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The Roads Less Traveled: A Metaresearch Analysis Of Local Histories In Racial Health Equity Research

Devin Trévion Brown
brown.devin39@gmail.com

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The Roads Less Traveled: A Metaresearch Analysis of Local Histories in Racial Health Equity Research

Devin Brown

Primary Thesis Advisor: Danya Keene, PhD
Secondary Thesis Advisor: Chelsey R. Carter, PhD, MPH

Thesis Submitted in Partial Fulfillment of the Requirements for the Yale School of Public Health
Degree of Master of Public Health in the Department of Social and Behavioral Sciences

May 2024

“...the reason to analyze health inequities is not to prove that injustice is wrong, since injustice is wrong by definition. Rather, the point is to illuminate how both injustice and equity can respectively shape people’s health and the health of our planet for bad and for good, so as to guide action and allocation of resources for prevention, redress, accountability, and change.”

Nancy Krieger
Abstract

While it is important that racial health equity research receive growing attention in the United States, doing so must involve a thorough recognition and interrogation of the role that structural racism plays in creating different outcomes for Black communities. History aids in making clear the process through which race can become biology as structural racism is embodied by members of Black communities. Guided by Táíwò’s conceptualization of “resource distribution and accumulation” as well as Carter’s discussion of “racialized local biologies”, this cross-sectional meta-research analysis sought to investigate when and how racial health equity research after 2020 utilized local history to understand and eliminate racial health inequities faced by Black communities. Of the 27 articles included in this analysis, nearly 60% of them used racism at the structural level to frame, contextualize, or analyze racial health inequities. In over 80% of studies, the scope of the study population was at the local level or smaller. However, only six (22%) used history as context for understanding or eliminating inequities for Black communities, and only four (15%) used history at the local level. These findings provide evidence not only of the severe neglect of utilizing local histories in health equity research, but also finds that history, in general, is absent when researchers investigate structural racism to advance health justice for Black communities. While the field of public health has done considerable work to shift its focus from individual behavior change to social determinants of health, it falls short of actualizing a greater potential without troubling how those determinants are siphoned along socially constructed lines, like race, by structural forces. History can help researchers fuel this inquiry moving forward.
Acknowledgements

I could not be more grateful for the guidance, mentorship, and encouragement I received from my advisors, Danya Keene, PhD and Chelsey R. Carter, PhD, MPH. They did not only support me through this thesis but nurtured my curiosities and passions all throughout graduate school. Without them, I likely would not have decided to take on this behemoth of a task and certainly would not have enjoyed the process as much as I did. Thank you, also, to those professors at the Yale School of Public Health whose classrooms provided me with the questions and insights that inspired this project and whose passions for uplifting students are unparalleled (Shelley Geballe, JD, MPH; Takisha Everette, PhD, MPA, MPH, CPH; Suzi Ruhl, JD). Thank you Diane Frankel-Gramelis, MS and Jen Farkas for the care you take of the students at this school. Lastly, thank you to Kate Nyhan, MLS for your expertise throughout the early stages of this project.

A big virtual hug for my parents and siblings for helping me get into positions to not only do well but to do good. Whether from pure luck or from stubborn persistence, we made it, we will keep on going, and we will bring others along. To my partner, who was alongside me, often in Zoom study huddles, during the moments of this project that felt like “another cold, dark night on the side of Everest,” I am incredibly grateful.

A special thank you to the Thougters™. Without the camaraderie that you both provided this would have been one lonely marathon indeed. Who said writing a thesis couldn’t be fun? And, of course, to all my family and friends—at YSPH, in Oklahoma, and elsewhere—your encouragement was never short and was always needed. Much love.
# Table of Contents

ABSTRACT ........................................................................................................................................... 2

ACKNOWLEDGEMENTS ...................................................................................................................... 3

INTRODUCTION .................................................................................................................................... 6

HEALTH EQUITY RESEARCH AND HEALTH EQUITY TOURISM ....................................................... 6
STRUCTURAL RACISM ............................................................................................................................ 8
LOCAL HISTORIES IN PUBLIC HEALTH ............................................................................................... 10

METHODS ............................................................................................................................................ 14

ARTICLE SEARCH PROCESS ................................................................................................................ 14
ARTICLE SCREENING PROCESS .......................................................................................................... 15
PROCESSING INCLUDED STUDIES .................................................................................................... 17

RESULTS ............................................................................................................................................... 20

STUDY CHARACTERISTICS ................................................................................................................ 20
THE USE OF LOCAL HISTORY .............................................................................................................. 22

DISCUSSION ......................................................................................................................................... 28

CONCLUSIONS .................................................................................................................................... 30

SUMMARY .......................................................................................................................................... 30
LIMITATIONS ....................................................................................................................................... 30
LOOKING FORWARD ............................................................................................................................. 31

APPENDIX 1 .......................................................................................................................................... 35

CITATIONS FOR REFERENCE .............................................................................................................. 41
List of Tables

Table 1. Data Extracted from Articles Included in Analysis

Table 2. Four Articles with Local Histories

List of Figures

Figure 1. Article Screening Process

Figure 2. Heat Map of Top Fields of Study of Included Articles
Introduction

*Health Equity Research and Health Equity Tourism*

Racial health equity research gained a global spotlight in 2020 amidst the COVID-19 pandemic and the United States’ intense historical reckoning—specifically regarding structural racism and the inequitable distribution of social determinants of health—following the murders of Ahmaud Arbery, Breonna Taylor, and George Floyd. Prior to this new focus, though, scholars from a variety of disciplines have engaged in this work since the 19th century. In his seminal report, *Philadelphia Negro*, W.E.B. DuBois shined a light connecting structural inequalities to the poorer health outcomes of individuals in Black communities.¹ In discussing the ways in which “racial discrimination was institutionalized within several sectors of society and was self-perpetuating”, he identified social causes for more severe mortality rates among Black people with tuberculosis in Philadelphia.² While health disparities research has continued to evolve in the 125 years since then, alleviation of the health disparities that Black communities face have been less substantial.³

Health disparities research is the empirical investigation of “systemic, plausibly avoidable health differences” between social groups (such as race, gender, and religion) that

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“adversely affect socially disadvantaged groups”.\textsuperscript{4} Aligning with other scholars who trouble the terminology \textit{health disparities},\textsuperscript{5} I will be using \textit{health equity research} for the remainder of this paper as it emphasizes moving beyond the mere identification or description of racial health differences to more adequately understand and interrogate differential health outcomes, their causes, and paths towards eliminating them. The present study sought to investigate when and how racial health equity research utilizes history at the local level to understand and eliminate racial health inequities.

Since 2020, numerous governmental bodies, scientific foundations, and academic institutions around the United States have declared racism a public health crisis.\textsuperscript{6} White et al. describe this global reckoning as an “inflection point” wherein structural racism has become integral to understanding health in the United States.\textsuperscript{7} While there has been growing attention to investigate racism, its “existence and effects” are far from novel.\textsuperscript{8} Following this increased interest in racial health equity research, many scholars who called this research area home for decades noticed what they called “health equity tourism”, whereby researchers—who, prior to 2020, had not engaged in health equity work—have joined \textit{en masse} in response to a growing number of resources (e.g., grant funding) and attention associated with it.\textsuperscript{9} A growing criticism of this tourism is the transplantation of investigators who have not developed expertise in racial

\textsuperscript{8} White Alexandre, Thornton Rachel L.J., and Greene Jeremy A.
health equity work who could eventually cause more harm than good—or, at least, produce ineffective work. Namely, the uncritical identification and description of racial health disparities can reify biological understandings of race, through which poorer health outcomes are erroneously understood as “[reflecting] the natural, inevitable order of things.”

Crucial to a more critical appraisal of health inequities is the focus on the role of racism, instead of race, in shaping poorer health outcomes.

**Structural Racism**

While it is important that racial health equity research receive growing attention in the United States, doing so must involve a thorough recognition and interrogation of the role that structural racism plays in creating different outcomes for Black communities. Poorer health outcomes for Black people around the country persist over time because racism is a fundamental cause of health inequities. In addition to the limited public health research focused explicitly at the health effects of racism on Black communities, much of that research focuses on racism at the interpersonal level, ignoring the ways in which racism functions at the structural level to pattern the distribution of social determinants of health and uphold racial hierarchies across various social institutions. Bailey and colleagues define structural racism as the “totality of ways in which societies foster discrimination, via mutually reinforcing systems of

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10 Braveman et al., “Systemic And Structural Racism.”
discrimination…that in turn reinforce discriminatory beliefs, values, and distribution of resources”. Of particular detriment to health is the unjust distribution of “economic, political, social, and even psychological rewards,” or resources, along racial lines, evidence of “racialized social systems” that perpetuate the accumulation of material advantages and disadvantages for particular racialized communities. Similarly, Táiwò discusses that current injustices have roots in past injustices as current racial health inequities can be traced to a racist distribution of health-enabling and health-risking resources in the past.

Understanding structural racism and its downstream manifestations—concentrated poverty, inequitable access to healthcare, disproportionate exposure to environmental hazards—is necessary in that it contextualizes racial health inequities in the United States, disrupting the notion of race as biology. When we focus this research on anti-Black racism as a risk factor for poor health, instead of race, we transition our focus from the idea that Black bodies have fundamental biological differences toward engaging the ways in which anti-Black racism has cumulative effects on the biologies of Black communities. The orchestrated concentration of economic, political, and social inequalities in society are embodied by Black people over time, shaping subsequent racial health inequities. Tracing structural racism and its history in the

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16 Táiwò, *Reconsidering Reparations*.
United States lends clarity to the process through which the perpetual, systematic subjugation and oppression of a Black people and their resultant health outcomes are passed from one generation to the next. This level of analysis, too, helps us upend what Gravlee refers to as “race-genetic determinism”, challenging the notion that there are inherent genetic differences between racial groups. Structural racism makes clearer the ways in which a greater consideration, or valuation, for white lives across time has resulted in a racist distribution of society’s resources—further challenging the idea of race as biology, rather that through the accumulation of disadvantages over time race becomes biology. For these reasons, Leith Mullings and colleagues invite us to place structural racism front and center of our work as public health researchers and practitioners; so as to most aptly identify, understand, and eliminate the ways in which it creates poorer health outcomes for Black people in the United States.

Local Histories in Public Health

Engaging structural racism and its influence on health outcomes requires a thorough recognition of its historical roots and the unique form it takes at national, state, and local levels. Subsequent health outcomes in Black communities cannot be sufficiently described or understood through a national or state-level analysis alone as has been the case with increased discussion surrounding redlining and racist housing policies of the twentieth century. History

19 Krieger, Ecosocial Theory, Embodied Truths, and the People’s Health
21 Gravlee; Mullings et al., “The Biology of Racism.”
22 Mullings et al., “The Biology of Racism.”
aids in making clear the process through which race can become biology as structural racism is embodied by members of Black communities, further combating race as biology in science, medicine, and lay conceptualization.\textsuperscript{24}

It is for this reason that neglecting to include historical analyses in research methodologies can hinder our efforts to recognize the root causes of racial health inequities.\textsuperscript{25} History not only tells the story of the construction of present-day inequities, but it also serves to locate responsibility in those “actors, decisions, and processes” that brought about these health inequities and have evolved to uphold them.\textsuperscript{26} Public health researchers and practitioners, by harnessing history, can better identify solutions that address the root causes within the “people, policies, and legacies of inequities” that uphold such health injustices.\textsuperscript{27} In this study, I operationalize history in the way it is used to contextualize the creation, development, and maintenance of racial health inequities, largely through the uneven distribution of health-enabling resources. This conceptualization of history is occasionally used in health equity research and interrogates the role of redlining and racial residential segregation in producing past and current social and environmental inequalities for Black communities.\textsuperscript{28}

\begin{thebibliography}{28}
\bibitem{Fleming2020} Kramer.
\end{thebibliography}
Public health researchers looking to ultimately eliminate these inequities must be concerned with how and why they occur in the first place and how those mechanisms responsible have been maintained or evolved over time. Historical narratives at the level of the city, town, or neighborhood—local histories—shed light on these processes by detailing the legal, political, and socioeconomic landscape over time that patterns the distribution of health-enabling or health-risking social and environmental determinants of health. Local histories hold power to illustrate communities’ specific histories regarding factors like residential segregation, economic divestment, and environmental racism. In this way, we can trace the patterning of what Carter calls “racialized local biologies” whereby structural racism and its manifestations at the local level can shape how diseases “adapt in certain racialized communities”. Because of the time required for this patterning to show up in the form of health inequities, taking the historical view is imperative in understanding how the accumulation of disadvantage affects health.

Public health has done better in recent decades to acknowledge and pay considerable attention to the social and environmental determinants of health as causes of health inequities, but less has been done to consider how those determinants are patterned over time: past, present, and future. While a nation-wide or even state-wide aggregation of health outcomes can provide insightful overviews for understanding inequities at those respective scales, this approach risks making a monolith of the greater diversity of Black communities, their members, and their histories. Thus, it is critically important to take into consideration the local histories of racism that shape the distribution of social and environmental advantages and disadvantages across

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racial lines. This patterning can be understood at the local level whereby specific laws, politics, and cultural norms take unique shape. Yet public health research broadly has not always illuminated this patterning effectively.

New research is needed to examine whether and how history is utilized in understanding and eliminating racial health inequities in public health research.\textsuperscript{31} Meta-research—as a methodology concerned with the research of research—is uniquely positioned to examine that utilization, or lack thereof historical consideration, by researchers. By detailing if, when, and how public health researchers engage local history in their health equity research methods, we can better grasp the extent to which they sufficiently address the roots of racial health inequities in Black communities at the local, state, and national levels. Existing literature has described public health’s ahistorical research methodologies, but none have worked to identify how prominent this issue has remained since the surge of health equity research after 2020.\textsuperscript{32} Guided by Táiwò’s conceptualization of “resource distribution and accumulation” as well as Carter’s discussion of “racialized local biologies”, this cross-sectional meta-research study sought to investigate when and how racial health equity research after 2020 utilizes local history to understand and eliminate racial health inequities faced by Black communities.


Methods

This study was concerned with current public health research methodologies, specifically those related to racial health equity research. While this was originally intended to be a scoping review study, conversations with the public health librarian indicated that a cross-sectional meta-research analysis was ideal for this project because 1) this search was not a comprehensive review of available research, and 2) the study’s research question is concerned with research methods rather than analyzing the findings of existing research. As opposed to typical reviews, this study does not aim to synthesize empirical evidence or identify trends in findings. Rather, this study focuses on public health research methodologies deployed in understanding and eliminating health injustices faced by Black communities in the United States with the aim to elucidate if, when, and how history associated with a particular place—at the locale—is utilized by public health researchers. Using Lens.org as my research database, this search was limited to primary research articles in peer-reviewed journals, published in English, from an academic institution in the United States between July 1, 2023, and December 31, 2023.

Article Search Process

The goal of this study was to find original research that discussed racism at it applied to racial health inequities for Black communities in the United States. The preliminary search included “racism”, “health”, and “Black OR African American OR African ancestry OR African” across publication titles, abstracts, and keywords. While racism is often used interchangeably with terms like racial discrimination or racial inequality, they are not synonyms. For the purposes of this study, explicitly naming racism was a crucial first step in critically engaging if it appears in search engines. Further, this study sought to honor Blackness in all its diverse forms: Black Americans, Afro-Latinos, Afro-Caribbeans, immigrants from the African
continent, and all others across the African diaspora. This influenced the reasoning for broadly searching for health equity studies that engaged these communities. Similarly, this study did not restrict the scope of this search to public health as a discipline, rather it sought to identify articles that ultimately aimed to improve health a population level.

The present study focused on the U.S. due to broader conversations about the ahistorical nature of public health—its research, education, training, and culture—and sought to add to that specific conversation, so it did not include internationally-based research. To directly examine how researchers utilize historical evidence, this analysis focused solely on peer-reviewed journal articles, excluding book chapters, reviews, meta-analyses, editorials, dissertations, and grey literature, as this study aims to illuminate the use of history within primary research. Additionally, because this study was interested with how racial health equity research has taken shape since 2020, only articles published after that time frame were reviewed.

**Article Screening Process**

The initial search yielded 295 articles based on their titles, abstracts, and keywords. I manually added 57 articles that Lens.org did not identify with specific dates (i.e., they had years of publication without detailing the specific month, so Lens.org did not locate them) providing a total of 352 articles. To respond to this limitation, I broadened the search beyond my six-month timeframe to all of 2023 and manually reviewed the respective dates of publication. To screen the articles yielded in this search, I created folders within the Lens.org interface. After reviewing

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a publication for inclusion and exclusion criteria, I moved them to a new folder that described
the respective reason for inclusion or exclusion. This process is illustrated with Figure 1.

This study focused on finding literature that ultimately, specifically, and explicitly
intended to benefit the health of Black communities in the United States. This excluded several
publications that focused on the mere identification of health disparities, which is incongruent
with my aforementioned focus on health equity over health disparities. The search also excluded
research on racial inequities that did not identify clear implications for health (e.g., disparities in
television viewership). Finally, numerous studies focused broadly on racial health inequities
inclusive of other historical underrepresented groups in addition to Black communities. Because
of this study’s theoretical framing and investigation of anti-Black racism, as well as my own
academic and professional foci, it was important to narrow my search to literature that is specific
to inequities faced by Black communities.

I reviewed articles based on inclusion criteria I could decipher from reading article titles
and abstracts. To include publications based on abstracts I required they be: 1) primary research
in peer-reviewed journals; 2) discussing public health, broadly; 3) specifically focused on Black
communities in the United States. These criteria excluded secondary research (with the exception
of secondary data analyses) and publications that were not journal articles (e.g., scoping reviews,
commentaries, or book chapters). To meet the second criteria, articles had to be directly or
indirectly related to the health of populations, which often included topics such as social
determinants of health, residential segregation, or patient-provider interactions. Upon reading all
abstracts, a total of 266 articles were screened out: not primary research (n = 145); irrelevant
topic (n = 21); not specific to Black people (n = 100).
In considering scope of eligible studies, I decided to only include those whose study populations were at the state level or smaller. This decision was guided by the focused interest of analyzing the use of local histories in improving health in Black communities; however, the need for local histories because less relevant—although not obsolete—when studies are considering populations at a national or regional scope. Therefore, I included studies who identified a state level scope or smaller (e.g., cities, counties) or those that identified participants being served at a specific health site (e.g., “large urban hospital”).

I repeated this process with 86 full articles with similar but more detailed inclusion criteria: 1) a study scope at the state level or smaller, 2) includes meaningful engagement with racism prior to the results section, and 3) is specific to inequities faced by Black communities. The exclusion criteria were scope of study larger than the state level (n = 23); studies not explicitly engaging racism in addressing health inequities (n = 17); studies not specific to Black populations (n = 10); not primary research (n = 7); study does not pertain to public health n = 1. One duplicate article was removed. After screening full articles, 27 remained and are included in the analysis of this study).

**Processing Included Studies**

The 27 articles were exported to an external spreadsheet where they were analyzed across three categories: 1) level of racism used to investigate racial health inequities 2) scope of the study population, and 3) whether the article used local history. This step included a high-level content analysis. For the first category, each article was grouped based on how the authors framed their study and its aims through an investigation of one or multiple forms of racism (internalized, interpersonal, institutional, and/or structural). This information was typically most clear towards the end of the introduction or background where researchers explained the impetus
and goals for the present study and how racism fit in. Authors most often included information regarding the scope of the study population in the methods, providing information about the state, region, group of cities, individual city, neighborhood/community, or a specific health facility. I then read the articles for any analysis or inclusion of national, state, or local level history.
Figure 1

Article Screening Process

Articles added from Lens.org search (n = 295)

Articles manually added (n = 57)

Articles captured for abstract + title screening (n = 352)

Articles excluded (n = 266):
Not primary research (n = 145)
Irrelevant topic (n = 21)
Not specific to Black people (n = 100)

Full-text articles screened (n = 86)

Articles excluded (n = 59)
Scope of study larger than state-level (n = 23)
Does not explicitly engage racism (n = 17)
Not specific to Black people (n = 10)
Not primary research (n = 7)
Irrelevant (n = 1)
Duplicate (n = 1)

Articles included in analysis (n = 27)
Results

Study Characteristics

Of the 27 articles included in this study, sixteen authors (59%) used racism at the structural level, six (22%) at the institutional level, four (15%) at the interpersonal level, and one (4%) at the internalized level to frame, contextualize, or analyze racial health inequities. In many cases, institutional racism was enveloped by structural racism once situated within other entangled institutions and social systems (e.g., criminal justice or residential segregation). In cases where a study sought to address multiple forms of racism, I defaulted to the highest form as the lower forms were subsumed by the higher (e.g., structural racism includes manifestations of interpersonal racism).

The scope of the study populations varied from the state level to health facilities. The vast majority (81%) of the studies had study populations at the local level with twelve (44%) at the city level, two (7%) across a group of cities, seven (26%) at a specific health or academic facility, and one (4%) at the level of neighborhood. Of the remaining studies, four (15%) were at the state level, and the remaining one (4%) was a state region (South Florida). Scope of the study population was important in analyzing which articles local histories because the relevance for local histories wane the larger the study population. In the same way national and state histories may not be the most accurately or directly applicable for members of a small community in that state, the local history of a particular community will likely fail to encapsulate the history of an entire country or state.

Only six (22%) of the 27 articles used history as context for understanding or eliminating racial health inequities for Black communities, and only four (15%) used history at the local
level. The other two (whose study populations were at the city level) incorporated United States history regarding historical origins of the strong Black woman schema and a few sentences discussing the medicalization of childbirth in the United States. This was determined in congruence with this study’s conceptualization of history: detailing a legal, political, and socioeconomic landscape over time in how it patterns the distribution of health-enabling or health-risking social and environmental determinants of health. I did not include studies that stopped after brief, unsubstantial mentions of history without any further engagement. I identified whether publications used history by scanning for this meaningful use of history throughout the paper, both in framing the purpose of a study and in contextualizing its findings. Many studies detailed the effects (often epidemiological or socioeconomic) of local histories without detailing those histories themselves. For example, Ogunwole et al. described health inequities in the context of “…Baltimore, Maryland, a predominantly Black city… with high levels of neighborhood violence and a history of discriminatory housing practices that have led to racial and economic segregation.” Nearly all studies, however, did not engage the locale at all, excluding any details about geography, demographics, or historical details of the study setting. Figure 2 shows the top fields of study from included articles.

The Use of Local History

Of the four articles that utilized local histories, there was great variety in the research topics addressed and methods or rationales for using those histories. Appendix 1 includes excerpts exemplifying their respective uses of local history. In their article, Swope focused on efforts of Washington D.C. elites to further segregate the city through “aggressive” housing reform. The author synthesizes qualitative, quantitative, and spatial data to challenge the characterization of alleys throughout the city—commonly inhabited by impoverished Black people—as having “unsanitary” conditions and “high disease prevalence”. By investigating local publications from the time period, epidemiological data, and historical mapping, Swope emphasizes the role of structural racism in creating poorer health outcomes for residents of alleys rather than the environmental conditions described by white D.C. elites. The use of local historical data sources served to challenge prevailing narratives, largely fueled by public health, that served to more intensely segregate Black residents of Washington D.C.

In another article, Henderson et al. conducted a quasi-experimental study to determine how the Flint Water Crisis may influenced maternal health outcomes from 2012 to 2017. Through comparing severe maternal morbidity rates of Flint, Michigan and two similar cities, they concluded that “regardless of a woman giving birth in a predominantly Black city, in the midst of an environmental hazard, or with respect to her age, maternal health disparities are still

37 Swope.
38 Swope.
present if that woman identifies as Black.” They hypothesized that “crisis level investments” during the Flint Water Crisis could explain the protective factor of what they termed the “Flint effect” on maternal morbidity rates among Black women. In their article, Henderson et al. utilize both an environmental history of the Flint Water Crisis as well as a demographic history of the city of Flint to contextualize health outcomes for Black women in Flint, providing invaluable context for racial environmental and health injustices in the city (Appendix 1).

Wu et al. piloted a telephone outreach program to reduce “disparities in COVID-19 access” for Black populations in the Milwaukee. While they were unsuccessful in increasing vaccination rates among their Black participants, their study highlighted the need to work upstream to improve “public health and community systems” to improve health equity. In a methodology study utilizing youth participatory action research, Schmidt-Sane et al. sought to understand how neighborhood factors of a community in Cleveland could affect health from the perspective of Black youth. Led by children in the community, the results describes how histories of racism lead to “present-day health and socioeconomic disparities” in one neighborhood in Cleveland. While these two articles included less extensive local histories than the previous two, they both utilized history to detail their respective cities’ past legal and political efforts to limit vital resources and opportunities for Black communities—largely through racial residential segregation—leading to inequalities in educational, economic, and

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40 Henderson, Shortridge, and Sadler.  
41 Henderson, Shortridge, and Sadler.  
42 James F. Wu et al., “COVID-19 Vaccination Telephone Outreach: A Primary Care Clinic Intervention Targeting Health Equity,” *WMJ: Official Publication of the State Medical Society of Wisconsin* 122, no. 5 (December 2023): 438–43.  
43 Wu et al.  
45 Schmidt-Sane, Benninger, and Spilsbury.
healthcare resources and access. These histories, while only a paragraph long, provide clearer insight into the role that structural racism played in patterning access to health-enabling and health-risking resources throughout Milwaukee and Cleveland. Each of the four articles analyzed racial health inequities through a grappling with structural racism at the level of the city. The extent to which they included history, quantitatively, ranged from paragraphs to entire articles.
Figure 2.

Heat Map of Top Fields of Study of Included Articles

<table>
<thead>
<tr>
<th></th>
<th>7</th>
<th>8</th>
<th>10</th>
<th>6</th>
<th>10</th>
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<tbody>
<tr>
<td></td>
<td>Anthropology</td>
<td>Economic growth</td>
<td>Economics</td>
<td>Environmental health</td>
<td>Family medicine</td>
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<tr>
<td>12</td>
<td>Gender studies</td>
<td>Gerontology</td>
<td>Health care</td>
<td>Health equity</td>
<td>Law</td>
</tr>
<tr>
<td>23</td>
<td>Medicine</td>
<td>Nursing</td>
<td>Political science</td>
<td>Psychological intervention</td>
<td>Psychology</td>
</tr>
<tr>
<td>16</td>
<td>Public health</td>
<td>Qualitative research</td>
<td>Racism</td>
<td>Social science</td>
<td>Sociology</td>
</tr>
</tbody>
</table>

*Source: Lens.org*
Table 1.

Data Extracted from Articles Included in Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Racism</strong></td>
<td></td>
</tr>
<tr>
<td>Structural</td>
<td>16 (59%)</td>
</tr>
<tr>
<td>Institutional</td>
<td>6 (22%)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>Internalized</td>
<td>1 (4%)</td>
</tr>
<tr>
<td><strong>Scope of Study Population</strong></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>State – region</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Local – city</td>
<td>12 (44%)</td>
</tr>
<tr>
<td>Local – group of cities</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Local – neighborhood</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Local – health/academic facility</td>
<td>7 (26%)</td>
</tr>
<tr>
<td><strong>Used History?</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>21 (78%)</td>
</tr>
<tr>
<td>Yes (state level)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Yes (local level)</td>
<td>4 (15%)</td>
</tr>
</tbody>
</table>
### Four Articles with Local Histories

<table>
<thead>
<tr>
<th>Title</th>
<th>Author(s)</th>
<th>Journal</th>
<th>Quantity of History in Article</th>
</tr>
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<tbody>
<tr>
<td>The Spatial Configuration of Segregation, Elite Fears of Disease, and Housing Reform in Washington, D.C.'s Inhabited Alleys</td>
<td>Carolyn B. Swope</td>
<td>Social Science History</td>
<td>Throughout entire article</td>
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<tr>
<td>Environmental crisis or an act of contemporary racism? A flint effect on maternal health disparities</td>
<td>Kionna L. Henderson; Ashton Shortridge; Richard C. Sadler</td>
<td>Human Geography</td>
<td>Two sections</td>
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<tr>
<td>COVID-19 Vaccination Telephone Outreach: A Primary Care Clinic Intervention Targeting Health Equity.</td>
<td>James F Wu; Martin D Muntz; Ann Maguire; Anna Beckius; Mandy Kastner; Brian Hilgeman</td>
<td>WMJ: official publication of the State Medical Society of Wisconsin</td>
<td>Paragraph</td>
</tr>
<tr>
<td>Youth Lens methodology: Critical participatory action research with youth in Cleveland, Ohio</td>
<td>Megan M. Schmidt-Sane; Elizabeth Benninger; James C. Spilsbury</td>
<td>Children and Youth Services Review</td>
<td>Paragraph</td>
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</table>
Discussion

There was a pattern among the four papers that engaged local histories: each analyzed racism at the structural level and focused on a study population at the city level. In other words, in every case local history was utilized, it was to explain the ways in which structural racism shaped, and still upholds, racial health inequities for the Black communities residing within a particular city. These studies differed primarily in the quantity with which they used history. The length of history included ranged from single paragraphs to multiple sections to an entire article interwoven with history. In a 2020 paper, Krieger provided conceptualizations of three forms of racism: structural, interpersonal, and internalized. 46 While Krieger includes “institutional legacies and indicators of injustices” in her conceptualization of structural racism, the dearth of literature regarding the context of racism within the biomedical institution—and healthcare, specifically—warrants a distinction. 47 In other words, institutional racism in the context of healthcare was salient enough to warrant its own category, especially among the papers included in this study.

There has been ample discussion regarding the ahistorical nature of public health research in the 21st century and the present study extrapolated that assessment to racial health equity research in a six-month period in 2023. 48 These findings provide evidence not only of the severe neglect of utilize local histories in health equity research, but also finds that history, in general, is missing when researchers investigate structural racism to advance health justice for Black

47 Krieger.
communities. Mapping the relationship between “governance, policy, … societal norms, and values” helps make clear inextricable links between the individual and the world in which they live in shaping health outcomes, whereby “no matter how empowered, knowledgeable, or willing someone is to change their behavior, they may not be able to do so because of structural determinants of health inequities.” While the field of public health has done considerable (but incomplete) work to shift its focus from individual behavior change to social determinants of health, it falls short of actualizing a greater potential without troubling how those determinants are siphoned along socially-constructed lines, like race, by structural determinants. History can help fuel this inquiry.

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Conclusions

Summary

The present study sought to assess the utilization of local histories in racial health equity research by reviewing peer-review journal articles from a six-month period in 2023. Of the 27 articles included in this analysis, nearly 60% of them used racism at the structural level to frame, contextualize, or analyze racial health inequities. In over 80% of studies, the scope of the study population was at the local level or smaller. However, only six (22%) used history as context for understanding or eliminating inequities for Black communities, and only four (15%) used history at the local level. These four articles were similar in that they analyzed racial health inequities through a grappling with structural racism. Each also focused their study at the local level, focusing on Black populations at the city level. The extent to which they included history, quantitatively, ranged from paragraphs to entire articles. These findings support academic discourse regarding the ahistorical nature of public health research and provides invitations for bolstering health equity research looking forward, particularly research that seeks to engage structural racism and its effects on the health of Black communities at the local level.

Limitations

In developing the idea for this paper, one major hurdle was the need to conceptualize and operationalize the use of local history in racial health equity research. I was unable to capture the discussion and interrogation of histories that do not make their way to the published article. It is equally likely that the realization of each of the included articles included extensive consideration of histories in congruence with the scope of the study. While true, there still exists
a crucial responsibility of public health researchers which is collecting and then *sharing* knowledge with the world to better prevent suffering and improve health. To engage histories without sharing them in these finished works, then, makes it more difficult for readers of public health to best contextualize the health inequities described. Although this study captured few articles that incorporated local history, the four articles offer a great diversity regarding the context to which researchers can and should go about including histories—from single paragraphs to weaving through the entirety of an article.

This analysis used narrow parameters—largely in the name of manageability for one investigator—so this study does not suffice to describe the research area of racial health equity in its entirety. I am hopeful that there are several studies outside of these parameters that include histories, and local histories, specifically. While aiming to capture studies who focused on Blackness in all its diversity, my search terms did not include descriptors such as “Afro-Caribbean” or “Afro-Latino”, making it possible that other eligible studies were not captured by my search. Additionally, I spend considerable time discussing how to operationalize “public health”, “racial health equity research”, and “history” with my advisors and the public health librarian, Kate Nyhan. While I ultimately decided on uses of these terms that were most applicable to this inquiry, different operationalizations are likely to differentially widen or narrow the focus of the search, yielding different sources for analysis.

*Looking Forward*

The centrality of historical processes to structural racism cannot be overstated. A historical lens offers insight into the scale, magnitude, and severity of the solution needed to adequately address structural racism as a historical exposure.\(^5^0\) Neglecting or refusing to navigate

\(^5^0\) Kramer, “Why History?”
history towards alleviating racial health inequities not only hinders progress but makes it more difficult to capture the important experiences, stories, and perspectives from those most affected. National narratives, while important and should be used, fail to include the particularities of how structural racism takes from at the level of the locale, missing invaluable factors and information to consider in understanding and eliminating such inequities. Histories equip and empower us to answer questions like: what local laws, policies, programs, or practices have helped shape this inequity? How were racially segregated communities formed in this locale? What structural or system-level solutions have been attempted? What made them successful or unsuccessful?

Thankfully, public health has role models to look to. The use of history is more readily embraced as a tool in environmental justice scholarship that uses history to uncover the roots of environmental racism at the local level.\textsuperscript{51} Scholars from critical medical anthropology call us to examine health in how it is “situated historically…viewed in a theoretical framework that critically examines [its] embeddedness in social, economic, and political structures.”\textsuperscript{52} Placed-based public health puts focus to solution development in interrogating causes of health inequities at the community level, developing and piloting health-improving programs, interventions, and policies.\textsuperscript{53} Further, methodologies like micro-histories invite us to reimagine how public health researchers might adapt to the growing need to include history by zooming

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\textsuperscript{51} Callewaert, “The Importance of Local History for Understanding and Addressing Environmental Injustice.”
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into local contexts, providing nuanced understanding and uncovering hidden or overlooked mechanisms of broader social phenomena.⁵⁴

A local focus on the health inequities experienced by Black communities can illuminate the ways in which systematically concentrated inequality “often manifests locally in small geographic areas.”⁵⁵ Similarly, analysis of the locale helps trouble the notion of Blackness as a monolith by better describing how inequities differ in both magnitude and severity depending on effects of “localized structural racism.”⁵⁶ Embracing the diversity of Blackness in the United States also provides opportunity to capture examples of communities’ abilities to thrive and adapt wherein researchers can answer questions regarding the conditions responsible for Black flourishing or the protective features of Black communities throughout the country.⁵⁷

Answering an interview question regarding the writings of Frederick Douglass and his commitment to telling the story of the enslaved, author Ta-Nehisi Coates reminds us that when analyzing the true performance of a system, we ought to “examine those in the worst shape.”⁵⁸ To examine the healthcare system in the United States, for example, we must examine those with the worst health outcomes, asking, “how do they fair?” This is the impetus for being concerned and bound up with the histories of Black communities. Public health has contributed, both directly and indirectly, to the demise of Black communities in the United States and has yet to maximize its role in bringing health justice to the homes of communities all over the country. For this reason, among others, engaging the locale is crucial to saving Black lives, preventing

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⁵⁶ Silva et al.
⁵⁷ Táiwò, Reconsidering Reparations.
suffering, and protecting communities. It is my hope that public health researchers, in the process, will become more eager to investigate local histories—traversing the roads less traveled.
Appendix 1
Excerpts of Utilization of Local History

Swope: The Spatial Configuration of Segregation, Elite Fears of Disease, and Housing Reform in Washington, D.C.’s Inhabited Alleys

“The fine-scale analysis afforded by mapping individual alleys is particularly useful for considering the meaning of segregation in the early 20th century. DC’s master city plan allowed for wide, deep lots, with service alleys that cut through the block. This allowed for the creation of smaller lots with smaller homes facing the alley in the rear of the street homes – intensifying as the population boomed following the Civil War, especially with formerly enslaved people, and a housing crunch ensued. The number of alley residents increased from around 715 residents in 1858 (Borchert 1982), to an estimated 7,676 to 10,614 residents by 1880 (Borchert 1982; Logan 2017; Groves 1974) and a probable peak of 18,225 residents by 1897 (Commissioners of the District of Columbia 1897). While initially these homes mainly served unskilled white workers employed nearby, sometimes by their landlord, the construction and ownership of alley homes became more speculative and disconnected from the adjacent street front homes, with residents experiencing little contact with distant owners; the alley population also shifted to majority Black (Borchert 1971; Jones 1929). Figure 2 shows the wide distribution of alleys across the city as of 1912–14, along with the size of their populations. Most were relatively small, although some were large, with as many as 308 residents living in the interior of a single block. Inhabited alleys were common in cities up to this point in Britain and the U.S. (Borchert 1982:224). DC’s “blind” alleys, however, were unique in that they were accessed only by narrow passages and formed “H” or “I” shapes of interconnected lanes, which did not allow for clean sight lines through the block, and thus, were “hidden” from the outside community (Groves 1974).
Unsurprisingly given they offered poorer-quality housing, alleys’ residents were typically socially marginalized, even in comparison with other Black Washingtonians – often migrants from rural Virginia and Maryland, and holding lower occupational profiles than their Black street front counterparts (Borchert 1982; Groves 1974, 1973).  

“Jones’ Monday Evening Club alley directory (1912), as well as an editorial (1913), devoted significant attention to condemning the health conditions in alleys. He pointed to overall mortality rates of 30.09 per thousand in alleys vs. 17.56 in streets and observed that mortality rates by race were higher among alley dwellers than street dwellers for all four infectious diseases which were supposedly the most common causes of death. Jones’ preoccupation with the health conditions in alleys reflected the concern in the broader alley reform movement. Alleys’ unsanitary conditions and corresponding high rates of disease were primary arguments made in a widespread campaign to eliminate alleys, which were regularly described as breeding grounds of disease, plague spots, and human pestholes.”

“Jones believed firmly in racial hierarchy, holding that Black people and other groups not perceived as fully white had not “evolved” to the same stage of civilization as Anglo-Saxon white people. He advocated providing narrow accommodationist vocational training for Black students, teaching them to be docile and industrial within the status quo. For example, in a Department of Education study he led on schools for Black students, Jones highlighted the ways that supposed characteristics of Black people justified inferior education (e.g., they should

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59 Swope, “The Spatial Configuration of Segregation, Elite Fears of Disease, and Housing Reform in Washington, D.C.’s Inhabited Alleys.”
60 Swope.
receive “simple manual training” because “the Negro’s highly emotional nature requires for balance as much as possible of the concrete and definite”) (Jones 1917, 23). He sought to assimilate Black people to Anglo-Saxon norms, which he believed to be inherently superior, but only insofar as it led them to understand their present subordination and suited their ability to perform their menial role in their current stage of civilizational “evolution”. He did reject the idea of absolute and eternal inferiority of Black people, contemplating that in the distant future, they might come to be capable of higher achievement if they successfully assimilated and “matured,” but for now, he felt, they must recognize their inferior station and learn to perform the associated responsibilities to white people’s satisfaction (Johnson 2000). By imbibing such notions as the need to strive to “develop” in order to “become the equals of other races,” a Black pupil might, “instead of regarding the difficulties of his race as the oppression of a weaker by the stronger,” view them as “the natural difficulties which almost every race has been compelled to overcome in its upward movement” (Jones 1906: 5).”

Henderson et al.: Environmental crisis or an act of contemporary racism? A flint effect on maternal health disparities

“The FWC began on April 10, 2014, when state-appointed officers made the decision to switch the water source from the Detroit municipal water supply to the Flint River to save money. This decision was initially made to address the economic crisis within the city of Flint (Butler et al., 2016; Masten et al., 2016; Mullen, 2020; Sadler and Highsmith, 2016). The roots of the FWC matriculated from the booming General Motors-led automobile industry in the 1930s–1970s.

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61 Swope.
During this period, the car industry in Flint and surrounding cities continuously poured lead, batteries, paints, lacquers, gasoline, and other toxic substances into the Flint River, the surrounding air, and soil for years (Butler et al., 2016; Rosener, 2016). The Flint River had not been used as a domestic water source by Flint residents since 1967 when the city of Flint switched its water supply to the Detroit Municipal water source (Wiitala et al., 1964); that is, until April 2014 (Hanna-Attisha et al., 2016). The 2014 switch of the water source without adequate water treatment led to thousands of Flint residents being exposed to lead and other dangerous chemicals through corroded water pipes (Danagoulian and Jenkins, 2019; Grossman and Slusky, 2019; Hanna-Attisha et al. 2016; Sadler and Highsmith, 2016). Similarly devastating as the actual exposure to contaminated water was the dismissal of complaints from Flint residents to government officials about the negative health effects observed once the water source was changed (Dolan et al., 2016; Felton, 2014; Morckel and Terzano, 2019). Flint residents did not receive the attention or assistance needed from the government for almost two years after the initial water source was switched.”

Page 3, “Environmental history of the FWC”

“In the mid-20th century, Flint consisted of a majority White population. In 1960, Genesee County, which contains the city of Flint, housed 374,313 residents of which 90.1% were White and 9.8% Black (Social Explorer & U.S. Census Bureau, 2022). Almost all of the Black population at this time resided in the city of Flint in a few relatively small neighborhoods. As the second Great Migration progressed, more Black citizens migrated to the north in search of jobs and opportunities that were not readily available in the southern US; however, these migrants were still subject to racial segregation in residences, education, and other social factors. As the

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62 Henderson, Shortridge, and Sadler, “Environmental Crisis or an Act of Contemporary Racism?”
Great Migration continued, more and more Flint neighborhoods consisted of Black communities. These trends reflected regional shifts in manufacturing employment. Around the 1950s, manufacturing jobs such as the Big Three automotive companies in Michigan (i.e., Ford, General Motors, and Chrysler) migrated to the suburbs resulting in decentralization of major companies, suburbanization, metropolitan fragmentation, and economic decline in cities such as Flint (Darden, 1990; Highsmith, 2014; Scorsone and Bateson, 2011). People living in inner cities who were able to and could afford to move closer to jobs in the suburbs relocated; most of these emigrants were White residents. Most Black residents remained in the central cities due to social and political constraints leading to metropolitan-scale segregation (Lee and Mohai, 2011). Urban access to suburban manufacturing job locations was limited by the lack of transportation from the inner city to the suburbs, which led to the economic decline of most inner cities in America in the second half of the twentieth century (Downey, 2005; Massey and Denton, 1993). Thus, Flint, along with many other predominately Black inner cities, experienced economic hardship and decades of economic decline (Frey, 1979).”

Schmidt-Sane et al.: Youth Lens methodology: Critical participatory action research with youth in Cleveland, Ohio

“Cleveland faces significant racial inequities in terms of educational attainment, socioeconomic status, and health outcomes (Aliprantis, 2019); the city’s long history of racist policies deliberately limited the opportunities of African Americans to access essential resources to support their well-being (Kirwan Institute, 2015). During the 1930s, African Americans were

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63 Henderson, Shortridge, and Sadler.
explicitly excluded from community institutions, businesses, and labor markets and segregated into separate, less-resourced schools, housing, and hospitals (Encyclopedia of Cleveland History, 2020). Increasing discriminatory practices such as red lining and racial zoning kept African Americans confined within the eastside neighborhoods, while whites moved to outlying sections of the city and to adjacent rural areas that would later become suburbs (Kirwan Institute, 2015). Today the population of the city remains residentially segregated by race.”

Wu et al.: COVID-19 Vaccination Telephone Outreach: A Primary Care Clinic Intervention Targeting Health Equity

“For many of our patients, the specific ZIP code in which they live in Milwaukee directly affects their health.30 Due to historical redlining – discriminatory practices of denying minority populations access to equal loan and housing opportunities – Milwaukee is one of the most segregated metropolitan areas in the United States.31 Racially hypersegregated neighborhoods in Milwaukee led to lack of investment and infrastructure in predominately Black communities, directly resulting in worse educational opportunities and health care access and food deserts – all leading to worse health outcomes among many other persisting downstream effects. Not only does Milwaukee rank consistently worst or near-worst across 30 indicators of racial inequality and last on a composite index of Black community well-being,32 inequalities for Milwaukee’s Black communities are worse today than they were 40 or 50 years ago.33”

64 Schmidt-Sane, Benninger, and Spilsbury, “Youth Lens Methodology.”
65 Wu et al., “COVID-19 Vaccination Telephone Outreach.”
Citations for Reference


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