individuals to help them cope with life stressors in general including for physical pain [67]. Starting with the least active strategy, planning as a response to racism is a method of preparing for the emotional pain of racism by actively strategizing how to cope with a future event. Research has started to demonstrate that the anticipation of a future racial incident might cause people of color to start coping prior to the situation, in order to limit the impacts of this stressor [68, 69].

The act of venting is more active and refers to a primarily verbal action of speaking to oneself or others emotionally about an event which has occurred in the past. This action externalizes the experience and provides an opportunity to process a racist event in a more tangible way than simply thinking or planning around it.

One of the most successful and healthy coping mechanisms used to combat the stress of racism is social support, which is also very effective and more active than venting and planning [70]. Social safety networks and communities of most any kind provide a way to self-express, obtain feedback, take agency, gain validation, and develop resilience. However, most importantly, social networks provide positive affirmation, which is deeply therapeutic in the face of racialized invalidation [71].

Religious practice is the most frequently used and one of the more active coping mechanisms, and as we have seen, among women specifically. Religion can provide a more expansive, firmly rooted perspective on self identity and one's place in the world. Religion also pairs the positive affirmation of identity with the concept of transformative meaning in suffering, such as from racist events. Transformative meaning, a type of positive reframing, is the concept that negative, even traumatic events can be meaningful when understood as a growth and learning experience [72, 73].

3.6 Eliminating racism and empowerment

Many coping strategies that may be personally helpful in the short term may not be effective for eliminating racism in the long term. Real social change will require an investment in strategies that cause racist acts to happen less often and dismantle structural racism. Understanding the source, history and nature of racism in the United States and how it functions is a prerequisite for addressing Black stress related to racism, since it can be difficult to theorize about solutions when the core nature of the problem is unseen or misunderstood. Black people will be best equipped to cope with racism when they understand the nature of racism, feel secure in their identity, and are prepared to address racism as it arises in the moment. As such, strong personal agency can be therapeutic in the face of racism. When a person can make a reasoned choice as to how they would like to respond to racism in the moment, it empowers them by providing more control over the discriminatory experiences they face.

Educating others about racism is a type of direct approach that can be an effective coping strategy that can help eliminate racism by reducing the overall level of racism in the community. As people understand how they commit racist acts, this awareness allows them to more easily make antiracist choices.

Empowerment enables people of color to move toward eliminating racism, which will ultimately lead to positive social change as racism becomes less acceptable and society becomes more equitable. Making a meaningful contribution to anti-racist / pro-justice causes around issues of structural racism can be a coping act of agency and self-affirmation [74]. For Black people with racial stress and trauma, healing and helpful coping strategies with benefits to both the individual and the community will result in better outcomes [74, 75] than using other types of coping strategies.

4. Discussion

4.1 Future directions

After completing this review of the literature, it is apparent that there are still gaps in our understanding of the role of emotional regulation and coping as strategies for Black people facing racism. All of the articles in this review are based on

American samples, with the exception of Joseph and Kuo's [33] study focused on Black Canadians. Sex and gender were conflated in this study, since the papers reviewed generally did not report these separately. Additionally, there is a lack of research that concentrates on the responses of Black sexual and gender minorities or those with intersectional identities other than gender. While researching for this paper, very few articles reviewed took into account the unique experience of living with multiple stigmatized identities. For example, the manner in which queer African Americans face racism may differ from approaches used by cis-heterosexual African Americans, and consequently, this would be important to explore and to compare.

Children were not included in this review. As evidenced by our literature search, there does exist some scholarly work focused on African American children's responses to racism which could be of value to understanding racism-related coping across the developmental lifespan. Further, not all online journal databases were utilized for this literature review so it is possible that some relevant articles and findings might be missing from this review and could have been excluded during the article review phases. Lastly, the effectiveness of the coping strategies Black people use to cope with racism was not explored in any study. Future research should examine the efficacy of these responses.

5. Conclusion

Black Americans make use of a variety of coping strategies to respond to racism. These usually include problem-focused coping strategies such as social support and emotion-focused coping strategies like religion/spirituality. Gender differences exist in this response as Black American women tend to prioritize social support as well as religion/spirituality to cope. Also, similarities can be found between how Black Americans cope with physical and emotional stress. As presented in this paper, people typically rely on active strategies when coping with racism, and active strategies mitigate the loss of agency which is a hallmark of racism. Approaches to racism should deemphasize avoidance to synergize with successful coping strategies already being used by the Black community.

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Conflicts of interest

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Perspective Chapter: Cultivating Environments of Belonging in Psychiatry, Clinical Psychology and the Allied Mental Health Fields

Felicia Lazaridou and Andreas Heinz

Abstract

Mental health science as a field of research, education and care practices has a fundamental role to play in mitigating the costs of racism for affected communities. The development and the implementation of solutions, such as *gaining perspective*, *encouraging mentorship* and *finding empowerment*, can only meaningfully occur through the involvement of lived experience expertise. Notably, as a first step, the inclusion of such expertise at a structural level would require the cultivation of environments of belonging in psychiatry, clinical psychology and the allied mental health fields for students racialised as Black and Of Colour. Black Lives Matter, as a specific political movement, articulates a critique of how certain subjectivities and identities belong more naturally in spaces of knowledge and power such as universities. This chapter reflects on belonging as a ‘feeling of mattering’ and a contemporary politics. It is argued that the possibility to facilitate the effective elimination of structural racism in mental health science requires the cultivation of environments of belonging at an institutional level causing greater inclusivity and enjoyment for Black students and students Of Colour in ‘liberated learning spaces’. A clear, actionable path to create environments of belonging to help resolve structural racism is outlined.

Keywords: racism, mental health science, decoloniality, interculturalism, belonging

1. Introduction

As people struggle with the social instabilities and stress-filled emotions necessitated by COVID-19, the pandemic has produced a significant need for mental health care [1]. Racism and the pandemic are a double burden of stress for racialised groups [2]. On the one hand, racism-induced distress and fear can increase the risk of negative mental health outcomes for those affected by COVID-19 [3]. Distress and fear over COVID-19, on the other hand, can additionally increase the risk of negative mental health outcomes for persons who are affected by racism [4]. The murder of George Floyd at the start of the pandemic heightened public awareness of racialised people’s experiences with racism [5]. Meanwhile, George Floyd’s murder also heightened racialised people’s anxiety and fear of racism. Moreover, keep in

mind that George Floyd was only the catalyst. Police brutality, as one format of structural racism, has been and continues to be a problem. Several social campaigns, including #SayHisName, #SayHerName, and #SayTheirNames, have attempted to raise awareness of the issue's scope [6, 7].

In Germany, the pandemic began at a time when there was an exceptional public interest in the problem of racism, following the murders at the Halle synagogue and the Hanau shisha bars, in which Jewish and Muslim persons were the victims of violent anti-Semitic and racist attacks [8]. Vicarious racism is a term used to describe when people are indirectly exposed to violently racist incidents, such as in the media [9]. Although vicarious racism does not pose a direct threat, evidence suggests that the anguish and terror induced by it are associated with unfavourable mental health outcomes [10, 11]. Throughout the pandemic, racism has been a societal stressor. Not to mention that the pandemic is associated with increased instances of interpersonal racism for many racialised groups, particularly against people of Asian descent [12]. For people from India, the United Kingdom, South Africa, and Brazil, the pandemic has also become linked to a higher risk of interpersonal discrimination because of unintended public stigma caused by the identification of various variations. In an attempt to eliminate discrimination, the World Health Organisation has altered the naming system to remove associations with the regions where they originated and has replaced them with Greek alphabet letters. The Indian variant (B.1.617.2) is now called Delta. The UK variant (B.1.1.7) is now called Alpha. The South African variant (B.1.351) is now called Beta. And the Brazilian variant (P.1) is now called Gamma [13].

The COVID-19 pandemic has brought to light several issues relating to structural racism and mental health, including the impact of pre-existing racism-induced disparities in rates of diagnosable mental illness as well as shortages in mental health care allocations [14]. These disparities are becoming exacerbated by infection containment strategies [15]. The fact that the pandemic is amplifying racism-induced disparities, rather than causing them in and of itself, emphasises the importance of reflecting upon how structural racism in society and in the mental health system perpetuates disparities. We recommend implementing decolonial intercultural competency into culture and migration mental health and prioritising the provision of emotional safety in services focused on (a) the ability to recognise social identities, socio-cultural formations, and essential humanity, as well as the ability to engage a decolonial approach when it comes to over-pathologising/under-pathologising variances in racism-induced difficulties, (b) the ability to strengthen the capacity of Black people and People of Colour to achieve the greatest possible gains at the lowest possible cost in terms of social efficacy and quality of life and well-being, and (c) the ability to respect each human being's intrinsic human dignity as a person, including his or her social and cultural history, regardless of developmental stage, existential state, or other extrinsic circumstances.

2. The racism-induced reactive negative emotionality cycle

The mental health of Black people and People of Colour is negatively impacted by a double exposure to vicarious racism and interpersonal racism, which is occurring in the context of ongoing societal pandemic stress and instability. Racism is a set of harmful events that occur due to racist attackers ascribing derogatory views to racialised aspects of the victims' personhood, such as their name and skin colour [16]. Racism sends the message to victims that their racialised characteristics prevent them from fully participating in the microcosm. A microcosm is a group

of people, an area, or a situation. Racism on the streets sends the message that they and their racialised attributes do not belong in the district or city, but racism at schools or universities sends the message that they and their racialised attributes do not belong in the classroom, for example. Sociologists have defined the emotionality of social and political belonging as an overarching positive feeling of affinity to the microcosm [17]. Similarly, and in contrast, the sense of not belonging is the conclusion of a slew of destructive emotions triggered by racism.

These reactive emotions can evolve into proactive emotions in the future. However, victims may become engulfed in a racism-induced reactive negative emotionality cycle in the first instance (see **Figure 1**). The psychological strains experienced by people within various intersecting systems of oppression and inequity increase their susceptibility to poor mental health outcomes that accumulate over time, according to social stress process models like the Immigrant Risk Model [18] and the Minority Stress Model [19]. Racism is one of the most pressing societal phenomena for mental health practitioners to increase knowledge about in the context of migration and culture. Racialised people's vulnerabilities to various injustices in their daily lives and the unresolved anger and bitter disappointment surrounding these racist experiences may act as precipitating factors for emotional alienation and further perpetuating factors for poor mental health [1, 20]. Through an intersectionality lens, understanding the emotional impact of racism allows us to realise the complexity of dynamic lived experiences under changing situations. For example, in mental health counselling, it is not about who has more or less racism in their lived experiences, but rather how racism is experienced qualitatively due to the junction of other ascribed social identities and the differential allocation of/access to resources that may make racism easier to handle [21].

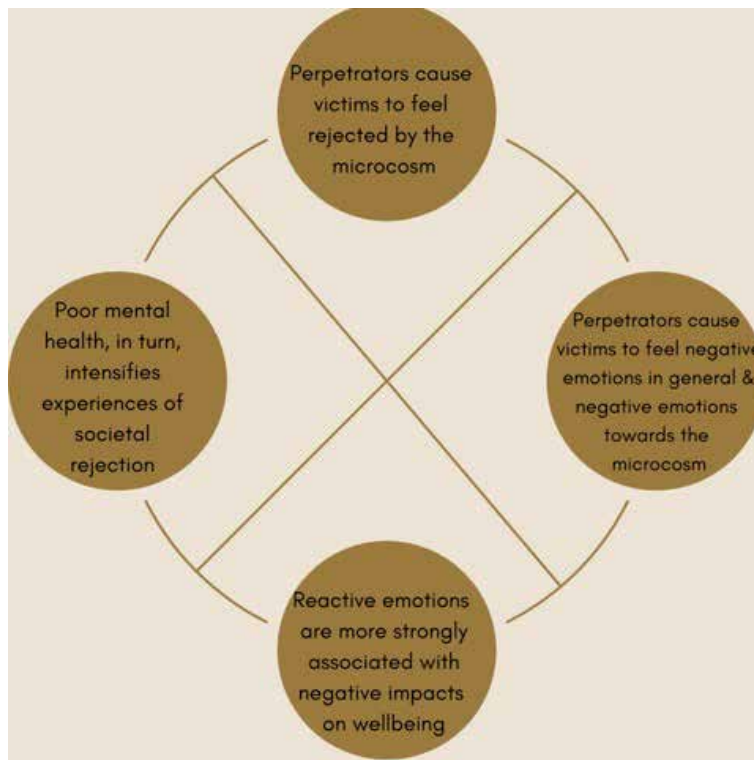


Figure 1.
The racism-induced reactive negative emotionality cycle.

In recent years, the usefulness of intercultural competency in overcoming racism in patient-professional communication and treatment provision has received some attention in the transcultural mental health discourse [22]. The phrase ‘intercultural competency’ is sometimes used interchangeably in the literature with terms like ‘multicultural competency’, ‘cross-cultural competency’ and ‘transcultural competency’. In so doing, interculturalists may draw upon philosophical tenets of interculturalism to provide a standard that aims to concretely centre the intrinsic human dignity of each human being as a complete person, including his or her background, regardless of developmental stage, existential condition, or other extrinsic considerations in patient-professional interactions [23]. Bhiku Parekh [24] describes interculturalism as,

“[the]cultural embeddedness of human beings, the inescapability and desirability of cultural diversity and intercultural dialogue, and the internal plurality of each culture...to illuminate the insights and expose the limitations of others and create...a vital in-between space, a kind of immanent transcendentalism, from which to arrive at a less culture-bound vision of human life and a radically critical perspective”.

(p 338–339).

Interculturalists have developed a plethora of best-practice guidelines for practical intercultural competency (e.g., [25–32]). Decolonial interculturalists conceptualise intercultural competence as two broad steps, notwithstanding the intricacy of many of these frameworks. On a structural level, the first step is to recognise the underlying fact of ethnocentrism in terms of the values and patterns of behaviour embedded throughout the depth and breadth of Western mental health science, including institutionalised practices and governance [33]. The second is a greater engagement with Black Lives Matter’s ‘embodied feeling’ to integrate non-Western worldviews, thereby facilitating the successful elimination of structural racism throughout Western mental health science [34].

3. Structural racism is structural exclusion from the priorities of intercultural concern.

Racism and other forms of stigmatisation in Western mental health systems creates delays and failures in access via self-stigmatisation [11, 35]. Actual and perceived structural racism exists throughout the depth and breadth of national political-cultural traditions and institutions, so racialised people do not necessarily expect to be humanised by mental health practitioners who are, for the most part, seen as one separable dimension in a *white* matrix of domination [36]. Research suggests that racism is associated with a lack of trust and satisfaction with services provided, as well as a lack of willingness to engage in the first instance and reduced adherence to recommended prescriptions [37, 38]. This *white* matrix of domination, according to Bell Hooks (quoted in Hill-Collins [39], p. 222), refers to.

“the ideological ground that they share, which is a belief in domination, and a belief in the notions of superior and inferior, which are components of all of those systems. For me it’s like a house, they share the foundation, but the foundation is the ideological beliefs around which notions of domination are constructed.”

The mental health system is just one system of many in which we live, all of whom have become constructed over time within a *white* politics of domination, which *white* society established, sustains, and condones [40]. As such, our systems

have been formed and continue to be maintained by an ethnocentric dominance structure that makes *whiteness* the default standard against which all racialised groups are contrasted [41]. It is in this juxtaposition that *whiteness* dismisses decolonial equality, diversity, and inclusion [42]. Black mental health professionals speak about an ‘unspoken level of comfort’ when it comes to connecting with the “anger of exclusion, of unquestioned privilege, of racialised distortions, of silence, ill-use, stereotyping, defensiveness, misnaming, betrayal and co-option” [43] that their Black patients bring to therapy sessions [44]. Black patients and Of Colour patients speak about how *white* privilege overrides good intentions in theory with *white* mental professionals and creates a lack of willingness to engage further about the topic of racism [45].

When it comes to clinical care, racialised patients want to be seen and treated by therapists who recognise their humanity, presence, and spirituality in all their diversity. Mental health professionals racialised Black and Of Colour make up a disproportionately small percentage of the workforce [32]. With the current emphasis on the value of lived experience expertise and the potential for including it throughout the research process, it should be clear that therapists who are racialised as Black and Of Colour are, to some extent, lived experience experts when it comes to the topic of racism. Many mental health professionals are positioning Black Lives Matter as a framework for supporting Black and Brown patients by focusing on reversing the impact of traumatic historical and current racism on mental health [22, 46, 47]. However, often this position is met with benevolent racism [48]. Such as the assertion that care provided by professionally competent *white* practitioners in racism-insensitive, non-diverse teams should be good enough to treat the kaleidoscopic origins, episodes, and expressions induced by racism, as well as the needs of racialised patients despite gaps that patients themselves have voiced. Recognition of socio-cultural formations - fundamental humanity - alongside an ability to give voice to patients is a crucial tenet of decolonial intercultural competency [49]. Kivel [50] describes a critical approach to intercultural competency as.

“...realizing the limits of your understanding. It should make you less arrogant and more humble. It should provide you with skills for promoting the leadership of those from the cultures in which you are competent. As we become more multiculturally competent, we increase our effectiveness in working with diverse populations, but we cannot substitute for people who are experts in their own culture”.

A decolonial framework of workplace belonging tries to comprehend group identification negotiations and how racism on various levels links with broader discriminatory experiences in the workplace [51]. Furthermore, more specifically, these cumulative experiences function as conditions of saturated disadvantage, negatively affecting workplace relationships, productivity, and mental health [52]. Romero’s [53] Rubik’s cube metaphor can help further to understand the relationship between several layers of racist encounters and compounded risk of having unfavourable mental health effects (**Figure 2**). In its entirety, the Rubik’s cube depicts the macrocosm of belonging (e.g., to Germany). Each of the Rubik’s cube’s 21 separable cubes represents a microcosm of belonging (e.g., to the city, to work, to a generation, to community and to family). Each face of a microcosm of belonging is assigned a colour representing an ascribed social identity (for example, orange represents racialised identity, blue represents gender identity, *white* represents socioeconomic status, yellow represents national identity, green represents age identity, and red represents sexual identity). A privilege-disadvantage continuum and a superiority-inferiority hierarchy exist inside each ascribed social identity (**Figure 2**). The privilege-disadvantage

Romero's (2018) Rubik's Cube Metaphor

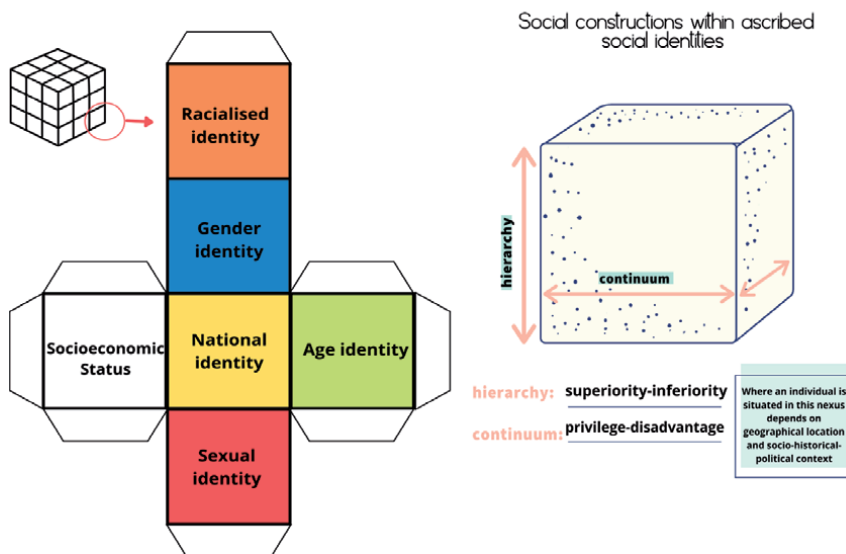


Figure 2.
One microcosm of belonging situated with the macrocosm.

continuum refers to the structural advantage that one group gains over another by systemic exploitation, which one group continues to benefit from to the exclusion of another group who is structurally disadvantaged due to a lack of access to the same possibilities [54]. The inferiority-superiority hierarchy describes how one group is treated by another group in terms of importance, as well as the dominant group's control over the subordinate group [55]. The geographical location and socio-historical-political context determine where an individual fits inside this nexus (**Figure 2**).

The meaning and expression of privileges and penalties intersecting across and within networks of probable social inequalities have sparked increased intellectual understanding among political allies who have chosen to stand together in solidarity in new geopolitical settings [56]. These profound forms of solidarity are not, however, indestructible: these relationships of compassion and understanding need constant care and attention to be maintained [57]. Racialised immigrants and refugees in European cultures have expressed frustrations surrounding the 'potential space' between embodied phenomenological experiences of racism and theoretical comprehension of racism [58, 59].

Many interculturalists (also known as 'white political allies') are embarking on self-reflection journeys to find ways to bridge the socially constructed 'us vs them potential space', thereby contributing to unity rather than antagonising tensions [60, 61]. However, there is a growing sense of dissatisfaction among racialised people who become burdened with teaching would-be interculturalists about racism without the appropriate infrastructure to support the duty [62]. Racialised patients describe having to teach their intercultural therapists in mental health services about their lived experiences of racism, with little assurance that their testimonies will be deemed reliable [63]. They describe how exhausting it is to explain one's existence at a first point, especially to those who cannot connect fully with the lived body of knowledge, suffering, and struggle [36].

An emerging generation of racialised Black and Of Colour young people have begun to articulate why it is far less stressful to communicate about racism among

people who share the lived essence of these experiences [64]. Patients who need to talk about racism often prefer to talk to racialised mental health providers because they have genuine, on-the-ground information [65]. Having a preference is not to suggest that *white* mental health practitioners cannot learn to work sensitively with people for whom racism has caused them harm [66, 67]. Many *white* practitioners, particularly those working from an intersectional perspective, are learning that the success of an intercultural competency movement in mental health related to racism relies upon their willingness and ability to embark on a journey of self-reflexivity [68]. Amid all these consciousness-building processes, however, it is argued by the decoloniality movement that intercultural competency as a tool for disrupting systemic violence and eliminating racism lost its utility because interculturalists have not gone far enough to question mental health sciences' dominant epistemology, ethnocentrism.

4. Ethnocentrism: western mental health science's dominant epistemology

The international resonance of the Black Lives Matter movement, and in Germany, the racist attacks in Halle and Hanau, have revived longstanding arguments concerning the negotiation of solidarities and the diversity of racist definitions [69]. For some, racism is a worldwide phenomenon in the sense that identical patterns of institutionalised racism are found around the world; others would, on the other hand, say that specific forms of racism are the result of historical disparities and political forces in the context of racism [70, 71]. The need for contextualisation is one of the reasons why some prefer to use the term racisms rather than racism to imply diversity rather than uniformity [72–75]. In an era of digitalisation in media, communication, and information technology, one of the consequences of the COVID-19 pandemic is that our world and societies are becoming even more rapidly submerged in a level of interconnectedness that we have never been accustomed to, and for which there is no precedent [76, 77]. As history unfolds before us, for some, it is clear that the dominant ideology of the Western World monopolises the context of geopolitical power dynamics, including the cultural fluidity of lifestyles, health and well-being pursuits, ethics and spirituality in the non-Western World [78]. Because history is time in motion, culture is in flux. Within this monopoly, socio-political systems conceived in the Western World form a Euro-American macro-culture that continues to invalidate indigenous epistemologies in non-Western World countries. The history and continuing system of mental health theory and care is one example of one such monopolisation.

With the mental health of African heritage patients as an example, African psychology matters in the examination and reconciliation of the time, space, and body - of lived knowledge in the African Lifeworld - to achieve psychological equilibrium [79]. African colonial education transports socio-political systems of thinking conceived in Europe and Europeanised America to communities in the Majority World, where they may have little relevance [80]. Elements of such Western approaches became invented for a more efficient teamwork approach to exploiting landscapes, agricultural harvests, and precious resources in other parts of the world to benefit the 'elite' Minority against the well-being of the 'second-class' Majority. As such, "the blood that has dried in its codes" legacy refers to the history of racism and colonial brutality that Western mental health science is rooted in ([81], p. 56). The erasure of socio-political systems of African thinking such as indigenous repertoires including preparationism, functionalism, communalism, perennialism and holicism is contributing to a sizeable gap between actual economic growth, human development

trajectories and the predictions made by human capital theory (cited in [82], p. 25; [83]). The canonisation of only *white* (political) intellectual achievements and the curating of reading lists containing only *white* knowledge and knowers, which can make the study of Western mental health science seem irrelevant for many racialised students, does not happen by chance: it is a deliberate move by those who benefit from this epistemological injustice [84].

In Western mental health science, ethnocentrism contributes racialised, gendered, and classed binaries of between-group cultural difference such as “native/migrant”, which are used to measure and explain harmful “us/them” comparisons of the human psyche, self-concept, and personhood (e.g., [33, 85–90]). Structural racism persists due to mental health service’s failure to recognise and confront its existence and causes through policy, example, and leadership openly and sufficiently. Racism can become entrenched in a mental health service’s ethos or culture if it is not recognised and addressed [33]. Thus, structural racism in Western mental health science reflects the occupational culture historically delineating the geopolitical “zone-of-being” bestowed upon the subjectivities, epistemologies, and identities emanating from Europeans and Europeanised Americans that these disciplines are built around (see [91]). In contrast to the geopolitical “zone-of-non-being” ascribed to all racialised Others “born with less” - if any at all - access to environmental resources and quality, material capabilities, and domestic/international socio-political power; thus, their subjectivities, epistemologies, and identities dubbed “primitive”, “inferior” and “uncivilised” are erased [92–95]. Furthermore, eliminating structural racism is to eliminate *white* societal investment in sustaining power disparities, both individually and collectively [96–99].

Influenced by the discourse of postcolonial scholars such as Frantz Fanon (1925–1961) [100–104], Edward Said (1935–2003) [98], and Gayatri Chakravorty Spivak, Ake [105] argues, like Fernando [33], that the dominant European epistemology underpinning social science - that is, the ethnocentrism of scientific knowledge - is the most pernicious form of structural racism [106–108]. According to Ake [105], the Western social sciences comprise a bourgeois ideology meant to serve capitalism principles and institutions, resulting in the capitalistic underdevelopment of non-Western communities [107]. Theorising decoloniality as an antidote to ethnocentrism, Bulhan [109], in a similar vein, argues that the dominant European epistemology of Western mental health science is a neo-colonial strategy that ignores the diversity of social and cultural variants, as well as their local meanings. In contrast to decolonial perspectives on the human psyche, self-concept and personhood, Western mental health science implants Eurocentric ‘universal’ scientific truths onto judgements of postcolonial people, postcolonial land and postcolonial states and societies [110]. It was, moreover, colonising non-Western people and penalising them for not fulfilling Western master narrative expectations [111]. International diagnostic criteria developed in the Western model of mental health are the epitome of stated Western master narrative [109–112]. In the current systems of diagnostic classifications, it is vital to know what constitutes ‘normal’ social behaviour and moral philosophical consciousness in each community context when using diagnostic criteria, as even supposedly objective disease criteria are defined with respect to social norms (for a criticism see Heinz [113]).

As Mfutso-Bengo [114] puts it, the continual ‘push-and-pull’ or finding an ethical balance between moral absolutism and moral relativism, presents awareness of social constructionism as a duty of care in therapists’ virtuous decision-making processes. Ethical balance orchestrates bridging capital for inclusive and intersectional links across approaches to ‘normality’ and ‘abnormality’, ‘health’ and ‘sicknesses’, and the sanctity of decolonial humanism and human rights [115–123]. The Azibo Nosology II (ANII) is an example of a classification scheme for the mental

health of people of African heritage that is based on African cultural knowledge and traditions, as well as and on the understanding that the curriculum and pedagogy of Western diagnostic manuals are hegemonic. Moreover, that the learned helplessness that results in the internalisation of epistemological injustice has harmful mental health consequences [124]. Some writers argue that Azibo [124], rather than DSM or ICD, provides a more culturally suitable diagnostic system for people of African heritage [125]. Local non-Western knowledge should be appreciated, but relativists should be wary of assuming that all local values must be honoured. Azibo's [124] nosology includes some misogynistic terms for women who have multiple lovers, as well as many other problematic categories including sexual misorientation and unwillingness to procreate.

When practitioners see mental health problems as arising from local socio-political contexts rather than from individual intrapsychic malfunctions, ethical balance is achieved [126]. For people of African heritage, these local contexts contain regional versions of systems of dominance such as racism, sexism, homophobia, ableism, and transphobia, as a reading of Azibo [124] would clearly point out. However, such approaches are rarely reflected upon in the currently dominant classification systems. Although the globalised Western nomenclature's science of praxis clearly has its origins in Europe and Europeanised America, European ethnocentric concepts have been widely and uncritically adopted in intercultural therapy with non-Western patients because they are believed to have universal applicability and philosophical value [85]. Improving diagnostic accuracy requires an ethical-political framework within which socio-cultural formations of moralised reasonings are deliberated upon to reach a consensus on what constitutes a clinically relevant mental illness for a patient and what are sickness-related social consequences within his/her/their system of community values as part of efforts to strive for more beneficence, nonmaleficence, and justice [127, 128].

5. Attending to Western mental health sciences' existential crisis

Even many interculturalists are concerned about the influx of non-Western migrants into Western civilisation. In 2015, the media began to report on a significant surge of migration throughout Europe because of, to quote Crastathis and colleagues, "...the accelerated conditions of war and state violence, which are inextricable from globalised capitalism, histories of colonialism, and contemporary imperialism" (p. 4) [34]. This particular influx of migrants and refugees was dubbed 'The Refugee Crisis' by the media. In Germany, Chancellor Angela Merkel's decision to extend an open-door policy was praiseworthy. Many people in many sections of German society exhibited welcoming, altruistic behaviour and attitudes. Meanwhile, *white* nationalist groups like The National Socialist Underground have already carried a series of racist murders of Persons of Colour, the Islamophobic Pegida movement gained popularity, and the rightist party Alternative für Deutschland (AfD) gained political ground in parliament [129, 130]. The emotive term 'crisis' in forced migration is not peculiar to this migration trend. Robinson questioned the term's use already in his 1995 article *The Changing Nature and European Perceptions of Europe's Refugee Crisis*. He believes that framing the concept of 'crisis' in the context of migration builds Europe up as the 'centre' of an imagined sanctuary, allowing European governments to enact draconian political control techniques under the guise of 'required security' [131, 132].

With this critique in mind, the declarative language of 'crisis' used in the context of migration is symptomatic of a political and existential crisis of privileged European citizenship [133]. In fact, the origins of the 'race' idea and the socially

constructed meaning of racism [134], as well as how ethnocentric theories have established methodological barriers to the care of racialised minorities [32], are at the heart of Western mental health sciences' existential crisis. The hegemony crisis is that the Western mental health sciences are openly biased. They favour quantification methodologies in a scientific paradigm that values positivism, causality, objectivism, and rationality. It fails to address that, in their attempts to distance themselves from philosophy and theology to be seen as a 'legitimate science', these disciplines neglect their own origin and have become positioned to produce and reproduce ethnocentric knowledge [91]. The crisis of legitimacy is the prevalent belief that these disciplines generate the most valid knowledge, with extended intercultural legitimacy and corresponding intercultural clinical utility, for all of humanity in their unadapted Western, academic, scientific formulations.

This existential crisis of ethnocentrism in the European-Europeanised American macro-culture of *whiteness*, that is, the Western mental health sciences, is a pervasive issue because: (1) for many people, *whiteness* is imperceptible, (2) the growth of capitalism required a *white*-racialised curriculum., (3) its cross-cutting nature lends itself too much to power, (4) we do not have to think since the *white* curriculum has already done it for us, (5) the academy's physical environment is based on *white* dominance, (6) *white* people are not the only ones 'included' in the *white* curriculum, (7) the *white* curriculum rests on a widely held belief, and (8) the *white* curriculum indoctrinates people into the belief that it is not proper if it is not *white* ([135], p. 643). The intercultural competency movement opposes the status quo by harnessing its conceptual nature, but it also needs a decolonial positionality in constructing an academic revolution against that *white* European and Europeanised American geopolitical milieu and its dominance. Western mental health science's existential crisis of conceptual problems impedes the cultivation of environments of belonging, for racialised students and employees, necessitating a resurgent and insurgent decolonisation of epistemological ethnocentrism [33].

The 'successes' or 'failures' of interculturalism lies outside the reach of socio-demographic methods to civic involvement without integrating a more deeply critical consciousness into a more socially engaged intercultural paradigm [136, 137]. As Bhattacharyya [138] reiterates, the problematic neglect of racism is embedded in many 'multicultural' approaches.

"... is not about multiculturalism [...] what this really is, is an attack on the claim that racism exists and shapes social outcomes, and as other (contributors) point out, this is a long-standing point of political debate and struggle. The most effective method of silencing a critique of racism is to argue that racism no longer exists. Those claiming to suffer from its consequences must be pursuing their own selfish agendas".

(cited in [136], p. 4).

This statement alludes to the problem of colour-blindness among a majority of interculturalists positioned in normative *whiteness*, many of whom can understand and deal with concerns of gender and socioeconomic status outside of the topic of racism but cannot deal with the issue of racism. Colour-blindness refers to *white* people's denial, distortion, and minimisation of racism's reality and its negative impact on many aspects of neo-colonial/neoliberal democracy [139]. Colour-blindness is a prevalent form of aversive racism that is part of "an epistemology of *white* ignorance" ([140], p. 37) [59, 141–145]. Aversive racism is a type of racism that is minor yet persistent and is often known as 'microaggressions'. The literature shows that microaggressions may have serious mental health repercussions for affected people [146]. Microaggressions such as colour blindness prevent persons

who are racialised Black and Of Colour from being heard. The erasure of Black and Brown knowledge and knowers in *white* institutional spaces is an epistemic injustice that excludes, represses, censors, abstracts, masks and conceals, which is why Gayatri C. Spivak posed the question “Can the Subaltern Speak?” [99]. People socially ascribed the subaltern position, that is, the racialised phenomenology of Black and Of Colour bodily experience, in other words, have long since struggled to have their voices heard, to have their experiences of racist injustices heard, all to no avail [99].

Feeling respected and treated correctly is fundamental to developing a sense of belonging in situations [147]. A sense of belonging and happiness are linked, and, unlike emotional alienation, belonging functions as a protective factor against mental health issues, including depression and anxiety [148]. Part of the efforts to eliminate structural racism is cultivating belonging settings on a structural level [149]. Workplace climate, which refers to a climate that encourages involvement with positive relationships, social connectedness, and mattering, is one of the most important aspects determining the ability of workplaces to cultivate settings of belonging on a structural level [150]. To this end, a decolonised workplace climate is a liberated space for ongoing learning, and it seeks a greater understanding of racialised employees’ ‘embodied feelings’ [151]. In a decolonial framework, gaining a better understanding of racialised employees’ ‘embodied feelings’ entails listening to their perspectives on ethnocentric mental health philosophy [152]. In epistemology, decoloniality is a fundamental questioning of a ‘naturalised’ and ‘normalising’ coloniality of knowledge/power/being/truth/freedom [153]. As concerns mount that evidence-based approaches established without proper embodied representation of those from the ‘periphery’ merely serves to reinforce structural racism. Belonging and inclusion are vital for performance-related outcomes at the service level:

“...if there are no Black academics moving up, then you end up with a lot of precarious Black labour in universities, with no power and no ability to set an agenda or to even check an agenda that is being set” (Prof. Robbie Shilliams, cited in Richards [154]).

On the one hand, decoloniality clarifies a shift in how coloniality is perceived: “from [the] occupation of land to [the] occupation of being”, as Bulhan [109] puts it, but it also clarifies that the contemporary implications of structural racism from a historical point of view transcend time and place [155, 156]. As a result, recognising the impact of racism directed at the group to which people belong is at the heart of a decolonial framework of workplace belonging in mental health services. The most common unintended residue of modest but powerful political anti-racism advances in recent decades is the popularised, habitual dismissal of institutional racism as simply ‘unconscious bias’ [157–159]. In contrast, the phrase ‘(un)conscious bias’ emphasises the fact that Western discourse frequently attempts to exploit the assumption that racism is a result of unconscious negative attitudes and behaviours. That in doing so it is hoped not to be held accountable through an “epistemology of *white* ignorance” ([140], p. 37). Thus, the term ‘(un)conscious bias’ challenges the symbolic racism embedded in the language of non-responsibility [160]. Kilomba [161], in her book *Plantation Memories: Episodes of Everyday Racism*, explains how Western mental health science is a *white* space corrupted with deeply rooted and pervasive racism, all too often dismissed as simply ‘(un)conscious biases’, and how this structural racism impacts the emotional safety of People of African heritage in a variety of everyday settings including in mental health services. Who gets published, gets funded, and sits on funding approval panels is influenced by these supposedly unintended ‘(un)conscious biases’ [161].

Because mental health practices are evidence-based, '(un)conscious biases' in the generation of evidence result in '(un)conscious biases' persisting in the provision of mental health services [162]. Furthermore, it results in the diffusion of '(un)conscious biases' into the mainstream culture milieu. Because of the current popularity of political correctness, racist 'social imagination significations' psychically necessitate neglect of racism as epistemic and ontological '(un)conscious biases' which nevertheless still serves to oppress, control, and assimilate Black people and People of Colour [163]. It is not by chance that inappropriate and culturally insensitive instructions and curricula are developed, designed, and delivered; instead, the beneficiaries prescribe them [140]. The *raison d'être* of continued colonial pedagogical strategies is to socially engineer future generations of scholars and practitioners into a collective consciousness of '(un)conscious bias' to maintain the harmful effects of racist ontological order on structurally excluded, marginalised, and oppressed groups [164]. On the other hand, the eradication of imposed European ethnocentric identification of itself as the (political)intellectual, ideological standard defining global mental health is part of eliminating structural racism in Western mental health science [84, 165].

The mental health system is one structure within a network of national-level political institutions and political-cultural traditions that racialised individuals experience as sources of emotional suffering, humiliation, and intra-psychic conflict [166]. Structures they report that fails to recognise their worth regularly [167]. All too often, *white* mental health providers have rejected racialised patients' problems with racism as excessively sensitive impressions of events, rather than seeing these issues as a sign that something is wrong with the system [168]. At its core, colour-blindness is an epistemological weapon that obscures the connections between systemic racism, life chances, and mental health [169]. Aversive racism exists in a spectrum of structural racisms. However, it is less severe than more extreme racisms, such as ethnocentrism and biological racism [163, 170]. There is still a lot of mistrust, scepticism, resentment, and unhappiness among many racialised populations about mental health practitioner's ability to provide emotional safety in therapy. Threads of these emotions bind together to form significant hurdles to voluntary participation and early intervention for mental health problems [45].

6. Conclusions

Decoloniality is a framework for a more socially engaged intercultural paradigm that lays the groundwork for solidarity among postcolonial, indigenous, and decolonial alternatives to hegemonic Western epistemology in order to achieve a common purpose [171]. Makhubela [172] uses Zizek's Lacanian theory of ideology to apply European philosophy to South African scholarship to create culturally diversified intellectual capital in a powerful counter-hegemonic narrative. He warns against the complacency that comes with 'intellectual rebranding' in the name of decolonisation [173]. According to Makhubela [172], genuine decolonisation requires us to delve deeply into its many theorisations to understand how we can channel an 'embodied feeling for culture' to operationalise it as a long-term goal requiring more extensive, coordinated, and sustained political support. Because as Ratele et al. ([173], p. 5) has said,

"...to paraphrase Audre Lorde [174], the coloniser's psychology cannot be used to decolonise the coloniser's psychology".

In order to allow racialised people to have their voices heard in narratives about them, the quest for a genuinely global decolonial stance in mental health science must incorporate ideas presented by racialised people [84]. In what ways might interculturalist collaborators assist without adopting a saviour mentality or its trappings?

1. Increase the voices of thinkers in the Western canon of psychological work who are not heavily representative of the key texts that maintain the ethnocentric epistemology, while amplifying the voices of thinkers from various cultural, religious, and politico-economic contexts and regions (Global South, Majority World, Non-Western, African, Asian, Latin American, women), to enable truly intercultural dialogue.
2. Encourage students to become aware of structural racism by including teachings about empires' particularly destructive role in shaping narrow ways of thinking in mental health science, which is responsible for a low opinion of even very sophisticated psychological ideas, thought, and concepts solely because they emanate from specific cultural, religious, and politico-economic contexts and regions.

The dearth of decolonial intercultural competency, an issue connected to the provision of emotionally safe environments in mental health care for racialised people, is exacerbated by the underrepresentation of racialised professionals and the pervasive ethnocentric epistemology at all levels of academia. As many Black people and People of Colour perceive or experience, going into counselling and psychotherapy often entails relying on an ethnocentric culture for profound recognition of the most intimate components of the human situation. Decolonial interculturalism-informed orientations, theories, training practices and methodologies acknowledge the daily occurrences of racism at many levels, as well as the intersection of additional societal injustices, which forces Black people and People of Colour into a constant stressful state of "I am therefore I resist" in order to survive ([175], p. 208). When Black patients and Patients of Colour are supported to "discover, uncover and recover" their sense of humanity in counselling and psychotherapy, they find dignity ([176], p. 496). With decolonial intercultural competency and cultural humility, recognition entails seeing and understanding and strengthening positive connotations associated with positive racialised persons' identity consciousness [177, 178]. The effective elimination of structural racism is a moralised imperative within this decolonial intercultural perspective. Requiring a devotion to authenticity, humility and reflexivity.

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Discrimination against Women in Mexico's Three Main Population Groups Integrating Mexican Society

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Abstract

Mexico is a highly unequal country. Among the inequalities that impede the social cohesion of a country, gender inequality is of paramount importance, affecting more than half of the population. Based on the concept of Horizontal Inequality (HI) the chapter analyzes discrimination against women in three population groups comprising the 125.5 million Mexican society: 23 million Indigenous population, the 2.5 Afro-descendant population and the 101 million remaining. Horizontal Inequality explains discrimination for reasons of ethnicity, gender, religion, and language, among others identity facts that are not of free decision and from which there is no group way out. Only individuals can escape from discrimination. It is expressed in different areas of social activity such as politics, economics, justice, social services and culture. To measure the magnitude of gender inequality, using information from *Censo de Población y Vivienda 2020*, a Gender Equality Index is constructed which measures the level of equality or inequality for each of the areas and factors of HI. The study shows the persistence of gender disparities, how generalized and heterogeneous it is. It proves that inequality differs between the ethnic groups and in the intensity of the factors that perpetuate it, with greater depth for indigenous and afro-descendant women and especially in political and economic participation.

Keywords: discrimination, gender inequality, horizontal inequality, Indigenous and Afro-descendant population, Mexico

1. Introduction

This study analyzes inequality affecting the 63 million Mexican women (or 50.1% of the total population) in the three Mexican population groups. The focus of the analysis is to measure women's inequality across all Mexican Societies and in the three and main population groups that conform to it according to the 2020 Population Census. The main interest is put in the discrimination of all women vis a vis men in total population and in each group and less on the characteristics of women discrimination in each. The intention is to reflect on and analyze the causes and consequences of the horizontal inequalities faced by women rather than to analyze them as an effect of the intersectionality of gender and ethnicity. In a strict sense, it

is not an intersectionality analysis although some aspects of interferences are discussed all along with the text. Both HI and interdisciplinary analysis overlap in important aspects and differs in others. Both start from multidimensional approaches, but while the former concentrates on dimensional intersectionality focusing on a global analysis of inequalities between groups as a whole, the latter concentrates on the analysis of those categories which are particularly deprived because of intersectionality [1].

In this study the focal analysis is on the discrimination exercised against women in society, which is reinforced with elements of intersectionality, it is discrimination that is reproduced within each population group. In a country as culturally diverse as Mexico, we consider it relevant to approach gender discrimination in society and the country's ethnic groups, two of them, the Indigenous and Afro-descendant population, objects of discrimination; this analysis has not been sufficiently studied from the perspective of HI [1] and in Mexico, partly because of the difficulties in identifying ethnic groups in the statistics.¹

Therefore, based on the HI approach, this study analyzes gender discrimination against women in the Indigenous and Afro-descendant populations and for those who do not self-identify as belonging to any of these ethnic groups. It shows the perpetuation of discrimination by the interplay between Mexico's original cultures and the formal and informal institutions brought by the conquerors, maintained and reinforced in the colonial era, and again in the political constitutions of the Latin American republics that gave the vote only to literate men and landowners. The right to vote was not extended to women until well into the twentieth century, later than to Indigenous and Afro-descendant men.

Horizontal inequality, or inequality between social groups that differ in ways such as ethnicity, culture, religion, or gender, is at the root of gender, ethnic, tribal and minority claims, fundamental rights contained in various United Nations agreements,² establishing minimum thresholds of equity in necessary goods but allowing a certain inequality in non-essential goods and goods distributed by merit. Horizontal inequality can be used to identify the areas and factors in which these gaps in rights and inequalities prevail between men and women.

Understanding the gender discrimination that affects more than half of the world's population requires accepting the intensity and variety of the factors that determine and perpetuate it. Measuring the inequality experienced by Mexican women implies recognizing both, the breadth and depth of the social gaps existing in the country, the social debt they imply and the profundity of discrimination that often passes for normal or idiosyncratic behavior.

A quantitative exploration was required to measure these gender gaps, so a Gender Equality Index is constructed, which allows estimating gender gaps in various factors and grouping them for each area of HI. An index is then provided for each area of HI to obtain an aggregate index as a global reference for gender inequality and from which it is possible to compare gender inequality between population groups. For so doing the *Censo de Población y Vivienda 2020* (Census of Population and Housing 2020) was used. The Censo is the statistical source in

¹ The identification of Indigenous people by language began with the 1990 population census; it was not until 2015 that Afro-descendants were identified.

² These agreements are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and on Civil and Political Rights (1966); the Convention on the Elimination of All Forms of Discrimination Against Women (1979); Declaration on the Right to Development (the fourth contains the recommendations); the Convention on the Rights of the Child (1986) and the 2007 United Nations Declaration on Indigenous Peoples.

Mexico that provides the latest official count of inhabitants in Mexico. It allows identifying the three main population conglomerates: the Indigenous population, the Afro-descendant population and all others.

2. The specificity of gender discrimination

Official recognition of women's political, social, cultural, collective and territorial rights has gained pace along with the institutions and policies created to defend them. Political participation quotas, equal pay for equal work, and incorporation of women into the police and armed forces have been legislated and complied with, and universities have been opened to women. Nevertheless, women face unabated inequality. Even the first initial analyses that apply the concept and methodologies of HI have prioritized other elements such as ethnic, linguistic or religious distinctions over gender. This paper does not intend to fully explain the causes of women's inequality. It aims to only suggest some areas that contribute to it such as religion and elements of classical and neoclassical economic theory, which require a more profound analysis that exceeds the scope of the present research.

One of the causes of pay inequality is differences in labor productivity, although it does not explain the 30% of the wage gap between women and men that is attributed to gender discrimination. Yet theoretical frameworks, concepts and neoclassical economic methods do not enable identification of the mechanisms that explain discrimination in economic policy decision-making. A good part of the gap in pay and other economic variables is due to the formal and informal institutions that, like religion, exist and regulate socio-economic life. This is a complex issue in societies where Catholicism is the predominant religion in ethnic groups. Religion helps support hierarchical androcentric attitudes and practices.

Another driver of gender inequality is the prevailing classical and neoclassical economic theory that idolizes the selfish *economic man* as the core of the economy hides the contribution of women to the advantages of men. Maximizing his profit, he is the Robinson Crusoe, the model hero of individual entrepreneurship. Any subject other than this prototype is merely an accessory that serves the economic man's self-directed interests. The *economic woman*, therefore, is altruistic, selfless, self-sacrificing, free of vice, and born to serve. Since all her decisions and their consequences arise from this natural rationality, her lower social status, income and education can be attributed to the free acceptance of this rationality, not to the rules of the market, a formal institution arising from the capitalist social organization model [2, 3]. This ideology is to be found in the discussion about employment and occupations in Sections 2 and 3.

Neoclassical theory hides processes that perpetuate gender inequalities through the axiomatization of human behavior. Assuming exogenous preferences hides the fact that preferences are induced rather than natural. If society, from childhood to insertion into the labor market, relegates women to certain activities, their preferences are adjusted to the possibilities, it is a prior and subsequent discrimination that results in less labor and political recognition [4]. One of the main contributions of feminist economic theory is its rejection of positivism for which there is no evidence of reality, only proof of the action of natural laws; absolute truths, obtained from supposedly rigorous and objective analyses. One of those absolute truths is the naturally different rationality of women.

For example, neoclassical economics and its facets and ramifications conceive as a historical fact that the economy is divided into the public and private spheres. It is irrefutable that the economic man has always managed the public sphere, which claims that his natural function is to set the agenda that determines power, wealth

and the distribution of income. The function of the home and women is repressed for the sake of this agenda, generating an unequal society [2, 3]. Newer concepts of macroeconomics and growth theory depart from this narrow model, conceiving society and the economy as developing in contexts of environmental and socio-cultural activity, which cannot be ignored if social sustainability is sought. Moreover, this development takes place in three spheres that are symbiotically linked: (i) the nuclear sphere—the productive unit—families, homes, and communities that supply and demand goods, services and care; (ii) the business sphere, the sphere of enterprises, including those whose objective goes beyond maximizing profit; and (iii) the public sphere, governments and non-profit welfare organizations such as the UN, the Red Cross, and others. The predominant ideas expressed in these contexts and spheres do not permit discrimination against women to be overcome, since that discrimination “... is deeply wedded to the prevailing power structure and that structure is patriarchal; that is, the orthodox economy expresses patriarchal power” ([5], p. 3).

3. What is horizontal inequality?

Horizontal inequalities are differences between groups with a shared identity, expressed in four areas that are circularly intertwined: (1) political participation, (2) economic aspects, (3) social aspects, and (4) cultural status. Each of these areas is made up of multiple factors of a different nature mutually affecting each other. Thus, the want of real political participation is manifested in all spheres and powers of government; legal and legislative, the armed forces, and the police. Socioeconomic and cultural elements intersect with all forms of property; access to services, education and health, justice, and social recognition; and their particular worldview and rationality. Discrimination in these areas, sustained for generations over the centuries, creates cycles of poverty, from which collective escape is impossible and individual escape is never easy. Eliminating gender discrimination, as well as discrimination for other reasons, is not a mere matter of labor insertion or solely economic measures, it requires actions in many other areas, such as education, granting women human rights, the freedom to decide on maternity and equal access to justice, among others.

3.1 Measuring horizontal inequality

Based on the concept of HI, this work measures gender inequality in the 3 population groups identified with information from the *Censo de Población y Vivienda 2020*.³ Indigenous population, Afro-descendant⁴ communities and the rest.⁵

³ The objective of the *Censo de Población y Vivienda 2020* is to produce information on the size, structure and spatial distribution of the population, as well as its main socioeconomic and cultural characteristics, in addition to obtaining the housing count and its characteristics. The periodicity is decennial. The Census used two instruments to collect data on dwellings and their inhabitants: the Basic Questionnaire, with which the exhaustive enumeration was carried out and which consisted of 38 questions; and the Extended Questionnaire, which was carried out in a probabilistic sample of nearly 4 million dwellings, was composed of 103 questions, including those of the Basic Questionnaire [6].

⁴ The ethnicity referred to as Afro-descendant throughout the study for brevity encompasses self-identification as Afro-Mexican, Black or Afro-descendant.

⁵ For whom it is not possible to identify their ethnic composition.

Once the size of the three social conglomerates and their gender structure was determined, the second step was to construct a gender equality index to identify and measure the gaps that persist and hinder comprehensive progress inequality between men and women within each population group. With the information above, the analysis of the differences in the level of education and employment was carried due to the importance of these two areas during the life span of all women.

3.2 The size of the indigenous and Afro-descendant population by gender

According to the *Censo de Población y Vivienda 2020*,⁶ there are 23,229,560 people, or 19.4% of the population, who self-describe as Indigenous and 2,482,098 people who self-describe as Afro-descendants, representing 2% of the total population of the country. The population that does not identify as either Indigenous or Afro-descendant is 100,867,437, or 80.4%. In all three population groups and the total population, women account for a greater proportion by about 2.5% (**Table 1**).

3.3 The gender equality index

Horizontal inequality is multifaceted; analyzing it requires taking into account various dimensions that may account for inequalities between groups. In this work, the axis is gender discrimination within three groups; the Indigenous population, the Afro-descendant community and those who do not self-describe as either of these.

To assign a magnitude to HI, an Gender-Equality Index (GEI) that measures the level of equality between groups has been developed. In this case the index compares men and women in the three population groups of interest. The index is based on the methodology of the European Institute for Gender Equality (EIGE), which produces a composite indicator to measure gender equality in the European Union (EU) and each of its member states.

The objective is to measure the disparities between men and women according to the selected set of dimensions, sub-dimensions and their decomposition into individual indicators. The index is adapted to the context and priorities of EU

Concept	Total	Men	Women
Total population	125,515,554	61,142,530	64,373,024
Not self-identified as Indigenous or Afro-descendant	100,867,437	49,153,310	51,714,127
Self-identified as Indigenous	23,229,560	11,280,059	11,949,501
Self-identified as Afro-descendant	2,482,098	1,228,157	1,253,941

¹Self-identified as Indigenous is specified for the population aged 3 years and older, the rest from 0 years.
 Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2020.

Table 1.
 Ethnic and gender composition of the total Mexican population.¹

⁶ According to the Extended questionnaire of the *Censo de Población y Vivienda 2020*, in 2020, Mexico's total population amounted to 125.5 million people. The estimates obtained with the data from the Extended questionnaire correspond to inhabited private dwellings and their occupants, therefore, they are lower than the results of the Basic Questionnaire that also includes collective dwellings, the Mexican Foreign Service and the homeless population [6]. It is with the information from the expanded questionnaire that the identification of the three ethnic groups is possible.

policy. In the present study, the dimensions were chosen according to the four dimensions of HI described above; societal, economic, cultural, and political participation, and their interrelationships.

The GEI is a composite indicator that is obtained by applying a multidimensional concept to integrate individual indicators into a single measure [7]. To select the individual indicators, various indicators that have been considered relevant to the measurement of gender equality were reviewed. These included those used by the EIGE, by the World Economic Forum for the development of the Global Gender Gap, and other lists of indicators [8, 9] based on a structure of dimensions and sub-dimensions suitable for addressing gender inequalities.

The list of indicators used for the GEI is presented in **Table 2**. Eleven individual indicators were chosen from among the four dimensions of HI. Data were obtained from the 2020 Census, except for the indicator “people who have not been discriminated against” (percentage of the population aged 18 and over), which was obtained from the *Encuesta Nacional sobre Discriminación (ENADIS)* [10].

To calculate the GEI, we started with the gender gap (GG) using the formula proposed by the EIGE, which is calculated from the ratio between the value of the indicator for women (X_{it}^{female}) and the average value for men and women (X_{it}^{mean}) of the individual indicator being considered. The values range between 0 and 1, where 0 corresponds to total inequality and 1 total equality. The formula is as follows:

$$1 - \left| \frac{X_{it}^{female}}{X_{it}^{mean}} - 1 \right| \tag{1}$$

Subsequently, the geometric means of the individual indices were obtained for each of the four dimensions of HI:

Dimension	Individual indicator
Societal factors	Persons with a bachelor’s degree (percentage of the population aged 15 and older)
	Persons with access to medical services (percentage of the population from 0 years of age)
	Persons with a birth certificate (percentage of the population from 0 years of age)
Labor and economic factors	Persons employed in the formal sector (distribution by gender, aged 15 and older)
	Persons employed full-time (distribution by gender, aged 15 and older)
	Employed persons whose income covers the food and non-food basket (distribution by gender, aged 15 and older)
Political participation	Persons with a high degree of socio-political participation (distribution by gender, aged 15 and older)
	Persons employed in management positions (distribution by gender, aged 15 and older)
	Persons employed in the armed forces (distribution by gender, aged 15 and older)
Cultural factors	Persons who have been discriminated against (percentage of the population aged 18 and older)
	Persons who can read and write (percentage of the population aged 18 and older)

Source: Authors.

Table 2.
Dimensions of horizontal inequality and its indicators.

$$D_k = \sqrt[k]{GG_1GG_2 \dots}, k = 1, 2, \dots \quad (2)$$

The GEI is obtained by calculating the weighted geometric mean of the indices for each dimension (D). The weighting (α) is the same for each dimension:

$$GEI = \sqrt{D_1^{\alpha_1} D_2^{\alpha_2} D_3^{\alpha_3} D_4^{\alpha_4}} \quad (3)$$

Substituting in Eq. (3), the following is obtained:

$$GEI = \left(\prod_{i=1}^n D_i^{\alpha_i} \right)^{\frac{1}{\sum \alpha_i}} = \left(D_1^{\alpha_1} D_2^{\alpha_2} \dots D_4^{\alpha_4} \right)^{\frac{1}{\alpha_1 + \alpha_2 + \alpha_3 + \alpha_4}} \quad (4)$$

3.4 What does gender equality reveal about gender discrimination in Mexico?

The gender gap values calculated for each of the indicators are shown in **Table 3**. It should be borne in mind that the level of equality between men and women for each category is being assessed within each population group. It can be observed that societal and cultural factors show values closer to one than do economic factors and political participation. This means there is less disparity between men and women in these areas, although certain features are worth noting in each of the dimensions.

The analysis of societal factors indicates that the differences are low between men and women who have access to higher education and health care; some differences favor men, but when these are weighted by the members of each gender in the respective category, it can be seen that the factors affect them both similarly. For enrollment in and access to medical services and registration in the civil registry, the situation is similar, with similar access rates for men and women. There has been an effort on the part of the Mexican government and civil society to make progress in recognizing social guarantees for men and women; although these are

Dimension	Individual indicator	Not self-identified as Indigenous or Afro-descendant	Self-identified as Indigenous	Self-identified as Afro-descendant
Societal factors	Bachelor's degree completed	0.976	0.963	0.967
	Enrolled in health care	0.984	0.979	0.983
	Birth certificate	0.975	0.971	0.990
Labor and economic factors	Formal employment	0.809	0.755	0.775
	Full time	0.741	0.637	0.725
	Food and non-food basket.	0.733	0.653	0.711
Political participation	Political office	0.740	0.609	0.882
	Management position	0.798	0.783	0.746
	Armed forces member	0.156	0.115	0.143
Cultural factors	Nondiscrimination	0.988	0.995	0.793
	Literacy	0.954	0.944	0.986

Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2020, and main results of the Encuesta Nacional sobre Discriminación (ENADIS) [10].

Table 3.
 Gender gaps by individual indicators of the dimensions of horizontal inequality.

yet sufficient, the gender perspective has been incorporated as a fundamental component of public policy. The results of this study suggest that a similar exercise should be carried out for a previous period, to make a comparison and test this progress over time.

The indicator with the largest gap among labor and economic factors is monthly income to cover the food and non-food basket, calculated by the *Consejo Nacional de Evaluación de la Política de Desarrollo Social (Coneval)*. The calculation was carried out at the individual level to compare income purchasing power between men and women, although family income is normally used. The lower level of income for women and their lower purchasing power is explained by such factors as job segregation⁷ and shorter workweeks compared to men. According to various studies [11, 12], job and sector segregation by gender contributes significantly to gender pay gaps and decreases workers' bargaining power. Information from the 2020 Census indicates that while employed women worked an average of 40.8 h a week, men worked an average of 47.7 h, which is also reflected in the gap between men and women who work full time.

The division of labor about reproductive work in the home by gender leads to differences in time use patterns between men and women [12]. Women who work generally distribute their time between their job and tasks in the home, so either they tend to be employed in jobs that demand fewer hours per week than men's jobs or else they have less free time.⁸

In terms of the gender gap in formal employment, women had higher rates of informal employment than men and hence less access to social security health care services. Among persons with a formal job, 62.9% of the first group (neither Indigenous nor Afro-descendant) are men. In the Indigenous population, the comparable percentage of men is 68.1 and 63.8% in the Afro-descendant community. This is associated with a higher proportion of women than men being self-employed (see **Table 7**), as well as with the higher proportion of women in the tertiary sector; namely, service industries and trade. For the three population groups, the occupations held by women with the highest frequencies are domestic work, sales clerk and shopkeeper.

Political participation is another dimension that shows persistent gender gaps. These gaps point to labor segregation and the obstacles faced by women to increase their participation in higher-ranking and decision-making positions. The biggest gap is seen in the armed forces. Men continue to predominate in the army, navy and air force. It is important to point out the modifications that are being made to incorporate women into military and air force training, which is why it is necessary to continue to make progress in institutional efforts to enable increased representation of women in the armed forces.⁹ The distribution by gender still favors men in socio-political participation and managerial positions. It should be noted that the gap between men and women is greater yet for the Indigenous population.

⁷ Job segregation by gender in the labor market refers to different distributions in branches of the economy and occupations by gender (horizontal segregation), and differential participation of men and women in higher-level occupations (vertical segregation).

⁸ According to the *ENUT, 2014*, women spent an average of 11.8 h per week on cultural activities, sports, games and hobbies, while men spent 18.5 h; that is, 56.8% more than women.

⁹ In 2007, a principle of gender equality in the armed forces was enacted. Out of 39 military schools, 19 admitted women with full participation, including training for roles such as military engineer and pilot. On April 5, 2018, legislators endorsed an Army and Air Force Education Act to apply to both men and women, granting them equal opportunities and treatment.

Dimension	Not self-identified as Indigenous or Afro-descendant	Self-identified as Indigenous	Self-identified as Afro-descendant
Societal factors	0.978	0.971	0.980
Labor and economic factors	0.760	0.680	0.736
Political participation	0.452	0.380	0.454
Cultural factors	0.971	0.969	0.884
Gender equality index	0.756	0.702	0.734

Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2020, and main results of the Encuesta Nacional sobre Discriminación (ENADIS) [10].

Table 4.
Gender equality index by the dimension of horizontal inequality.

The literature on occupational and sectoral segregation has shown that differences between men and women are not explained by the predictions of neoclassical theory; it is different investments in men's and women's skills or different preferences (which are considered exogenous) that explain gender differences in employment [12]. These differences are explained and reinforced by the configuration of the education system and the labor market. The lower level of participation of women in managerial positions and political representation cannot be reduced to a matter of preference but rather ascribed to social and institutional limitations.

Cultural factors show a narrower gap between men and women than does employment. However, it is worth noting that it is more difficult to specify indicators for this dimension of HI than for the others examined. The percentage of people who were not discriminated against for at least one reason in the last 12 months before the survey was analyzed [10]. Values close to one mean that the proportion of men who considered that they were not discriminated against is similar to that of women. This does not mean that discrimination was not experienced, but that there is no significant difference between men and women.

Table 4 shows a summary of the indices for each dimension and each population group, from the geometric mean (Eq. (2)) and the gender equality index (Eqs. (3) and (4)). The dimension with the highest gender inequality is political participation, and the dimension with the lowest gender inequality is that relating to social factors. It should be noted that the three groups are very similar. The GEI is lower for the Indigenous population, which indicates wider gender disparities for this group.

The results obtained for Mexico are close to those estimated by the World Economic Forum for the 2020 Global Gender Gap. This index measures differences between men and women in four areas; health, education, economics and politics. According to the 2020 World Economic Forum report, Mexico ranked 25th out of 153 countries, with a value of 0.754. As with the index in this work, a value of one represents perfect equality. The lowest scores—less equality—corresponded to economic participation and opportunity, and the most equality between men and women was found in the areas of education, and health and survival.

4. Two main areas of horizontal inequality: education and employment

From the several areas in which HI manifest, special consideration is given to education and employment, due to the more close links to economic disparities and

differences and as a first step to quantify some basic factors of discrimination. It does not imply that gaps in other fields, such as health, political participation or any other are less relevant.

4.1 Educational and schooling gaps

Education is a key element for people’s development. It confers knowledge, skills and abilities that are necessary although not sufficient to participate effectively in society and the economy [13, 14]. The most damaging gap is illiteracy, as it imparts an enormous personal and social disadvantage that marginalizes, isolates and devalues individuals, even in their social environment [15, 16]. Female illiteracy is higher across society, especially among Indigenous groups. Indigenous female illiteracy is 1.3 times that of Indigenous men, and double that of non-Indigenous and Afro-descendant women. The situation is similar for other educational variables the level of schooling, close to 9 years of accumulated education, is low and shows the greater segregation of the Indigenous population, especially the female population, whose schooling barely corresponds to completed primary school, which in turn is related to lower participation in undergraduate or graduate studies (Table 5).

4.2 How does work perpetuate gender inequality

Employment is one point in the life history of discrimination, which begins at birth, continues in food supply and nourishment, in access to education and health care services, in political and legal decision-making processes, or economic activities in which women take part; in other words, everything that constitutes the “traps of inequality,” a euphemism in social science jargon. Thus, it is still difficult to identify the reasons why such discrimination persists despite an accumulation of institutionalized policies and actions aimed at eliminating labor discrimination. This, because of the complexity of distinguishing between inequalities based on statistics and the legitimate selection of employees for specific jobs, is observable only when job requirements list non-essential qualities that are mostly found in certain individuals.

Selection processes are complex and there are always doubts about the qualifications of the candidates. Employers seek to minimize these by appealing to discriminatory practices that create “statistical discrimination or at the discretion of the employers” [17–20]. Since it is difficult for employers to accurately gauge the performance of a job applicant, they tend to judge candidates according to “characteristics that are easy to observe, such as race, sex, or age, assuming that members of

Characteristic	Not Indigenous or Afro-descendant			Self-identify as Indigenous			Self-identify as Afro-descendant		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Unable to read and write	6.0%	5.9%	6.1%	12.2%	10.5%	13.9%	7.3%	7.3%	7.3%
Undergraduate or graduate degree	16.8%	17.0%	16.6%	8.9%	9.1%	8.7%	17.3%	17.9%	16.7%
Average total years of schooling	8.9	8.9	8.9	7.1	7.2	7.0	8.8	8.9	8.7

Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2021.

Table 5.
Educational characteristics by ethnic group and gender.

certain collective groups will have below-average performance” ([17], p. 68), as well as preferring people from certain schools, of certain political or religious beliefs, or a particular gender.

In Mexico, although there is no *direct or formal employment discrimination* enacted by discriminatory laws that might express such an ideology as apartheid laws in South Africa did [21], or that would exclude women from certain activities (army, police, firefighters), there is still *indirect employment discrimination* as a result “of apparently impartial provisions and practices that are detrimental to a large number of members of a specific group” ([17], p. 22; [22]). These standards are exclusionary if they do not account for the situation of certain social groups or categories of workers and the places where they live, such as unfavorable conditions for education or health, or less developed road infrastructure in poorer regions or neighborhoods [17].

Labor discrimination is structural; it permeates the entire social order. All working women suffer the effects of economic, social and political factors that restrict their social, political and labor participation; this is a confirmed fact. These restricting factors include inequality in the ownership of assets—land, financial resources, education, health, food and place of residence, constituents of human capital and, due to their relationship with productivity, income and public and private spending. Labor is the largest income component in almost 80% of households. It constitutes demand for households and individuals and aggregate demand and economic growth. Thus, as long as labor discrimination based on gender and ethnicity persists, a vicious circle is created and reproduced; from labor discrimination to low growth, from low labor productivity to reduced labor income, constricted internal demand, little economic growth and stagnant productivity. It has been found that the larger the population that experiences labor discrimination, the more difficult it is to stimulate the economy and reduce inequality [14, 23, 24].

Indirect employment discrimination pervades the public and private spheres in various forms that involve frequent practices of differential treatment of certain people [22] and constitute the “glass ceiling” of social and labor gender discrimination. These are standards that categorize people based on skin color or hair, body shape and gender and limit the social acceptance and employment opportunities of individuals who do not meet the favored criteria. Labor discrimination based on these opinions is prohibited by law, but the practices persist and are not captured in census statistics or surveys. It is unusual for an employer to say openly that they would not hire a person because they are Indigenous, female, or because they do not dress in accordance with social criteria.

Examples of this kind of discrimination can be seen in movies and advertising, which apply selection standards that cannot be used in other sectors, as they would violate anti-discrimination laws. Although movies and advertising are not typical of the world of work, they do display evidence of discrimination and latent social prejudices, and expose the spread and reproduction of social complexes; as such they are an X-ray of society. They are also a domain of ethnic and gender discrimination and an expression of male hierarchy. The world of sports is similar, having systematically discriminated against women’s access to certain sports. Where progress has been made (e.g., soccer, wrestling, boxing, tennis, among others), women athletes’ income is lower and the sports enjoy little publicity. Puyana and Horbath [23] describe these indirect practices of ethnic discrimination in the labor market in more detail.

Another example of multiple discrimination is given by cultural patterns that, like the racialization of beauty, draw a subtle connection between physical attributes and character and morality, placing an entire community or gender in a lower position on the social scale. To move up the social ladder, money is not enough. It is essential to have class; to know how to dress, speak, how to behave [25]. These

establish relationships of submission and complementarity that encapsulate the lack of respect given to the worldviews of women and of Indigenous peoples [3]. These practices are exposed, for example, in the statements of a legislator and president of *Comisión de Derechos Humanos* who, in rejecting the request of some Indigenous women for better-paid work, advised them to stick to domestic work, making handicrafts, and growing prickly pears [26].¹⁰ Another example was the (informal) proposal that the number of children per family is limited as a condition of eligibility for social programs such as *Cruzada contra el hambre*, or to limit support based on the number of children, as these would encourage larger families [30].

The distribution of economic activity by gender shows patterns in the allocation of economic and reproductive labor. The term “reproductive labor” refers to family care-giving and domestic housework, “whose main characteristics are not having remuneration through a salary (although it could be debated whether or not there is another type of remuneration), that it is an eminently female job and that it remains invisible even to those who carry it out” ([31], p. 67).

Reproductive work, which is relegated to the domestic, non-productive area in classical and neoclassical economic theory [3, 31], constitutes the core of gender inequalities. Yet this is not the result of a choice, but rather of a social allocation that is related to the multiple restrictions faced by women; “these restrictions result from the formal and informal rules that largely determine the behavior patterns, expectations and labor and professional aspirations of men and women, and also structure the operation of labor markets” ([11], p. 5). The 2020 Mexican Census reveals marked differences by gender, with the percentage of employed men in each population group exceeding that of women. The employment rate of Indigenous men is more than double that of women. The proportion of Indigenous men seeking employment was also higher. The higher economic participation of men is also reaffirmed by the greater percentage of men seeking employment. In the case of the first group (neither Indigenous nor Afro-descendant) and of Afro-descendants, these percentages are triple those of women seeking employment, and in the case of the Indigenous community the proportion is 4.7 times as great. The higher rates of economic activity in turn explain the higher percentage of retired and pensioned men (**Table 6**).

Differences between men and women in the distribution of employment status are evident in the percentage of people whose main occupation is that of carrying out household tasks. The percentages are quite different. While 2 or fewer out of every 100 men reported household tasks as their main occupation, for women, the proportion is 37 out of 100. The figures are similar for Afro-descendant women (36 out of 100), and higher for Indigenous women (45 out of 100).¹¹

Table 7 shows the distribution of employment and occupational status as a proportion of the number of people who reported their activity. The largest proportion of people in the three groups and by gender is as an employee or worker, although more women than men report that they are self-employed, which is associated with lower demand for women’s labor and with work options that allow them to continue reproductive work. Self-employment is a way to deal with the lack of job opportunities, a problem that is more accentuated for Indigenous women.

It is worth highlighting the higher percentage of unpaid workers among Indigenous and Afro-descendant persons. The proportion of Afro-descendants who are

¹⁰ Hopenhayn and Bello [27], Yanes [28] and Moreno Figueroa [25] and Moreno Figueroa and Saldívar [29] delve into the placement of the Indigenous population in a subordinate position.

¹¹ According to the results of the *Encuesta sobre Uso del Tiempo (ENUT) 2014*, women dedicated an average of 46.9 h a week to household tasks and caregiving, while men spent an average of 15.7 h.

Employment status	Not self-identified as Indigenous or Afro-descendant (%)			Self-identified as Indigenous (%)			Self-identified as Afro-descendant (%)		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Employed	52.3	67.1	38.6	51.2	69.0	34.7	57.0	71.6	42.8
Looking for work	1.9	2.9	0.9	1.7	2.8	0.6	1.7	2.5	0.9
Pensioner or retired	4.0	5.0	3.1	2.5	3.4	1.7	3.5	4.4	2.6
Student	15.1	15.3	14.8	12.5	12.7	12.3	12.0	11.6	12.3
Homemaker	20.0	1.5	37.1	24.5	2.0	45.4	19.3	1.8	36.2
Unable to work	1.4	1.6	1.2	2.1	2.5	1.7	1.4	1.6	1.2
Unemployed	5.0	6.1	3.9	5.3	7.3	3.5	5.0	6.1	4.0

Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2020.

Table 6.
Employment status by ethnic group, 12 years and older. The percent by employment status.

Type of job	Not self-identified as Indigenous or Afro-descendant (%)			Self-identified as Indigenous (%)			Self-identified as Afro-descendant (%)		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
employee or worker	65.6	63.7	68.7	48.6	46.1	53.4	60.2	59.3	61.6
laborer (day laborer or employed laborer)	4.1	6.0	1.0	8.5	11.9	2.4	4.7	6.9	1.2
paid labor helper	4.2	4.4	3.8	6.9	7.1	6.3	5.0	5.2	4.7
supervisor or employer	3.3	3.7	2.7	2.2	2.3	2.1	3.9	4.1	3.4
self-employed	20.4	19.9	21.1	25.5	23.7	28.7	22.2	20.5	25.0
unpaid worker	2.3	2.2	2.6	8.2	8.9	7.0	4.0	4.0	4.0

Source: Authors, based on microdata from the Extended Questionnaire, Censo de Población y Vivienda, 2020.

Table 7.
Type of job by ethnic group, among employed persons. Percentage by type of job.

unpaid is almost double the proportion in the first group (neither Indigenous nor Afro-descendant), and for the Indigenous population, the difference is triple.

5. Conclusions

Gender discrimination was examined through the concept of HI. The analysis confirms the initial expectations: gender discrimination exists despite policies aiming to reduce or to control it. Furthermore, the study shows women's inequality exists within the three self-identified population groups Indigenous population, the Afro-descendant community, and the rest of the Mexicans registered as such in the Population Census 2020. Both qualitative and quantitative exploration yield evidence of the existence of gender gaps that persist and exacerbate each other in each social group, and in each of the dimensions of HI (political participation, economic aspects, societal aspects and cultural status).

Gender discrimination has historical roots, and these run deeper for Indigenous and Afro-descendant women, resulting in slower progress and recognition of their

social and economic participation. A greater gap is identified for Indigenous and Afro-descendant women than for men within the same ethnic groups in terms of education, economic participation and political representation. It should be noted that these disparities are wider in the Indigenous group. The results show that gender discrimination, as a specific type of discrimination, intensifies ethnic discrimination.

The Indigenous and Afro-descendant populations were defined for this study by a self-identification criterion in the *Censo de Población y Vivienda, 2020*. Census information was used to estimate the gender equality index, which measures discrimination in four of the main areas in which discrimination manifests and suggests particular policy actions to address it. Individual indices were estimated for each dimension of gender inequality finding higher inequality economic sphere and in political representation than in cultural and social factors. The persistence of greater women inequality in these spheres' points to a hierarchical social structure that continues to exclude women from all population groups from benefits and opportunities of social and economic development. By doing so, it makes it more difficult, if not impossible, to reduce overall inequality.

It should be noted that the calculation of the gender equality index in this study was conditioned by the availability and structure of the data provided by the 2020 Census and ENADIS [10] (our complementary source to explore differences in discrimination between men and women in each of the ethnic groups). The results suggest that future research in this area should consider increasing the number of individual indicators for each dimension of HI using additional complementary sources. Further studies should also include data for a previous period, to make comparisons with data from the present time. However, the greatest limitation is the information available for the Afro-descendant community.

It is necessary to extend the analysis and understanding of gender discrimination. The importance and relevance of this problem, which affects more than half of the world's population, including Mexico, demand that the intensity and variety of the factors that determine and perpetuate gender discrimination be measured. Like all discrimination, but to a greater degree, gender discrimination affects the foundations of society and impedes its collective and comprehensive development because the larger the discriminated population is, the more difficult it will be to speed out economic growth and and reduce income and wealth concentration. Today, women still face structural disadvantages, as they did centuries ago, that are rooted in theoretical conceptions that prevail over economic and rational concepts and fail to recognize women's essential participation and contribution in all spheres of society. If society does not promote substantive equality that would eliminate all gender inequality in all areas, it will maintain its traditional repressive character.

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Perspective Chapter: Black Lives Matter and the Anti-Woke Campaign in the UK

Andrew Pilkington

Abstract

The murder of George Floyd by police officers in the US in 2020 reignited the Black live matter movement and reverberated across the world. In the UK many young people demonstrated their determination to resist structural racism and a number of organizations subsequently acknowledged the need to take action to promote race equality and reflect upon their historical role in colonialism and slavery. At the same time, resistance to these challenges has mounted, with right-wing news media and the UK government drawing upon an anti-woke or anti-PC discourse to disparage attempts to combat structural racism and decolonise the curriculum. This chapter argues that the campaign to discredit anti-racism culminated in 2021 in the production of the Sewell report commissioned by the government. This chapter critically examines this report and the discourse which underpins the report. The discourse is consonant with that of the anti-woke campaign propagated by the right-wing news media and the UK government, and entails the reproduction of rather than opposition to structural racism.

Keywords: racism, political correctness, culture wars, discourse, racial and ethnic disparities

1. Introduction

Black Lives Matter is an antiracist social movement which first emerged in the US in 2013, with the use of the hashtag # BlackLivesMatter. The trigger for the emergence of this movement was the exasperation felt by many over the acquittal of George Zimmerman for shooting dead an unarmed black teenager, Trayvon Martin in 2012. While the movement spread beyond the US in subsequent years, with one first emerging in the UK in 2016, what reignited and indeed popularized this movement, and transformed it into a global phenomenon, was the murder (caught on video) of George Floyd at the hands of a Minneapolis police officer, Derek Chauvin in May 2020. Floyd's murder prompted widespread demonstrations in solidarity with victims of racial injustice across the world. In the UK, this entailed protests across the country and in one instance in Bristol the toppling of the statue of a slave trader, Edward Colston and throwing him into the harbor. A national conversation ensued with renewed reflection by a number of cultural institutions about their historic role in colonialism and slavery, increasing numbers of corporations signing up to the Business in the Community Race at Work Charter, and sports teams, especially in football following the precedent first set by Colin Kapernick of the NFL in 2016

and taking a knee in protest at racism and police brutality. The conversation was inevitably a heated one, with vehement criticism of ‘baying mobs’, ‘virtue signaling’ organizations and booing of footballers taking a knee. The UK government had to respond and in June 2020 announced the creation of a Commission on Race and Ethnic Disparities. The commission chaired by Tony Sewell produced its report in March 2021, but the report proved just as contentious and polarization has persisted.

I am concerned in this chapter to demonstrate that an anti-political correctness (or anti-woke) discourse is critical to understanding the backlash to the Black Lives Matter movement evident in the UK. This is therefore a ‘perspective’ chapter which does not purport to generate new primary data but rather to provide a narrative that draws on secondary data to explore the role of the state, the media and other actors in the reproduction of structural racism. Right wing media have routinely drawn upon an anti-PC discourse to discredit antiracism and other social justice initiatives and the advent of a populist Conservative government, all too ready to demonstrate its anti-PC credentials through its ‘war on woke,’ helps to reinforce the hegemony of this discourse. In the first part of this chapter, I shall seek to demonstrate the pervasiveness of this discourse and the way the government has sought to mount its anti-woke agenda. In the second part of the chapter, I shall summarize and critique the Sewell report, arguing that the report itself is consonant with the government’s anti-woke agenda and does not therefore challenge structural racism.

2. Political correctness and the anti-woke agenda

Although we are continually being reminded that we live in a world where political correctness (or its surrogate wokeism) is pervasive, the concept itself remains unclear and indeed contested. A few writers embrace the term to signal their belief in the importance of being inclusive [1]. More commonly, however, the term is used in a disparaging way to mock what is seen as a ludicrous attempt to avoid the real issues or warn us of the dangerous new culture threatening free speech and plain honest speaking. In the process a contrast is often drawn between political correctness and commonsense: ‘Voters seek return to common sense in revolt against political correctness’ announces a not untypical headline in one broadsheet [2].

The invocation of the common refrain, PC gone mad serves to link the positive and negative usages of the concept together in a revealing way. A narrative is constructed which suggests that at one stage PC was indeed progressive in promoting social justice for minorities but that it has gone too far so that now ‘people are becoming frightened of saying the wrong thing, using the wrong language about a pretty wide range of opinion’ [3]. This view is widely shared: ‘The progressive movement, that has done so much to tackle inequality and unfairness, has been captured by ultras who demand absolute conformity with every article of their faith’ [4]. Another journalist, further right on the political spectrum, concurs. The decline of religion and subsequently secular ideologies has left a vacuum which has been filled by social justice zealots. Failing to acknowledge the success of previous human rights campaigns in righting historical injustices relating to race, gender and sexuality, new theories emerged ‘to suggest that things had never been worse. Suddenly - after most of us had hope it had become a non-issue – everything seemed to have become about race’. A crusading desire to right perceived wrongs has entailed the creation of ‘a set of tripwires laid across the culture...What everyone does know are the things that people will be called if their foot ever nicks against these freshly laid tripwires. “Bigot”, “homophobe”, “sexist”, “mysoginist”, “racist” and “transphobe” are just for starters’ [5].

There is little doubt that political correctness (and wokeism) now typically carries negative connotations. Few people consequently identify themselves as

supportive of PC and when they do, they sound on the defensive [1]. More typically, those who are sympathetic to the causes associated with PC will studiously avoid defining themselves as advocates of PC. The same is also true of a related concept, 'woke' which, though initially coined to refer to awareness of racial injustice 'has been weaponised' by the right wing media and subsequently used in a derogatory fashion [6]. Here are two examples: 'The woke left is the new Ministry of Truth... Good people are silenced in an Orwellian nightmare where a tyrannical minority decide what we're allowed to say [7]. And 'The march of wokeism is an all-pervasive new oppression' [8].

Although media references to political correctness and woke are widespread, these and related terms such as cancel culture are rarely defined. Instead they are used to depict the Other in a disparaging way and often to suggest that there are powerful forces suppressing inconvenient truths and steadily eroding our freedom. One broadcaster believes that we need to wake up before it's too late: 'We've become a timid, mute, fearful society in which everyone must walk on constant eggshells for fear that they will be next for the social media pile-on and politically correct execution' [9].

This characterization of PC and woke is highly influential and clearly resonates with many people. One survey in 2020 CSS found 'six in ten' agreeing 'that political correctness gives "too much power to a small minority of people who like to take offence", with nearly eight in ten agreeing 'that "you have to walk on eggshells when speaking about certain issues these days" and over eight in ten agreeing 'that "too many people are easily offended these days"' ([2]; see also [10]). The media in short portray political correctness in a derogatory fashion and most people buy into this picture.

We should note that the attack on PC is often part of a sustained campaign waged by conservatives and integral to the culture wars they believe play well with many people [11]. In the UK the right-wing press has waged a long campaign against PC (or its surrogates such as wokeness and cancel culture) which has provided fertile ground for Boris Johnson's brand of populism and helped contribute to the decision for Britain to leave the European Union (Brexit).

Boris Johnson as both a right-wing journalist and politician has not been averse to speak disparagingly of people of color, and indeed extolling political incorrectness. My central concern here, however, is with his response as Prime Minister to Black Lives Matter (BLM). Nigel Farage, a central figure in the Brexit campaign, was highly critical from the start of a movement he castigated as a threat to the British way of life. He prodded Johnson: 'I'm afraid Boris Johnson and the government have gone along with this PC woke agenda' (Farage quoted in [12]). Provoked by Farage, Johnson used a Conservative conference speech to nail his mast to the wind: 'We are proud of this country's culture and history and traditions; they [Labour] literally want to pull statues down, to rewrite the history of our country, to edit our national CV to make it look more politically correct' (Johnson quoted in [11]).

This speech is part of a wider campaign waged by the right-wing press and increasingly by the government against PC [13]. The 'war on woke' entails identifying different threats to our way of life and lampooning institutions for their virtue signaling capitulation to PC [14, 15]. One example relates to the initial decision of the BBC to perform an orchestral rather than choral version of two patriotic songs at the Last night of the Proms: 'Right-wing newspapers seized on the story...with the Sun running the story under the headline "Land of woke and glory". They saw the lack of singing as a surrender – not a practical decision that reflected the difficulties of putting on a prom during a pandemic. Cue the intervention of the prime minister: "I think it's time we stopped our cringing embarrassment about our history, about our traditions, and about our culture and we stopped this general fight of self-recrimination and wetness" (Johnson quoted in [16]).

In some cases, there have been veiled threats of funding cuts and proposed new laws. The Culture Secretary announced to museums and funding bodies: ‘The government does not support the removal of statues or other similar objects...You should not be taking actions motivated by activism or politics’ (Dowden quoted in [17]). The Communities Secretary has subsequently proposed new laws to protect ‘statues, plaques, memorials or monuments...from being removed “at the hands of the flash mob, or by the decree of...town hall militants and woke worthies”’ (Jenrick quoted in [18]). Meanwhile the Education Secretary summarily dismissed calls for changes to the history curriculum in schools to incorporate Britain’s colonial past and involvement in slavery: ‘We have an incredibly rich history, and we should be incredibly proud of our history because time and time again, this country has made a difference and changed things for the better, right around the world’ (Williamson quoted in [19]). At the same time he has introduced new legislation on free speech ‘to counter what he called “unacceptable silencing and censoring” on campuses, despite the paucity of evidence of ‘no platforming’ and repeated reference to a key example of silencing and censoring when in fact ‘the event went ahead’ [20].

A particularly revealing intervention has come from the Minister for women and equalities in a speech where she set out a new approach to equality ‘based on “Conservative values”...and ‘pledged that equality will now be “about individual dignity and humanity, not quotas and targets, or equality of outcome”’. The UK had focused too much on ‘fashionable’ race, sexuality and gender issues: We will not limit our fight for fairness to the nine protected characteristics laid out in the 2010 Equality Act, which includes sex, race and gender reassignment...the focus on protected characteristics has led to a narrowing of equality debate that overlooks socioeconomic status and geographic inequality. This means some issues – particularly those facing white working class children – are neglected (Truss quoted in [21]).

In a year when we had become more aware of racial injustice and ethnic disparities in outcomes, the Minister seemed to be ‘play[ing] to the culture wars gallery and to be pitting the needs of minorities against those of the working class, when neither of them have been properly addressed’ [22]. Challenged about this, ‘Home Secretary Priti Patel [who described the Black Lives Matter protests as “dreadful”] backed Ms Truss’s plans: “We’re focusing on the people’s priorities – we shouldn’t be indulging in fashionable issues of political correctness”’ [23].

In all the cases mentioned above, Ministers of Departments, including the Prime Minister, have played a role in undermining a movement concerned to combat structural racism. While there may be divisions within the government, no Ministers have publicly challenged the anti-woke agenda trumpeted in these six cases, let alone exhibited sympathy towards an anti-racist movement or advocated any concrete measures to eradicate racial disparities. The government has instead intervened to subvert the fight against structural racism [13, 24].

In the US the attacks on PC have clearly been orchestrated. ‘Most of the conservative books and articles...repeat the same stories, use the same terms and [are] largely funded by bodies known to have right-wing leanings’ [25]. And, not surprisingly in a global world, something like that is evident now in the UK, with the recycling of the same themes, the same examples and indeed the same purported intellectual roots in postmodernism/cultural Marxism. The examples are typically ‘exaggerated or fabricated in some way’ [25]. Famous examples in an earlier period include the story that ‘local councils in London had banned black coffee and black bin liners on the grounds that they were racist’ [25] and the story that you could no longer celebrate Christmas in Birmingham because the city council had replaced it with Winterval, a story the Daily Mail later acknowledged to be false in 2011. On examination ‘almost all claims that “political correctness has gone mad” turn out

to be based on hokum and hot air' ([26]; see [2] for further examples). This unfortunately does not mean that they are not believed even years after first being aired. The campaign 'by the conservative right in the US [has been] very successful' in creating a PC bogeyman and stigmatizing the Left [25] and there is evidence that it is making significant headway in the UK [27].

A recent book which expressly looks at culture wars as they are playing out in the UK is very revealing in this context. The authors argue that 'culture war issues are those concerned with identity, values and culture which are vulnerable to being weaponised by those concerned with engaging and enraging people on an emotional level' [27]. In contrast to the US where 'groups split the same way on issue after issue' the UK witnesses a much broader consensus on many of 'the issues which most polarize the US, including climate change, gender equality and racial justice' [[27]; see also [10]]. One might have anticipated therefore that the UK would have avoided the culture wars waging in the US. This is not the case, however. 'There has been a huge surge in media coverage mentioning "culture wars"...and since 2016 coverage of the UK culture wars has taken off' [28]. The major driver for this is a political calculation: for key Conservative party strategists, 'the culture wars playbook is an indispensable part of holding together their winning electoral coalition post-Brexit' [27]. It seeks to demonstrates to working class voters in northern England who voted Conservative for the first at the last election that the government sees the world as they do and it seeks to tempt the Labour opposition to challenge them on territory of their choosing [6]. And all the while the media fans the flames, incentivized by their algorithms to pursue contentious stories.

Three main criteria indicate that we are witnessing a cultural wars issue: a group is represented as undermining order and tradition; we are depicted as losing out to the Other; and the issue is being blown out of all proportion.

An example of the first criterion is the attack on museums and the most popular heritage body in the UK, the National Trust for having the temerity to reveal their historical links to colonialism and slavery. The ensuing rows feed into a new political battle ground, with 'government ministers positioning themselves as "defenders" of history and the nations's pride', thus framing attempt to reconsider museum collections and 'expand the historical records as "attacks" on history and by implication, the nation and its people' [27].

An example of the second criterion of a culture wars issue is the attack on the concept of 'white privilege', a concept coined to point to the fact that White people, by virtue of being White do not have to deal with racism [29]. Racism is exemplified by the massively disproportionate use of stop and search on Black people relative to White people and is illustrated graphically in the experience of Bianca Williams, the British sprinter who was handcuffed during a stop and search operation in July 2020. Kemi Badenoch, Equalities Minister criticized the concept in Parliament in October 2020: 'We do not want to see teachers teaching their white pupils about white privilege and inherited racial guilt'. And the same refrain was evident in the Conservative dominated education report in June 2021 which claimed that white privilege may have contributed towards the systematic neglect of white working class pupils. The report juxtaposes poor white pupils and poor racialised pupils, and thus pits different groups against each other. This example constitutes 'the latest step in an ongoing campaign to use the underachievement of poor white people as a weapon to demonise antiracism and keep the same people angry at the wrong target' [30].

A recent example of the third criterion of a culture wars issue is the condemnation of the decision by students at Magdalen College, Oxford to remove a portrait of the Queen from their middle common room. The Education Secretary branded the move absurd: 'Oxford University students removing a picture of the Queen is simply

absurd. She is Head of State and a symbol of what is best about the UK. During her long reign she has worked tirelessly to promote British values of tolerance, inclusivity and respect around the world' (Williamson quoted in [31]). In the same week, the Culture Secretary also had recourse to Twitter, arguing that the decision of the English Cricket Board to suspend an English cricketer for a series of racist and sexist tweets when he was 18 was over the top. And the Home Secretary, initially supported by the Prime Minister, dismissed the decision by the England football team to take a knee during the Euros as 'gesture politics' and refused to condemn a section of the crowd for booing the team when they did take a knee [32].

The consequences of culture wars are disturbing in three ways. Firstly, they distract attention from substantive issues. The Black lives movement highlighted the importance of addressing structural racism, but the impact of stories about Rule Britannia being played but not sung at the Proms and pulling down historical monuments with racist links 'is to reframe the whole Black Lives Matter movement as being primarily about issues like this, leaving the casual observer thinking "all these street protests because you don't like old songs or statues?"' [27]. Secondly culture wars are divisive, stoking the idea that if a minority benefit, the majority must lose out. This is evident when for example the interests of minority ethnic groups and the white working class are deemed to be divergent. Thirdly culture wars produce an increasingly toxic public sphere, demoralizing people pushing, say, for racial justice. And they can backfire, with the comments of senior politicians arguably facilitating the racist abuse Black footballers faced after England lost in the final of the Euros. A senior Conservative politician puts it well: 'If we whistle and the dog reacts, we can't be shocked if it barks and bites. Dog whistles win votes but destroy nations...It shames me that in 2021 some in politics are still playing fast and loose with issues of race' (Warsi quoted in [33]).

3. Changing the narrative: the Sewell report

The confluence of widespread support for Black Lives Matter and the evident ethnic disparities in Covid-19 related mortality in a pandemic propelled Boris Johnson as Prime Minister to announce the setting up of a Commission on racial and ethnic disparities in June 2020. 'It was no use just saying that we have made huge progress in tackling racism...There is much more we need to do...We have to look at discrimination but what has slightly been lost in this is the story of success... What I want to do as prime minister is change the narrative so we stop the sense of victimhood and discrimination...and we start to have a real expectation of success' (Johnson, my emphasis, quoted in [34]). A month later, the membership was announced, with Tony Sewell as Chair and all the commissioners bar one being from an Asian, African or Caribbean background. The Commission was enjoined to inform a national conversation on race led by the evidence and building on the Race disparity audit launched in 2016. The key objectives were to identify persistent disparities in four priority areas, notably education, employment, criminal justice and health; to provide explanations for such persistent disparities; and to make appropriate recommendations to address them. The commission was asked to produce its report by the end of the year.

The decision to set up the Commission was greeted by many antiracists with skepticism, given the plethora of previous race inquiries, including seven since 2010, and 'no fewer than 200 unimplemented recommendations made by reports ordered by the Government' [35]. This disquiet was magnified by the fact that Munira Mirza, Head of the No 10 policy unit was placed in charge of organizing the commission and Tony Sewell was subsequently asked to be Chair. Both were

on record as skeptical of racism, as a causal factor for ethnic disparities generally [36] and education in particular [37]. Particular venom was expressed towards the concept of institutional racism, which in their eyes has become the ‘new orthodoxy’ [36] and for which the ‘evidence...is flimsy’ [37] but whose pervasiveness has ‘corroded BAME communities’ trust in public services’ [36] and resulted in some of them inculcating ‘the discourse of the victim’ [37]. It is revealing as we shall see that the positions adopted earlier by Mirza and Sewell are not only consonant with those of Johnson but also permeate the final report. The latter eventually saw the light of day at the end of March 2021.

The tone of the report [38] is set in the foreword written by the Chair. ‘Put simply we no longer see a Britain where the system is deliberately rigged against ethnic minorities. The impediments and disparities do exist, they are varied, and ironically very few of them are directly to do with racism...The evidence shows that geography, family influence, socio-economic background, culture and religion have more significant impact on life chances than the existence of racism’. Indeed it needs to be recognized that some White groups are also faring badly. While it is acknowledged that ‘racism’ is still ‘a real force in the UK, all too often ‘historic experience of racism still haunts the present’ and this perception inhibits acknowledgement ‘that the UK [has] become open and fairer’, with the data pointing in fact to ‘many instances of success among minority communities...An unexplored approach to closing disparity gaps [is] to examine the extent individuals and their communities [can] help themselves through their own agency, rather than wait for invisible external forces to assemble to do the job’. It is crucial in this context that we do not use concepts such as institutional racism loosely and in the process generate among members of minority communities ‘a fatalistic narrative that says the deck is permanently stacked against them’. Although ‘the UK is open to all its communities...the door may be only half open to some, including the White working class’. The report hence makes a number of recommendations in each of the priority areas examined in the report. These include measures to encourage the police to be ‘a more welcoming organization and Black communities...to overcome the legacy of mistrust’; and the creation of a ‘new Office for Health Disparities...to respond to the specific health and wellbeing of ethnic groups’. In education, ‘the “Making of Modern Britain” teaching resource, is [the] response to negative calls for “decolonizing” the curriculum. Neither the banning of White authors or token expressions of Black achievement will help to broaden young minds’. Rather than ‘bringing down statues’ it is important that ‘all children reclaim their British heritage’. In employment, it is important that measures are adopted which ‘foster talent from a wide range of backgrounds’ rather than engage in virtue signaling measures targeted at White people such as “unconscious bias” training’. Conscious of the fact that different communities have very different experiences, it is also argued that the term BAME (Black, Asian and minority ethnic) has past its sell date. Implementation of these (and other) recommendations ‘will give a further burst of momentum to the story of our country’s progress to a successful multicultural community – a beacon to the rest of Europe and the world’.

The introduction reinforces the themes outlined in the foreword. We do not live in a post-racial society. Racism still exists but we have come a long way as the success of ethnic minorities in education and to a lesser extent employment testifies. In addition, the roots of disadvantage are complex and as much to do with social class, family culture and geography as ethnicity. Indeed, the disparities found often do not have their origins in racism, a concept that has become inflated. Contrary to ‘an increasingly strident form of anti-racism that seeks to explain all minority disadvantage through the prism of White discrimination’, minority success and failure is often nothing to do with discrimination but stems instead from the cultures and

attitudes of minorities, especially ‘family life and structure’. The report seeks to be balanced, paying attention to minority successes in say overall health as well as the impediments to full participation. On this basis, it makes 24 recommendations around 4 themes (building trust; promoting fairness; creating agency; and achieving inclusivity) to address disparities.

‘BLM marches’ the report argues sought change in the UK as well as the US, but the narrative of many young people, focused on the belief that ‘nothing has changed for the better’ as a result of ‘institutional racism and White privilege’, alienates ‘the decent centre ground...The big challenge of our age is not overt racial prejudice. It is building on and advancing the progress won by the struggles of the past 50 years... The more recent instances where minority communities have felt rightly let down’ such as ‘the Grenfell tragedy or the Windrush scandal’ or ‘the disproportionate impact of COVID-19’ did ‘not come about because of design, and [were] certainly not deliberately targeted. We are as a society more open than 50 years ago, as the evidence of a commissioned study of social mobility [39] demonstrates. This study indicates that ‘ethnic minority children with parents in routine manual jobs were much more likely to achieve upward mobility compared with their White peers’ and that in spite of variations, ‘there have been more signs of social progress than regress...with some groups, like those from the Indian and Chinese ethnic groups doing even better than the White ethnic group, and other groups catching up’. We need therefore to look beyond race, especially given that in education, ‘White working class children trail behind their peers in almost all ethnic minority groups’.

‘Overt and outright racism’ still persists and is particularly severe in social media. We should be careful, however, not to be swayed by overly ‘pessimistic narratives about race’ generated by the ‘rise of identity politics’, which is in turn characterized by lobby groups with ‘a pessimism bias’ who highlight lived experience rather than objective reality: hate crime is not in fact rising; and higher mortality from COVID-19 is not a function of racism but socio-economic status and other factors. Ethnic minorities clearly are able to overcome obstacles and achieve success as is evident in a commissioned study on educational achievement [40]. This study demonstrates ‘that attainment is closely related to socio-economic status – once this is controlled for, all major ethnic groups perform better than White British pupils except for Black Caribbean pupils’. There are significant differences, however, between minority groups and this means that the concept of BAME ‘is no longer helpful’ and we need a more nuanced approach. The same goes with the language of race and racism. There is a tendency to conflate discrimination and disparities and to employ racism (especially institutional racism) in an inflated way. Macpherson’s definition of institutional racism which points to processes within organisations that have a discriminatory impact, the report argues, ‘has stood the test of time’ but ‘given that reporting hate crime and race-related incidents is now largely encouraged by police forces...and ‘there is much greater awareness and willingness to record and monitor such incidents’, the police can no longer be characterized, as the MacPherson report [41] did in 1999, in these terms. The perception that racism is increasing is facilitated by social media and is not helped by ‘the subjective definition of a racist incident...To limit the widening charge of racism’ we should assess ‘the intent of the perpetrator as well as the perception of the victim’. We also need clear definitions of different kinds of racism and distinguish different ‘forms of racial disparity’: explained (by other ‘factors such as geography, class or sex’) and unexplained racial disparities. We need to dispense with the notion of white privilege (as opposed to affinity bias) because it ‘fails to identify the real causes of disparities, and...is divisive’. Nonetheless racism persists and the report recommends strengthening the Equality and Human Rights Commission with additional resources to drive it out.

The UK suffers from ‘acute geographical inequality’ which ‘in simple numerical terms’ (but not proportionate terms) is ‘overwhelmingly a White British problem’. This reinforces the Commission’s view that ‘its recommendations should focus on improving outcomes for all - not centre on specific ethnic groups alone’. Nonetheless ‘racial disadvantage often overlaps with social class disadvantage’, with ‘people from minority communities...more likely to live in households with persistent low income’. Some groups have ‘transcended that disadvantage more swiftly than others’, with Indian and Chinese ethnic groups being significantly more successful than Black Caribbean and Pakistani/Bangladeshi ethnic groups. The commission identifies two factors which militate against success: family breakdown and limited cultural integration. Family breakdown is higher among Black Caribbeans and a lack of cultural integration is evident among Pakistani/Bangladeshis who tend to abide by different social norms, especially in relation to gender, with low economic activity and lack of English speaking among women evident. The commission is adamant that this is not about allocating blame.

When it comes to what we think about race, the Commission, while recognizing the continuing presence of discrimination, is optimistic both in the direction of travel and by comparison with other countries. What is crucial is that ‘we respect ethnic identities but also share a common, unifying, civic identity as British citizens’.

The four chapters focused on education, employment, crime and policing, and health cover a lot of detailed ground. My summary of these chapters perforce will need to be selective and below I shall focus on those parts which have not been mentioned earlier.

The education chapter focuses predominantly on schooling but does briefly allude to higher education. ‘Most ethnic minorities do relatively well in accessing higher education, including those from lower socio-economic backgrounds’ with ‘White students...the least likely to go to university’. At the same time, the report acknowledges that students from the minority groups are less likely than their White peers ‘to ‘progress to the more elite high tariff universities’ and that ‘once at university ethnic minority students -with the exception of Asian students – are more likely to drop out, have lower levels of attainment, and lower earnings after graduation’. In the light of this, the Commission recommends better careers advice and ‘stronger guidance from the ‘Office for Students’.

The employment chapter argues that ‘there has been a gradual convergence on the White average in employment, pay and entry to the middle class, with some groups overtaking the White majority and others somewhat underperforming’. The picture is not quite as bright when it comes to advancement ‘into the very top positions in professional, business and public life’. It is acknowledged that ‘bias, at least in hiring, exists as ‘job application field experiments...carried out in the UK since the late 1960s’ demonstrate. The report warns us, however, to be circumspect: ‘We know that discrimination occurs, but these field experiments cannot be relied upon to provide clarity on the extent that it happens in everyday life’. Varying promotion rates may also signify discrimination. Certainly ‘there is a perception that people at the top tend to have affinity bias, appointing people in their own image’. We are all prone to affinity bias but the bias of those who ‘tend to dominate the top positions... matters more...Many companies have been prompted into intense soul-searching with regard to race, prompted by the Black Lives Matter movement. They have adopted various diversity and inclusion [initiatives]’. Unfortunately, ‘most researchers remain sceptical about the impact of unconscious bias training, quotas and diversity specialists’. The answer is certainly not unconscious bias training, which is counterproductive, discriminatory and ‘alienating’. Far more useful are “‘nudge”-style procedures’.

The crime and policing chapter expends considerable energy examining the ‘disparities in rates of stop and search between Black and White people’. In the Commission’s view, these disparities need to be placed in the context of ‘disparities in crime, and often violent crime, that lie behind stop and search’. We need ‘to acknowledge other factors, in addition to racism, when considering disproportionality’ especially given that ‘great strides have been made towards becoming a service that can fairly police a multi-ethnic society’. There is a mismatch between government and police narratives over the drivers for the use of stop and search, with knife crime highlighted by politicians and drug offenses by the police. While there are indeed significant national disparities in stop and search, they need to be analyzed at ‘smaller geographic areas’ with ‘relatively high crime rates where stop and search is used more’. Both the communities and the police need to take action; there need to be ‘community based initiatives to divert young people away from criminal activity’, but at the same time the police need to ensure that stop and search is ‘used fairly and properly’ to prevent encounters with a few ‘rogue elements within [the police]’ reinforcing historical mistrust generated by ‘unfair and excessive policing in the past’. In addition to disproportionality in stop and search, there is also evidence of disproportionality in the use of restraint, sometimes with tragic consequences. While we cannot be sure ‘that racism was a factor in deaths in police custody’, there needs to be increased ‘training in de-escalation techniques’ and more monitoring by senior officers. In addition, the legitimacy and accountability of stop and search need to be reinforced through the use of body worn video. And there needs to be a more uniform approach to promote transparency, community involvement and scrutiny. There is also in the Commission’s view ‘a case for treating low-level class B drug possession through alternative pathways outside of the criminal justice system’. While progress has been made in creating ‘a more diverse police force... policing remains a cold spot, especially at the top’. This is partly because ‘police from ethnic minority backgrounds’ often experience ‘shocking abuse’ from ‘other ethnic minority citizens in the communities they serve’. The commission found ‘no available data on charges of racism in the police workforce’ though it does mention ‘significant differences between White and ethnic minority officers in the amount of internal conduct allegations and the severity assessments made by professional standards departments’. Despite the progress towards a more diverse workforce, the Commission nonetheless acknowledges that ‘progress remains frustratingly slow’.

The health chapter argues that for many key health outcomes, ‘ethnic minority groups have better outcomes than the White populations... Ethnicity is not the major driver of health inequalities’. Although the evidence is that deprivation, geography and differential exposure to key risk factors are far more important, it is acknowledged that we need further research to understand differences between ethnic groups, given that this was beyond the remit of the major review of health inequalities, the Marmot review. It is acknowledged that there are significant ethnic disparities in mortality arising from COVID-19, but it is stressed that this is ‘driven by risk of infection’, occasioned by living in densely populated areas/households and comorbidities, ‘as opposed to ethnicity alone being a risk’. Unlike other reports, the Commission found ‘no overwhelming evidence of racism in the treatment of and diagnosis of mental health conditions’. There is disparity in community treatment orders and detention, but this is not necessarily evidence of racism since there is a difference in the prevalence of mental illness, though albeit a key risk factor here is racism.

The conclusion to the report stresses that we should abandon ‘the old idea of BAME versus White Britain’ and be optimistic. Yes, there are disparities but they are not always negative and cannot be understood purely in terms of ‘race based discrimination’ We need also to consider ‘the role of cultural traditions’ and social

class, and recognize the importance of agency. The BLM movement has put the race issues back on the agenda, but we should not be fatalistic, accentuate differences and offer solutions based on the binary divides of the past. Instead we should be infused with the spirit of British optimism, fairness and national purpose that was captured by that 2012 Olympic opening ceremony, and has animated this report’.

4. Challenging the narrative

The report purports to be balanced and provide an evidence-based contribution to the national conversation over race inspired by the Black Lives Matter movement. And there is indeed much of merit in the report which is consonant with the academic literature in this field:

- Britain is characterized by ‘racial disadvantage and ethnic diversity’ [42]. Minority ethnic groups continue to face some common disadvantages in comparison to the majority ethnic group, partly because of racial discrimination (racial disadvantage) but at the same time there is considerable diversity in the socio-economic position of different minority ethnic groups (ethnic diversity).
- Racism persists and has a significant impact on individuals and families in minority communities.
- We cannot assume that racial disadvantage/ethnic disparities stem from racism or racial discrimination, but need to examine the evidence carefully and employ key concepts in an analytical way.
- There is considerable evidence that minority ethnic groups have made considerable strides in education and to some extent in employment.
- We need to recognize the agency of minority ethnic groups who continue to invest in education and draw on the cultural capital of their own communities to resist discriminatory practices and thus improve their situation.
- Britain has been less reluctant than many other countries to collect data on people’s ethnic identity and has been at the forefront in Europe in developing anti-discrimination/equality legislation.
- Further measures need to be taken for Britain to become a vibrant multi-cultural society which strikes an appropriate balance between the need to treat people equally, to respect different ethnic identities, and maintain shared values and social cohesion.

Despite these merits, any hopes that the report would shift the national conversation away from ‘culture wars’ towards a balanced informed discussion about race were quickly dashed, with the same antagonists in the culture wars at each other’s throats again. The resignation on the day of publication of No 10’s race advisor, Samuel Kasumu, who had earlier expressed dismay at the government for pursuing a ‘politics steeped in division’, was an early portent. Some commentators welcomed the report seeing it as a powerful challenge to ‘the pessimistic identity-politics-based race narrative that has become so influential in recent years’ [43], but most were highly critical, with one journalist describing the report as ‘shoddy...littered with mistakes and outright mangling of sources, alongside...

selective quoting' [44] and one academic describing it as 'poisonously patronizing' and 'historically illiterate' [45].

What is evident when we examine the report is that the central thrust of its narrative has an 'optimism bias', which, while recognizing racism and racial discrimination, tends to downplay their prevalence (as evidenced in attitude surveys and field experiments), significance (as illustrated not only by racist abuse but also micro-aggressions) and systematic nature (with organizations across the board producing unequal outcomes). There is some justification in seeing education as a success story, but the world of work is another matter. Here the report's optimism bias glosses over what is for many members of minority communities a difficult transition. Field experiments clearly demonstrate racial discrimination in the labour market. Such discrimination is associated with ethnic penalties, but the latter varies by group, with some groups having more resourceful social networks so that they are able to be relatively successful in spite of discrimination [46]. Investment in educational pays off, but the return for minorities is less than that for their White peers. Ethnic minority graduates are much less likely to be employed than their White peers six months after graduation, even after controlling for class and education, and an earnings gap apparent in the early career of British graduates persists long after graduation [47]. Ethnic pay gaps are in fact large and stable once suitable controls are put in place, and it's by no means clear that things are getting better. Comparison of disparities in pay, employment and unemployment among different ethnic groups shows that there has been little change over the past 25 years. Indeed for black, Pakistani and Bangladeshi men and women pay gaps with white men and women have widened. While 'there are some groups for some labour market outcomes where there is clear evidence of reducing ethnic penalties, the overriding impression is of stasis' [48, 49].

The report rightly says that the system is no longer rigged against ethnic minorities, but when commentators attribute disadvantage to racism or racial discrimination, they are not typically arguing that the racism or racial discrimination is intentional. Indeed, the contention in the report that racism requires 'the intent of the perpetrator as well as the perception of the victim' contravenes the tenor of equality legislation which does not require proof of intention when a judgment as to whether discrimination has occurred is made. The report frequently focuses on racism at the individual level and here it rightly acknowledges its toxic nature on social media. Much less attention is paid, however, to the historical roots of racism [see [24]] or the structural forces that sustain it, or (as we shall see below) racism at the institutional level.

The Commission is clearly correct in recognizing that race and ethnic disparities do not in themselves demonstrate racism or discrimination. Correlation is not the same as causation. The commission's approach in seeking to explain disparities is, however, deeply flawed. It divides disparities into two kinds, explained and unexplained, as we saw earlier. This means that disparities 'are either explained by factors other than racism – or there is no evidence so they are unexplained'...there is [thus] no way, within its framework, to demonstrate that racism or discrimination...is actually causing the observed disparities in outcomes' [50]. Even worse is its use of regression analysis from which it commonly infers in the report that racism is a less significant factor than other factors. This is a statistical error. 'The impact of someone's race on their health cannot be dismissed by saying "well, actually, poverty is the "real" cause, if poverty and race are – as they are in the UK – inextricably linked...Structural inequality is a complex interplay of causes and outcomes – and one variable can be both at once. Sticking in as many variables as possible on one side of a regression and claiming you've "explained" away race and racism...is not a credible analysis' [50]. This has been labeled "the garbage can"

approach to statistics: the calculations appear to be scientific, but in reality they are meaningless'. What is more, this approach 'displays a basic misunderstanding of how racism works. Often various statistical factors, such as people's socioeconomic status or geographic location, are themselves products of racism' [51]. The higher mortality rate of ethnic minorities from COVID-19 'can be attributed to living in deprived areas, crowded housing, and being more exposed to the virus at work and at home – these conditions themselves the result of longstanding inequalities and structural racism' [52].

At the launch of the report and in the press release, Tony Sewell stated that the report found no evidence of institutional racism. This was a significant and incendiary claim because the Macpherson report had argued in 1999 that institutional racism was rife in Britain. The Commission's report itself, however, is more circumspect, in acknowledging the existence of institutional (as well as individual) discrimination and even recognizing merit in MacPherson's definition of the term. And yet when we examine the report, there is an extreme reluctance to point to any examples of institutional racism. An obvious example is the Windrush scandal in 2018 which saw significant numbers of Black Caribbeans being wrongly detained and in some cases deported by the Home Office. The Commission mentions the scandal but emphasizes that it was not intentionally designed or deliberately targeted. What it does not mention is that an independent review led by Wendy Williams found that the Home Office had displayed 'institutional ignorance and thoughtlessness' on race issues, 'consistent with some elements of the definition of institutional racism'. Interestingly, she adds a coda which is pertinent to the authors of the Sewell report: 'There seems to be a misconception that racism is confined to decisions made with racist motivations...This is a misunderstanding of both the law and racism generally' (Williams quoted in [53]).

The extreme reluctance to identify any examples of institutional racism is further evidenced by the one occasion when the question of an organization being institutionally racist is addressed. The charge that the police remain institutionally racist is dismissed on the flimsy grounds that there is more reporting and recording of racist incidents. It seems remarkable that the report did not examine, as previous research has done (see [54]), whether prevailing cultural assumptions and routine practices in the police continue to have a discriminatory impact, before reaching its judgment. The crime and policing chapter, while providing some pertinent data, ultimately shies away from seeing institutional discrimination, preferring instead to believe that there are a few 'bad apples' or 'rogue elements'.

Rather than flirting with the notion that powerful organizations may be institutionally racist, the report tends to be uncritical towards them. While I recognize that it may be politic to assert that the government which has commissioned the report takes race equality seriously and has sought to implement the recommendations of previous reports, both claims are highly questionable. Arguably, the recommendation to the government to strengthen the body responsible for enforcing anti-discrimination legislation is a brave one, but it is notable that it eschews any comment on the EHRC's steady emasculation since 2010 and does not incorporate a recommendation to the government to activate the socio-economic duty, Section 1 of the Equality Act and in this way address the socio-economic disadvantage highlighted in the report. What is more evident is that the issue of race inequality, which was propelled into the limelight by the Macpherson report and for a period was taken seriously by the Labour government, dropped off the agenda until the Black Lives Movement resuscitated it. The consequence of the neglect to address race equality in the intervening period is that many of the recommendations the report makes have been made before. Examples are manifold: in education, improving data collection, monitoring and quality of analysis, and providing better

careers guidance; in employment, advancing ‘nudge’-style procedures such as name blind CVs, transparent performance metrics, proactive mentoring and networking procedures; in policing, training in de-escalation techniques, increased monitoring by senior officers, more community involvement, measures to increase police diversity; and in health, more research. There is only one occasion when the Commission shows some exasperation when it fulminates that ‘the gap in achieving the right workforce mix has been driven by a lack of consistent political and police leadership focus on this issue over the last 40 years’ [38].

The report rightly acknowledges the agency of ethnic minorities who have indeed been resourceful despite facing unique hurdles. Although the Commissioners acknowledge the importance of structural factors such as socio-economic position in influencing outcomes, their emphasis on agency means that they are often concerned to emphasize what people can do for themselves. This is important, but to produce significant change in, say, employment or health outcomes, we need to address the structural factors responsible. And there is a danger in honing in on individuals, families and communities rather than structural factors. The danger is that the responsibility for disadvantage is seen to lie within those individuals, families and communities. This is evident when the report explains why some minority groups have been less successful in transcending class disadvantage than others. ‘Its answer is “family structures” and “cultural traditions”’ [55]. Family breakdown, which is in fact an attribute of poverty, entails negative outcomes for Black Caribbeans, while lack of fluency in English, among a small number of older women, purportedly holds back the economic advancement of Pakistani/Bangladeshi. The report is at pains to point out that it is not blaming the communities in question, but in arguing that the causes of disadvantage lie primarily within those groups, ‘social issues...are reframed as moral choices and the behaviour of individuals’ [55]. Despite the protestations of the authors of the report, this is tantamount to a victim blaming discourse.

5. Conclusion

Black Lives Matters (BLM) have put structural racism back on the agenda, but the initial optimism felt by many anti-racists that at last action would be taken to promote racial justice has been somewhat dashed by the backlash to this agenda. This backlash needs to be seen in the context of an anti-political correctness discourse which is extremely pervasive. This discourse comprises a major interpretive framework in the media uncritically reproduced by many journalists. Populist politicians are all too happy to propagate this discourse and indeed have not been averse to fermenting culture wars and pursue an anti-woke agenda which they believe play well with their constituents. The Sewell report was commissioned by the government in the UK because it needed, given the popularity of the BLM movement, to be seen to be responding. The government was careful in its choice of Chair and choice of Commissioners, and we should not therefore be too surprised that the final report draws upon many right wing tropes and was consonant with the positions earlier taken by Boris Johnson, Munira Mirza and Tony Sewell: challenging the pertinence of key concepts such as institutional racism, white privilege and decolonizing; questioning the purportedly subjective definition of a racist incident; stressing what people can do for themselves; critiquing diversity specialists, unconscious bias training and quotas; downplaying racism and playing up geography and the White working class; presenting a caricature of antiracism as pulling down statues, excising White authors etc.; dismissing what it characterizes as identity based politics; and extolling Britain as a beacon to the world. Far from


the report moving us beyond the culture wars, it has itself become employed as a weapon in these wars. ‘The report strikes a major blow against institutional woke-ness’ shouts one academic [56]. In the process, the report has become the latest manifestation of a strategy to delegitimize antiracism; ‘anyone who talks about racism is simply doing Britain down, smearing white people, forcing a woke agenda “down our throats”’ [56].

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Section 3

Education

Perspective Chapter: Behind the Exceptional Educational Pathways of Canadian Youth from Immigrant Background - Between Equality and Ethnic Hierarchy

Pierre Canisius Kamanzi and Tya Collins

Abstract

This chapter aims to show that, behind the general exceptional academic pathways of Canadian students from immigrant backgrounds, some of these young people, belonging to racialized ethnic minorities, are less likely to access and graduate from postsecondary education. Its specific objective is to describe the general portrait of their educational pathways. A synopsis of some recent studies shows that that these students often face structural barriers at the institutional level. Comparative analyses between young Canadians of immigrant origins and their peers who are not recognize the remarkable success of Canadian immigrants, a rather exceptional phenomenon compared to what is observed internationally. However, this chapter stresses that this portrait must be nuanced: a number of studies highlight significant disparities among young people from immigrant backgrounds according to the ethnocultural and geographic origin of their parents. The situation is less favorable or unfavorable, in the case of certain racialized groups. Therefore, following an overview of the contribution of studies inspired by a postpositivist approach, this chapter highlights some dimensions that have been traditionally obscured. This allows for a better understanding of the relationship between the effects of various factors (individual, institutional, systemic) that structure and perpetuate inequalities and ethnic hierarchy among students from immigrant backgrounds.

Keywords: Canadian immigrants, academic pathways, educational inequalities, racialized groups

1. Introduction

A large international body of research denounces the existence and persistence of significant inequalities in terms of academic success between young people of immigrant origin and their peers whose parents were born in the host country. To various degrees, the academic results of the former are inferior to those of the latter [1–3]. This disparity markedly reduces access to, and perseverance in higher education. In Canada, the situation of young people of immigrant origin seems rather

exceptional: in general, their academic results at the primary and secondary levels are comparable to and even higher, in certain cases, than those of their peers whose parents are Canadian by birth or part of a majority group, i.e., of Euro-Canadian descent [4–6]. In this light, are academic and social inequalities non-existent between Canadians by birth and their fellow citizens of immigrant origin? The situation seems somewhat qualified because the success of students of immigrant origin obscures significant disparities along ethnocultural lines. Though young people whose parents are from European, Arabic (North Africa and the Middle East), and East Asian countries have levels of academic success that are comparable to and even higher than those of their peers whose parents are Canadian-born, those whose parents have immigrated from the Caribbean, Sub-Saharan Africa, Latin America, and, to a lesser degree, South Asia have lower levels of learning achievement and access to higher education than the others [7–10]. Furthermore, even the few who attain university have perseverance and graduation rates that are relatively inferior in comparison to the others' [11]. Consequently, this chapter is proposing to explore why this is happening. Drawing on the existing literature, we will show that these young people have had experiences associated with hidden systemic discrimination.

To begin, it must be noted that this chapter concerns a cross-sectional and critical analysis of recent studies on this issue, rather than primary research. The cases we reviewed made it possible to highlight their convergences and general trends. As such, we demonstrate that, behind socio-economic integration and the undeniable academic success of young Canadians from immigrant backgrounds, there is an emergence and a perpetuation of inequalities as well as a certain ethnic hierarchy.

The chapter is divided into three sections. The first provides a general portrait of young immigrants' academic pathways. The second and the third respectively address the institutional and structural factors of systemic discrimination in the academic environment. We end with a conclusion that identifies potential solutions to reduce these inequalities, and prospects for future research that might inform public policies in education.

2. Young peoples' immigrant origins and academic pathways

Using data from PISA tests (reading, mathematics, and science), Hochschild and Cropper [4] compared the results of students from immigrant backgrounds to those from non-immigrant families in eight industrialized countries (Switzerland, Germany, Belgium, United Kingdom, Australia, France, Canada, and the United States). Their analyses reveal that students from immigrant backgrounds demonstrated inferior performances comparatively to other groups, with the exception of those from Canada and Australia, where the results between immigrant and non-immigrant student groups were comparable. Moreover, in Canada's case, there was no difference in terms of higher education access [8, 12–14].

This exceptional situation has been attributed to the specificity of Canadian immigration policies, which are distinguished both by their selective nature, which favors educated and qualified immigrants, and by concrete measures for integrating newcomers [6, 15]. The situation is also associated with parental educational and cultural capital, manifested in the high educational and professional aspirations they hold for their children.

Nevertheless, this general portrait must be qualified. An abundance of scientific literature testifies to the existence of disparities along ethnocultural lines, particularly in terms of access to and graduation from higher education. If students whose parents are from Europe and East Asia have the highest graduation rates, those

whose parents are from the Caribbean, Latin America, and Sub-Saharan Africa have the lowest rates [8, 13, 16, 17]. Recent studies have highlighted belonging to a racialized group (socially assigned a racial identity within a structural domain of power) plays for parents and students [18]. This situation particularly concerns students from Black communities. Though these students are distinguished by a higher level of aspiration to post-secondary studies than their non-racialized peers [19], they are more inclined to access technical studies in college than other students, and less likely to access university and obtain a diploma [10]. Moreover, adults belonging to these communities suffer more discrimination on the job market, even when they are highly qualified [20]. They are more vulnerable to unemployment and receive salary incomes that are markedly lower than those of members of the non-racialized majority [21], which in turn has negative effects on their offspring's schooling. The influence of their low socioeconomic status seems to weigh heavily and lastingly on their children's schooling, as the work of Abada et al. [16] has shown. These authors show that race and ethnicity are important factors in the production and perpetuation of social inequalities in the educational systems of Canadian provinces.

Research on the academic pathways of young Canadians of immigrant origin is dominated by empirical studies based on quantitative data and methods that emphasize individual and school characteristics, such as the parents' school performance, socioeconomic status, and ethnocultural origin. Although this research provides a good understanding of the pathways of students from immigrant backgrounds in Canada, its scope is limited. Beyond individual and collective attributes, recent qualitative studies highlight the influence of institutional contexts, practices, and policies. Many authors show that educational inequality along ethnic lines is produced through the relationships students have with the schools they attend; in other words, it falls within the responsibilities of the schools and their members [22–24]. This is illustrated in the subsection below, which examines the integration experiences of students from immigrant backgrounds and their interactions with the institutional structures of the schools they attend.

3. Institutional barriers to socio-educational integration

Students' educational perseverance and success are the result of their social experiences and academic pathways, which are formed through the relationship between their individual projects and their commitment to the institution they attend [25]. In other words, perseverance and dropping out can be considered as an effect of the quality of the experiences resulting from the individual's interaction with the school. Integration, which can be defined here as the process by which students engage intellectually and socially in the community, is a decisive factor in persevering in school. As for the academic path of students from immigrant backgrounds, research has identified a number of phenomena likely to have a negative effect on and even compromise integration success. These phenomena may occur prior to their entry into post-secondary studies (preadmission), at the time of transition, or over the course of their studies.

In Canada as elsewhere, even before they access higher education, many students of immigrant origin are likely to have had school experiences that were unfavorable to success. This is the case for members of racialized groups. They are relegated to special education and vocational streams more often, which strongly reduces their chances of admission to postsecondary education, particularly university [10, 16, 26]. This aspect deserves to be highlighted because vocational high school graduates who access postsecondary studies, particularly university, are rare [27], as are vocational college graduates who obtain university diplomas [28]. Studies conducted in the

provinces of Quebec and Ontario highlight the early downgrading of Black students and their subsequent overrepresentation in the category of students with adjustment problems and special needs [29].

Contrary to government discourse, the recent implementation of accountability policies since the 2000s has particularly contributed to increasing educational inequalities based on students' social and ethnocultural origin [30, 31]. Far from improving the social inclusion and success of all students, the use of standardized tests and competition between schools rather marginalizes students from socioeconomically disadvantaged families, racialized ethnic minorities (especially those from Sub-Saharan Africa and Latin America) and Indigenous communities. For these students, such practices are said to constantly fuel anxiety, frustration, humiliation, and feelings of incompetence, which can drive them to dropping out [32].

A study conducted by Anisef et al. [33] in Ontario province (N = 8,443) revealed that students who had been placed in enriched streams in high school had 9.36 times more chances of accessing postsecondary education than their peers in regular streams. Yet, while a growing number of students from immigrant backgrounds are in enriched streams [34], certain groups are excluded from them in subtle ways. This is the case of students whose competencies in the language of instruction are deemed inadequate and of those who belong to racialized groups of Southeast Asian, Sub-Saharan African, and Caribbean origins [10, 17]. A recent study by Kamanzi [35] in Quebec province showed similar findings: Black students from families who had immigrated from Sub-Saharan Africa and the Caribbean were markedly less likely to attend a private or public school offering enriched programs in all or some of the subjects taught. Conversely, they are overrepresented in public institutions exclusively offering regular (basic) programs and are more likely to have repeated a grade or experienced adaptation or learning difficulties. Although they demonstrate resilience and perseverance until college, they are less inclined to graduate from it and access university because of previously vulnerable academic pathways.

Beyond educational competencies, students' academic integration into is conditional to his/her access of information that they and their parents can use to develop future projects aligned with their values, and those of other members of the community. While certain students from immigrant backgrounds benefit more from resources that come from their families (academic, cultural, and social capital), facilitating their pathways to and in postsecondary education, others must demonstrate greater autonomy and resilience to structure their role as students.

Qualitative studies reveal that access to information is a major obstacle. It is a recurring theme in the discourses of the young Canadians of immigrant origin investigated by Magnan et al. [36], who, when the time came for them to make decisions regarding postsecondary studies, were, along with their parents, mistakenly presumed by school personnel to be equipped to decode the mechanisms of the transition from high school to college or university. Such presuppositions can in certain cases lead to obstacles, such as the feeling of being unable to fulfill admission conditions for the postsecondary education program of their choice [37]. This situation particularly concerns students from the Caribbean and Latin America [37, 38].

Immigrants face many other obstacles associated with the quality of their social networks. Among these obstacles are constraints related to a misunderstanding of the admissions process, a lack of information about learning assessment requirements, language tests, and the need for extra courses [39]. Many of the students that were interviewed also reported that they received little aid or services when they needed them and that they dealt with university personnel ill-disposed to listening to them and taking the time to support them [39, 40]. Everything seems to indicate that these students continually face hidden systemic discrimination [22–24].

4. Structural barriers and systemic discrimination

Though the sociopolitical context for welcoming immigrants to Canada is undeniably more favorable to their integration than in other countries of immigration, research has demonstrated that inequalities persist in a number of areas, including education. Though certain groups of immigrants are, for example, overrepresented in university education, others are underrepresented [33]. A study by Abada and Tenkorang [7] based on data from the ethnic diversity survey conducted by Statistics Canada in 2002 revealed that the rate of university attendance at eighteen years of age is higher for students of Chinese origin (54%) and from Southeast Asia (44%), but lower for members of Black communities (31%), in comparison to Canadians by birth (36%). Based on data from a longitudinal survey (the Youth in Transition Survey), Kamanzi et al. [8] and Thiessen [13] came to similar conclusions. According to Thiessen [13], the low level of academic competence and higher education attendance observed in young people from Black and Latin American communities is the effect of interacting cultural and structural factors. Their schooling is undermined by both cultural values that are often unfavorable to educational success, and the poor living conditions of their families. Other work has highlighted the existence of systemic discrimination toward certain ethnic groups through ethno-cultural grouping practices [23, 41]. Such practices particularly affect students from Black communities, as the work of Henry and Tator [23] has shown. Potvin and Leclercq [42] have noted common institutional practices that consist of relegating these students from the youth sector to the general adults education sector (short vocational training), precluding them from pursuing higher studies. Belonging to a racialized group, particularly a Black community, is a major factor of vulnerability, primarily because of the lack of diversity in schools' teaching and administrative staff (associated with a lack of role models), the Eurocentric character of the curricula, and the students' day-to-day experiences of discrimination and racism [23, 36, 39, 43].

Numerous studies in Canada describe perceived discrimination and racism self-reported by students from immigration backgrounds [38, 39]. In quantitative terms, the study by Abada, Hou, and Ram [16] on inter-group differences in university completion in fifteen racialized groups of second-generation immigrants (born in Canada, but whose parents are immigrants) reports that 50% of these students have felt marginalized because of their ethnicity, their culture, the color of their skin, their accent, or their religion. According to the same authors, the feeling of exclusion experienced since childhood, affects academic perseverance and success.

In qualitative terms, examples of perceived discrimination and racism have also been reported by students. Among other things, they refer to a stigmatization of *otherness* founded on a lack of linguistic competence or accent [39], an unexpected, increased categorization of "minority" status and racial difference by the majority group [39, 44], and violence (harassment, bullying, and threats) experienced in the academic environment [23, 45]. In addition, the prejudices and ideology of the dominant group, and the stereotypes, prejudices, and pure and simple ignorance of the teaching staff in relation to the *Other* [racialized students] contribute to provoking stress, despair, and a feeling of alienation in immigrant students and have a negative effect on their school performance. This at least is what can be deduced from a qualitative study of 22 students from Southeast Asia conducted by Samuel and Burney [46] in an Ontario university. According to these students, the outsized importance accorded to Eurocentric curricula elicits feelings of exclusion and marginalization. Even when elements of the curriculum are not Eurocentric, the students observed a penchant for Anglo-Saxon assumptions and premises. Similar perceptions were reported in studies of immigrants from the Caribbean, Central Asia, and Sub-Saharan Africa [38, 44, 45].

Of all students belonging to racialized groups, Black student in particular are most at risk of experiencing discrimination, which considerably reduces not only their chances of accessing postsecondary studies, but also their perseverance in them. Qualitative studies conducted on these students reveal how constantly they are faced with racial stereotypes and prejudices: they describe teachers and, more broadly, academic staff tending to underestimate the students' levels of academic engagement and consequently their academic competency [38, 44]. At the high school level, students mentioned the fact that guidance counselors pushed them toward less demanding and less valued studies, such as lower-level courses, with the effect of restricting and even eliminating their chances of being admitted to university [38, 44]. Once in postsecondary studies, their risk of dropping out is the highest (29%), as shown in a study conducted by Abada and Tenkorang [7] in the province of Ontario. Far from being arbitrary, the prejudices and stereotypes these students face are, in part, anchored in systemic racism and exercise a negative effect on these students' feelings of confidence and motivation and, consequently, on their perseverance and success in school [19].

5. Success and perseverance of racialized students: where resilience and destiny meet

Research recognizes in human beings the ability to produce and mobilize protection mechanisms that enable them to overcome situations of adversity or bypass them to succeed [47]. Commonly referred to as the concept of resilience, this phenomenon refers to the capability and ability of an individual or social group to return to a stable state after disruption caused by personal constraints and environmental factors [48]. In the world of education, resilience refers to students who, despite obstacles related to their personal difficulties or obstacles related to the school and family environment, manage to cope and succeed in their studies [49]. Referring to certain of these students' ability in situations of ethnic or racial discrimination to overcome various discrimination-related obstacles and succeed in adapting exceptionally, Anisef and Kilbride [50] speak of *ethnic resilience*.

Recent research has shown that these students manage to procure resources independently — despite the multiple obstacles barring their access to the information they need to make informed decisions throughout their education up to postsecondary studies—demonstrate motivation for success, and reverse teachers' negative image and low expectations of them—in short, to take control and make it on their own [38, 39, 44, 46, 51]. However, research emphasizes that there is price to pay, often a heavy one. Despite the fact that they are often relegated to second-rate programs and institutions, some of these students use them as a springboard to “get out” and access the most prestigious, or at least the most desired, choices. They even manage to strongly affirm their ethno-racial identity and make it an instrument in structuring their academic and professional careers [38, 39, 44, 46, 51]. However, as mentioned above, many do not escape structural obstacles and end their educational pathways by shortening studies or simply dropping out because of various forms of segregation and systemic discrimination.

Though academic aspirations and commitment to studies are essential conditions to accessing postsecondary studies, they aren't sufficient to succeed and obtain a diploma. Just as it is important to recognize the *compensatory advantage* of resilience, it is also important to take into account the *cumulative disadvantage* that the academic pathway presents in elementary and secondary school [52]. In other words, depending on the scope of the social and academic exclusion mechanisms at work in the context, the former may prevail over the latter and vice versa.

6. Conclusion

The objective of this article was to show that, behind the general portrait of the exceptional academic paths of Canadian students of immigrant origin, some of these young people, belonging to racialized ethnic minorities, are less likely to access and graduate from postsecondary education. The studies reviewed show that these students often face structural barriers at the institutional level. In elementary and high school, they report having been victims of prejudice and stereotypes, which would partially explain their lower levels of success and perseverance in comparison with others. Their cognitive potential is often underestimated by teachers, which causes them to develop a low feeling of competence and motivation to perform. In terms of institutional services, they are more likely to be relegated by guidance services to low-level streams offering little or no opportunity to access postsecondary studies. They also have less access to information on admission requirements for postsecondary studies and receive little help in terms of preparation strategies for various national assessment tests. These different types of segregation form part of a larger world of hidden, indirect systemic discrimination [23]. In other words, there is a kind of ethnic hierarchy as elsewhere like in U.S. [53].

At the root of this type of discrimination, are economic and symbolic power struggles. In the contemporary period that characterized by the expansion of the knowledge economy more than ever, education and academic qualifications have increasingly become tools for maintaining or acquiring strategic social positions. Education, therefore, becomes a field of competition and power struggle between different social groups, ethnic groups included. The winners are those who have the economic, social, cultural and political resources. Despite equal opportunity policies, we find ourselves, to varying degrees between societies, in a situation of effectively maintaining inequalities [54].

In order to eradicate this discrimination, public policies must put in place meaningful institutional measures based on the principle of equity and on fighting exclusion, whatever its form. From a moral and political standpoint, such measures are aligned with principles of equality and social justice. In contemporary societies, equality of access and of success at all levels of teaching, including postsecondary studies, is recognized as a common good [55] and an instrument for promoting individual and collective welfare and social inclusion [56]. From an economic standpoint, these measures are an opportunity to identify, develop, and value the potential of all citizens whose talents in human capital terms are randomly distributed throughout society, including in socioeconomically disadvantaged communities [57]. A range of Canadian research has demonstrated the capacity for resilience of some of these students who belong to racialized groups [35, 50]. Despite the negative influence of the precarious socioeconomic conditions of their parents and of multiple school and social integration challenges, some of these students demonstrate perseverance and performance in postsecondary studies. Often associated with the quality of the different forms of capital (academic, cultural, and social) that their parents—themselves resilient and faced with socio-professional segregation [21, 58]—seek to mobilize, this resilience is also attributed to these students' cognitive potential and commitment to succeed, despite the aforementioned obstacles.

Therefore, public authorities are called upon to put more emphasis on improving conditions for learning and on supporting success. In the present context, such measures would cover not only educational resources (time, the quality of school and extracurricular activities, and material resources) to address the gaps inherent in social origin, but would overcome the effects of the socio-academic segregation to which these of all students are exposed [59]. Among other things, they involve

diversifying the school's teaching and administrative staff, providing access to information and support and assistance services, and giving the staff professional training in interculturality. Such measures build on the strengths of resilience to promote excellence, as Motti-Stefanidi and Masten [59] emphasize: "focusing on strengths and resilience, instead of on weaknesses and psychological symptoms, among immigrant youth has significant implications for policy and practice" (p. 19) That said, in the long term, the solution should rather be to eradicate the racism underlying society and establish true social and academic justice where recourse to resilience and survival mechanisms is no longer required.

It is important to pursue research through different disciplines (particularly sociology, political science, psychology, and anthropology). With the goal of better informing public and institutional policies, this research must take an intersectional approach to appreciate the complexity of the modes of multiple-identity interaction in different contexts [60]. This approach has the advantage of taking into account not only the interaction between an individual's multiple identity markers, but also the way inequalities are constructed and renewed via social power relationships, contributing in this way to forging social identities [61]. By focusing the research on systemic and structural factors, future studies would shine a light on the macro-sociological dynamic of immigrants' academic paths and of inequalities in education.


It would also be possible to call into question the status quo models in higher education, which value certain forms of knowledge over others, and to counteract the processes that can lead to justifying systemic discrimination and resorting to deficit thinking toward groups that are "othered" [61]. Finally, such studies would support and inform the promotion of political and structural changes in higher education for the benefit of all young Canadians, regardless of their origin.

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Ethnic Minority Students in the UK: Addressing Inequalities in Access, Support, and Wellbeing in Higher Education

Julie Botticello and Titilayo Olufunmilyo West

Abstract

This chapter focuses on UK higher education and how structural racism is perpetuated through inadequate attention to access, support, and wellbeing. Inequalities in higher education correspond with those in health, where there are marked disparities between ethnic majority and ethnic minority populations, as COVID-19 revealed. The research employed a qualitative methodology to explore students' experiences of higher education at a widening participation university during lockdowns resulting from COVID-19. Twenty undergraduate students participated in focus groups and semi-structured interviews across the academic year 2020–2021. These were audio recorded, transcribed, and coded using thematic analysis. The findings reveal that ethnic minority students suffered from inadequate access to technology, insufficient attention to child-care responsibilities, a dearth of peer-to-peer interactions, and limited institutional support for mental wellbeing. Inclusive support services and welcoming learning environments, including space for peer-to-peer learning, however, were emphasised as enablers for effective learning and emotional wellbeing. This study has shown that inequalities in access, support and wellbeing in higher education remain. Overcoming these inequalities requires equitable access and support provisioning for ethnic minorities so that all students can fulfil their potentials, at university and after.

Keywords: access, COVID-19, social determinants, structural racism, support, wellbeing

1. Introduction

This chapter considers the relationship between inequalities in health with those in higher education, drawing on qualitative research undertaken with UK undergraduate students during the pandemic academic year, 2020–2021. Two sets of research were conducted at the same university – one by a lecturer and another by an undergraduate student – with a view to capturing the embedded inequalities in higher education, which was magnified, though not produced by, the situation of COVID-19. The chapter considers students' experiences and argues that embracing and supporting material and emotional needs are essential for overcoming racial and ethnic inequalities in higher education. Taking a whole person

approach, however, necessarily means redressing the structural racisms in society and in higher education, evidenced by the social determinants of health, so that all students, including those from ethnic minority groups, can have their potentials fulfilled as a matter of principle.

2. Conceptual frameworks

2.1 Systemic racial inequality in UK higher education

There have been increasing numbers of widening participation students entering higher education over the last few decades in the UK, in line with an increasing number of students overall [1]. Widening participation indicates those students who have not traditionally accessed higher education: those from low income or disadvantaged backgrounds, being mature, having disabilities and/or being from certain ethnic groups [2]. In the UK, widening participation has meant that since the 1980s, more working class and second-generation children from families arriving in post-World War II/end of the British Empire migrations have enrolled into university education [3, 4]. In the academic department where this research was undertaken, 71% of students identify as being from ethnic minority backgrounds [5]. Further, most are Black African, women, in their 30s, with families and work in the health system. They reflect the widening participation trend, by being mature, from minority ethnic backgrounds, of lower social and economic standing, who seek education and training [6] to improve their life circumstances.

While there have been increases among different social and economic groups accessing higher education over several decades, challenges remain in meeting the widening participation remit of addressing the unequal access to and progress through it [2]. These include “pronounced differences in continuation and degree awarding outcomes for white and BAME [Black, Asian and Minority Ethnic] students, with lower rates of BAME students continuing or qualifying and receiving a first/2:1 compared with their white peers [1]”. “Increasing access without increasing chances of success is becoming a new form of social exclusion within higher education [7]”. Social exclusion is one of the fundamental causes of inequality [8]. This exclusion is especially so when disaggregating data around race and ethnicity. Concerning continuation rates from one year to the next, in aggregate, there is a gap of 3.5 points between Black and Asian ethnic minority students and white students: 86.7% versus 90.2%, respectively [1]. However, when disaggregating the data, the lowest continuation rates were found among students from Other Black Backgrounds, with a gap of 8.7 points (81.5%) and Bangladeshi students, with a gap of 7.3 points (82.9%) compared with white students (90.2%). In terms of degree attainment and classifications (first/2:1 both of which constitutes a ‘good degree’ outcome), the gap between white students and all other students is 13.3 points. Once disaggregated, however, this number rises to 23.3 points for Black African students, 19.2 points for Black Caribbean students and 24.4 points for Other Black Background students in comparison to white students [1]. Ethnic/racial inequality is also evident in graduate employment, with 50.1% of white graduates working in professional roles within 15 months of graduation, whereas only 43.0% of BAME graduates had professional employment within the same time period [1]. These disparities represent endemic ethnic/racial inequalities in higher education whose impacts endure beyond graduation.

The blame for these differential outcomes across different racial and ethnic groups has often been laid at the feet of the students – in what is known as the deficit model. This model frames “students and their families of origin as lacking

some of the academic and cultural resources necessary to succeed [9]” amid an assumption of equity across society. As will be explained below for health, many of the inequalities present in society are not the result of individual, family or community failings, but are the result of institutional and political structures [10, 11] that enable some to achieve success and disable others from the same. Laying the blame at the individual, their family and/or community is an example of prioritising values and expectations that the dominant population and calling these normal; this is white supremacy. White supremacy describes “the operation of forces that saturate the everyday mundane actions and policies that shape the world in the interests of white people [12]”. This prioritisation of a monocultural and monolingual society is an explicit act to “eradicate the linguistic, literate and cultural practices many students of colour brought from their homes and communities [13]”. Individuals, families and communities, who have other values, norms and expectations, instead of being acknowledged and embraced for these alternative sets of expertise and resources [13, 14] risk being classified as “subnormal [15]” or having deficiencies, due to operating from a different set of cultural mores and norms [16]. The deficit model does not interrogate the “multiple, intersecting factors” [17] within higher education that impact on the continuation and successful awarding of ethnic minority students. These factors include those from staff, such as implicit biases and low or lack of expectation for success, as well as from students, about their own fears of conforming to the negative lens through which society sees them and their potential [17]. The fault of who can be successful in higher education is a systemic problem and higher education needs to be conscious about its role in maintaining “barriers to student success [9]” through its assumptions and exclusive practices that reflect whiteness.

2.2 Racial/ethnic, social and economic inequalities underpin inequalities higher education

In February 2020, the UK’s Health Foundation published a report [18] on the social determinants of health, providing an update to its predecessor from a decade earlier [19]. Over the 10-year period, health inequalities were found to have widened, with declines in education funding, increases in precarious work, including zero-hour contracts, lack of affordable housing and increased use of food banks. Plus, life expectancy had plateaued after a century of increases [20], with outcomes worse for ethnic minority groups [18]. One month later, the World Health Organisation [21] announced the outbreak of a viral infection that began an unprecedented time throughout the world. From an equity perspective, the pandemic of COVID-19 has “exposed and amplified inequalities [22]”. At the time of writing, there have been upwards of 250 million cases and over 5 million deaths worldwide [23]. Although a pandemic, its responses have largely been at the level of the nation-state [4]. To tackle the virus’s spread, the UK government introduced strict measures, including social distancing, wearing masks, and nationwide lockdowns [24], with UK universities quickly shifting from face-to-face teaching to online learning [4, 25] and rapid adaptation to teaching and learning remotely [26].

However, these restrictions did not equalise the risks of exposure to or mortality from COVID-19. As several authors attest [10, 11, 27, 28], inherent racial and ethnic inequalities in the UK pre-date the pandemic. The fundamental risks from COVID-19 are situated firmly around “the role of systemic racism and socio-economic inequalities [27]” that pushes the burden of co-morbidities onto Black and Asian ethnic minority groups. Existing inequalities around health care standards, misdiagnoses, pain threshold assumptions, poorer maternal health outcomes, and an association of ill-health with poor personal choices have made health care facilities unsafe places

for BAME groups [27]. Racism, not race, is a fundamental cause of these disparities, suggesting that poorer educational opportunities and outcomes, impacts of the criminal justice system, housing and employment together drive stress and contribute to co-morbidities [28]. These may increase risk of COVID-19 infection [29]. The inequalities surrounding COVID-19 in England and those related to geographical region, gender, age and deprivation are cumulative, and confer more risk onto minority ethnic groups in relation to COVID-19 [11]. Reference [10] effectively summarises these findings, by stating that “racism both shapes social determinants of health and has its own effect on the health of ethnic minorities”.

The linking of social and economic inequalities with health inequalities in England is not new. There have been several reports throughout the twentieth and twenty-first centuries calling out inequalities [19, 30–32]; with some authors linking inequalities to ethnic and racial discrimination [18, 33] and noting these as structural and institutional problems, rather than “individualised” issues [34]. “Systemic problems such as racism require structural interventions and reforms across the broad spectrum of society, including in healthcare, education, employment, and the criminal justice system [10]”. COVID-19 is yet another cog in the wheel of ethnic and racial inequalities, which impact students’ lives and their potential for success in higher education.

As a Public Health academic and student, we align ourselves within the social determinants of health ethic, to understand “the causes of the causes [8]”, which emphasise the foundational character of deprivation and exclusion as underlying health inequalities. The “responsibility for health is shared across society [35]”; similarly, the responsibility for equitable education is equally shared across society. Therefore, it is imperative to address the inequalities in the system of education – by changing educational and systemic cultures of practice [1] – to achieve equity of process and outcome for all.

Following on from these two frameworks – of recognising that systemic injustices in higher education negatively impact ethnic minority students and that social and economic inequalities underpin health inequalities – this research proceeds with the following research question:

What were the impacts of the COVID-19 lockdowns on ethnic minority students at a widening participation university in the UK?

3. Methodology

This research adopted a phenomenological, hermeneutic methodology of qualitative enquiry [36]. Exploratory and interpretative, qualitative methodologies seek to understand and explore the how participants perceived particular phenomenon [37, 38]. By doing so, researchers gain insight into the lived experiences of their participants [39]. Further, the research process undertaken was based in social constructionism [37, 38, 40–43], wherein participants and researchers collectively identified key insights, enabling the process of research to be more democratic and participatory [44].

The purpose of this research was to interrogate how higher education needs to improve to meet the needs of ethnic minority students. Two separate but related research projects inform this work. The data for one was collected to understand the impact of remote delivery on student wellbeing and mental health, using one-to-one interviews; the data for the other was collected to understand the impact of pedagogical practices on student learning and belonging, using focus groups and anonymous module evaluations. Purposive sampling [45] was used for each, by inviting undergraduate students in the department to participate. Ethical approval

Participant	Gender	Age	Ethnicity
Participant 1	Female	18–25	Black African / Black Caribbean
Participant 2	Female	18–25	Black African / Black Caribbean
Participant 3	Female	>46	Black African / Black Caribbean
Participant 4	Female	26–45	Black African / Black Caribbean
Participant 5	Female	26–45	Black African / Black Caribbean
Participant 6	Female	26–45	Black African / Black Caribbean
Participant 7	Female	26–45	Black African / Black Caribbean
Participant 8	Female	>46	Black African / Black Caribbean
Participant 9	Female	26–45	Black African / Black Caribbean
Participant 10	Female	26–45	Black African / Black Caribbean
Participant 11	Female	>46	Black African / Black Caribbean
Participant 12	Female	>46	Black African / Black Caribbean
Participant 13	Male	18–25	Black African / Black Caribbean
Participant 14	Female	18–25	White British
Participant 15	Male	26–45	Southeast Asian
Participant 16	Female	26–45	Black African / Black Caribbean
Participant 17	Female	>46	Black African / Black Caribbean
Participant 18	Female	26–45	White British
Participant 19	Female	26–45	Black African / Black Caribbean
Participant 20	Female	>46	Black African / Black Caribbean

Table 1.
Participant demographics.

was granted for each research project, and each participant consented to being included. All participants were fully informed about their rights, information security, intended use of data and that participation was fully voluntary [46].

The research comprised semi-structured one-to-one interviews, a focus group, anonymous pre- and post-module evaluations, and researcher reflections. Interviews lasted a median time of 20 mins. The focus group lasted 35 minutes. Each researcher used an interview guide but welcomed participant input which was relevant to the topic. The total number of participants was 20. **Table 1** represents the participant list.

Eleven students took part in the one-to-one interviews and nine further students participated in the focus group and the module evaluations. Black African/Black Caribbean students (n = 17), white British (n = 2) and Southeast Asian students (n = 1) participated. Females (n = 18) outweighed males (n = 2). The demographics represented in the dataset weigh more heavily toward ethnic minority representation; this is due with the self-selection process for participation and remains in line with student demographics in the department.

4. Data analysis

Interviews were recorded, and the recordings were listened to repeatedly for accuracy. The interviews were then transcribed and read numerous times to familiarise and to begin interpretation of the data. The researchers used thematic

analysis [47] and recursive analysis [48] to analyse the data and inform the coding. Based on these analyses, common themes were recognised. These themes were then compared across the two data sets and overarching themes were agreed upon by the two researchers. Consequently, a descriptive study has been chosen to represent the data because it helps summarise the essential features of the collected data. It also facilitated data management and its coded representation transparently and systematically [49].

5. Findings

The findings reveal limitations in resources and support for ethnic minority students in the shift to online learning during the pandemic. Peer-to-peer support was noted as particularly important and harder to attain. There was also fear that the consequences of the present situation would inhibit future prospects. Inclusive institutions and learning environments were revealed to be enablers for learning, even during the pandemic. In circumstances where students felt welcome, they were able to share more of themselves and their experiences and to collaboratively learn together.

5.1 Lack of access and support during COVID-19 lockdowns

In this section, access to learning and student support during the pandemic lockdowns are explored. Complexities around learning at home without adequate support and insufficient resources, such as not having access to a good broadband connection or the ability to gain technical skills, led to feelings of anxiety, stress and isolation.

When we start [our] education, we start in a class, not online, and when things change, we have to change. (Participant 17)

I can say it's very distressing, very stressful, to do the learning alone, because of things like getting online, joining the lesson, technical problems, needing help but nobody [is] available. (Participant 11)

I don't understand anything. It is difficult for me. (Participant 19)

These participants reflect that the shift to online learning created technical challenges that were hard to overcome. While personal change would be required to keep pace with new circumstances, the tangible support available to make those changes was expressed as lacking, with the consequence of students feeling lost and unable to learn.

Participant 15 provides an example of one of the learning challenges that was hard to elicit when online – peer-to-peer learning and support.

It is particularly challenging being online. So, for example like, [Participants 19 and 20] approached me, so what we are doing for [our other class]? Unless you actually get to meet people, it is hard to establish those connections and make that happen. We have been given a [spreadsheet] to go on, but it is like, just looking at numbers, so people do not know who is who? (Participant 15)

Here Participant 15 articulates how difficult it can be for students, who did not know already each other, to build connectivity and rapport from scratch and remotely. Learning alone is one of the challenges faced in the online environment,

and even with technical access to lectures, peers learning from one another is important. Participants elaborated on the positive value of being on campus – for the moral boost of being with others, access to study materials and chance encounters. As they reflect,

The campus environment has a positive effect that makes learning enjoyable, and also for being able to dash in and out of the library. (Participant 2)

We are missing that, by not being on campus, to find opportunities and be like, “Oh [lecturer] can I speak to you for a moment?” “You know. Or [student 8] needing to ask, “Are you in the group?” (Participant 15)

Other participants also corroborated, stating that not having ready access to campus made them lose their daily structure and their peer-to-peer relationships, which then inhibited their motivation and initiative. However, even in compromised conditions of learning, opportunities can be made available for student connection. Participant 15 continues.

I want to add, [we need] more chances for outside of class social opportunities, even if it is online. For example, like for weeks, a lot of people were confused about [another class's] presentation and [finally] right after the end of class, we had [the] opportunity to discuss. [...] I asked something, it got answered instantly whereas on WhatsApp, [...] it is so easy to misinterpret. And so, [...] we can get things done, [...] rather than having to take days to get answers back and forth. (Participant 15)

He notes that these interactions, which enable the students to seek what they need themselves, even whilst in an online learning context, can support students to learn from and support one another. Participant 20 notes that being able to engage with fellow students “helps us to meet others to help us”, again highlighting the value of peer support in learning. In online situations, this can be facilitated by lecturer assistance, to give time and space to students to connect with one another, enabling some of that isolation and stress to be overcome.

In addition to access and peer support issues, many students who are also parents, had to contend with educating their children whilst also studying full time themselves. This multiplied their burdens and took away time and energy from their own studies. Participant 6 reflects,

As a mother, having the children at home with home-schooling, it's been very challenging, trying to cope with them, their teaching, and when they run into problems, they will be disturbing me during my lesson. I'm drained and tired most times, and sometimes it's difficult for me to focus on my work. (Participant 6)

The impact of learning remotely, with inadequate technical support, barriers to peer support, while also raising and home-schooling own children created uncertainties about the future. Students were worried about not achieving the results they wanted to achieve and how this would affect their future aspirations and progress. Participant 1 summarises this concern:

My biggest fear is not getting the grade that I would love to have, finishing and not getting a job. I am very anxious about the uncertainties around the world right now, and the fact that I could finish and not know what to do is very distressing. (Participant 1)

The fears arising from COVID-19 also extended beyond grades and job prospects to existential concerns over life itself. Some participants expressed their worries about how the lockdown would not stop the spread of the virus, as transmission continued to escalate despite restrictions. Those participants who were lone parents expressed worry about catching the virus, dying from it, and on the fate of their children. Participant 11 expresses this, saying, she was fearful to catch COVID-19,

Because I'm a lone parent and my children will be on their own; so that kind of experience really was a very, very fearful experience. (Participant 11)

The reality of COVID-19 was not just that it impacted on student learning and future aspirations. It was also a fear of sickness and death, and the repercussions these would have on loved ones. The crisis of COVID-19 also revealed inequalities in access to education as well as barriers to learning and support, which particularly impinged on widening participation, ethnic minority students, who already suffer from economic, social and health inequalities. Within higher education, lack of technical support, lack of structured opportunities to engage with peers, being overly burdened by looking after children's needs whilst also aiming to meet their own, combined with increased risk of sickness and death, lead to fear and uncertainty about the long-term consequences for themselves and their families.

5.2 Inclusively attending to the emotional wellbeing of ethnically diverse students

This section focuses on the emotional wellbeing of ethnic minority students, through inclusive practices, and how their knowledge bases and experiences can be more fully valued within higher education institutions.

Considering mental health as one facet of emotional wellbeing, many participants revealed that they did not know that the university had a health and wellbeing team. Two participants who were aware of these services shared that they had used them before and found them useful. A further participant revealed that she had used private counselling services instead because it was offered in her native language, which made it easier for her to communicate effectively. As she says,

So [I] start with this counselling, outside of university, [...] in my language [...]. For me, it is easier to express myself. (Participant 6)

Participant 6 choose to go outside of the university for this service to achieve a higher level of self-expression. This insight reflects that students arrive at university with a range of knowledge bases and life experiences, many of which are unrecognised and not accommodated for by the university. This recognition of student knowledge from outside the university also relates to classroom learning. This is where the content discussed and the approach used can either include or exclude students, based on their experiences and capabilities. Participant 13 considers his sense of engagement with one of his classes as it related to his paid work, stating,

When we were talking about the gender related risks, that's when I become much more engaged. I say engaged. That moment stuck out to me because, like I was saying before, [I have] a real-life example. So, I related to it more because I actually have an understanding of what [we] were talking about. (Participant 13)

Enabling both the content of classes and the approach in classrooms to be inclusive is something many participants commented on. Regarding the latter,

Participants 12, 13, 15 and 16 offered that they would like their teachers to be “more approachable”, “more supportive”, and “more welcoming, so [students] don’t feel condemned for being confused”. They also wanted teachers to create time and space for students “to have an input” and “express [their] feelings”. Participant 12 summarises, saying that the teaching flow should be an ongoing dialogue between the lecturer and the students, as it “allows us to really interact [...] It draws us in”. Participant 13 shares again about what this inclusive approach looks like in practice.

[My lecturer] did an example, today actually, and I actually picked up on it. When [my lecturer] said, “we are going to be looking at the book”, [she] said, “Rather than us just reading it, we are going to go through it together”. So, there are different types of learners. Some people can just read it, and get what’s going on, but what [my lecturer] did, is what I really appreciate, is that [she] went through the extract, paused, had a sort of discussion with everyone, to see if everyone’s on the same page and if everyone’s actually understanding what we are reading. So, I think that was really good. (Participant 13)

Content and approach are both important for creating inclusive learning environments for students of diverse backgrounds, where in some cases, extra consideration may be needed to ensure everyone is together and some are not being left behind, especially, if English is not the first language, as is the case with Participant 6. Furthermore, inclusive content and approaches equally provide opportunities to refute negative stereotypes and create opportunities both for discussion and for learning, in the widest sense, as explored in the following example.

Some participants in the focus group recalled an experience they had had in a previous class. This related to a teaching session that was synchronously online and face-to-face, with students self-selecting how they wished to attend. The class was discussing communicable diseases and had considered data on the prevalence of domestic violence, as it links to sexually transmitted diseases (STDs) in different parts of the world. Participant 15, who was in the room, inferred from the data that Sub Saharan Africa had the highest prevalence of domestic violence in relation to STDs. Participant 12, who was online, disagreed with the interpretation, and talked the class through the data to show that it was Southeast Asia that had the higher prevalence. She then went onto challenge the class about the tendency to perceive Africa as a negative example; even reading data incorrectly to support the view. Participant 15 and the rest of the class agreed with Participant 12 and conceded the error. During the focus group, Participant 15 raised this incident for further discussion, reflecting how that difficult classroom situation became a teaching moment for him.

I would bring up when [Participant 12] rightfully took issue to Africa being mentioned [negatively] a few times. But I think it was great that we had a moment where we could clarify why we were talking about this subject or that subject. So that we make sure. That is why it is important to cite and reference, so that we make valid claims, rather than unsubstantiated, unfair generalizations, which [are] dangerous. (Participant 15)

This vignette reveals that learning online can be as engaging as being in the room, provided that the material being discussed is as relevant to the students as people as it is to the intention of the session. It shows that learning possibilities span different ages, ethnicities, cultures, and genders. It also demonstrates that students explicitly learn from one another through discussions and working out their disagreements, which emphasises the importance of peer-to-peer learning. Further, gaining clarity on a specific issue and how it relates to pervasive systemic biases can

have enduring impacts not just for academic education, but for social and cultural competence in general.

The discussion recounted above was prompted by the course material being explored. The session could have remained a dissemination style lecture, delivered by the teacher, which may have shut down any possibility of student-to-student dialogue. Instead, the session was open for participants to feel welcome to bring their contributions to the classroom space (even while online), whether as disagreement, consensus, or resolution.

This section has shown that emotional wellbeing in higher education for ethnically diverse students requires a range of potentials to be in place. The knowledge bases and experiences which ethnic minority students bring to the university need to be reflected within the university, whether this is in the services offered or the content of courses. Students' emotional wellbeing is also affirmed by attentive teaching practices, which include the students in their learning, whether being led by their lecturer or directly addressing one another in class. This section demonstrates the importance of recognising and valuing ethnic minority students as complete persons, who can formulate significant learning experiences for themselves, their classmates, and their teachers.

6. Discussion

This chapter has explored some of the challenges for equality that ethnic minority students face in higher education in the UK. Through qualitative research undertaken during the pandemic lockdowns in 2020–2021, this research has shown that access to learning, via technology, through peer-to-peer interactions, amid childcare responsibilities, coupled with negative impacts of COVID-19, limited student potential. It further found that inclusive support services and learning environments which valued student knowledges and life experiences beyond those limited by white supremacist ideologies [12], facilitated engaged learning and emotional wellbeing.

This is important because although widening participation initiatives aim to be inclusive of more diverse learners, in this case, of mature students, with families to look after, from minority ethnic backgrounds, and often of lower social and economic standing [2], inequalities remain. Education can reproduce existing social and economic inequalities, through failing to attend to what students need from their education and delivering in a way that is exclusive to these needs [50]. COVID-19 did not create the inequalities experienced by ethnic minority students; rather it exacerbated already existing inequalities [11, 18, 22, 28]. Without due attention to ensuring policies and practices are equitably designed for all students, as a matter of social justice, the system will continue to disadvantage and disenfranchise these groups [7, 12].

This chapter has proposed that a relationship exists between the social determinants of health and inequalities in access, support, and emotional wellbeing in higher education for ethnic minority students. One of the fundamental causes of health inequalities is social exclusion [8]. Lack of hope and limited opportunities to transform one's circumstances are consequences of this exclusion [8]. Structural racism affects the social determinants of health and affects the health of ethnic minorities [10]. COVID-19 further impacted on student mental health due to isolated learning [4, 25, 51–53]. Although COVID-19 was the same storm everyone experienced [54], not everyone had the same vessel of resources through which to weather it. Additionally, ethnic minority students had to bear further burdens, including fears of sickness and death from COVID-19, and the consequences for families and loved ones. This was not unfounded, as statistical reports have shown

that morbidity and mortality from COVID-19 were higher for ethnic minority groups than white groups [55].

When considering the factors impinging on emotional wellbeing at the university, small successes of inclusive and supportive practice have also been highlighted. Intangible qualities, such as feeling welcome, being able to share feelings, as well as being able to make mistakes, were noted as important. Being able to express oneself, linguistically and experientially, was also offered, which speaks to being recognised as unique individuals, rather than as receptacles of a standardised experience [12]. This inclusion is constitutive of the social justice project [13]. Creating enabling spaces where the whole student is welcomed and valued further arises through engendering and fostering humanistic dialogue [42, 56]. Discussing topics that “transgress [57]” the normative boundary of the classroom, including speaking about systemic racial inequalities [12, 58, 59], can move learning toward an interconnected project of co-construction among teachers and students [60, 61] and create opportunities where everyone learns.

This research has some limitations. As a qualitative exploration, the findings relate to those who chose to participate in the research and cannot necessarily be generalised to all students of ethnic minority backgrounds in the UK. A bias of females to males exists in the data set, and while this bias is reflective of national trends in higher education [1], the experiences reported cannot stand for students of all genders. The research took place within one academic department at one widening participation university, which may point to challenges faced in that specific department and/or university and not to higher education throughout the UK. As the researchers were known to the participants, with one holding power as a lecturer, participants may have not accurately represented their views due to influence or fear of consequences. Further research across the university, in comparison with other universities, and by researchers without connections to the participants, would increase robustness of the data and its interpretations.

Based on the findings from this research, there remain several challenges to be addressed if inequalities are to be overcome. There are inherent structural inequalities, particularly in relation to race and ethnicity, in UK society and in higher education institutions. Resistance to acknowledging that there are implicit structures of oppression against ethnic minority students and communities needs to be overcome through listening to and acting on the experiences of ethnic minority students and communities. Recognition of the rich and life affirming experiences, knowledge bases, and potentials of ethnic minority groups as valuable needs to be declared, supported and promoted, within the university and across society, as part of the dismantling of white supremacy. Restructuring policies and practices, from the highest domains of the state, down to the personal tenets held in one’s heart, needs to occur, so that ethnic minority students can have their potentials fulfilled as a matter of principle.

7. Conclusion

This research invoked a social determinants of health perspective with which to explore how structural racism in society continues to exclude ethnic minority students from achieving their potential in higher education. It has found that social exclusion, a fundamental cause for ill health, is likewise a fundamental cause for the inequalities ethnic minority students experience in higher education. While widening participation initiatives have sought to make higher education more accessible to the diversity of population groups within the UK, to which students from varied backgrounds have responded, there remains intractable inequalities that

inhibit equitable progression through university and into graduate employment. Insufficient access to the resources for remote learning, including fellow students, combined with the burdens of child-care, home schooling and the increased risk of illness and death from COVID-19, placed substantial and unequal stresses on ethnic minority students in their quest for success in higher education. To effect change, countering white supremacist ideologies is needed in educational practice. Affirming and valuing the diverse skills, experiences, and needs of ethnic minority students, helps place wellbeing at the center. Recognising that students have much to teach one another, especially when able to engage in co-constructive dialogue, can further assist in countering current imbalances in higher education systems. Glimmers of good practice, however, will remain isolated and marginal until structural racism and the foundational inequality of social exclusion in the widest sense, are tackled at institutional and structural levels within higher education and across society.

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Conflict of interest


The authors declare no conflict of interest.

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The increasing recognition of the role of structural racism affecting vulnerable groups motivated the scholarly work presented in this volume. The authors' rigorous scholarship seeks to help readers identify and understand how structural racism impacts vulnerable groups and how effective practices may dismantle these structural forces. Nine chapters provide unique, comprehensive, and science-based approaches to identify and eliminate structural racism within healthcare, politics, and education systems. Policymakers, system administrators, scholars, students, and the public will benefit from the authors' critical examples of structural racism within public systems across different countries, as well as from their proposed solutions.

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