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Chandra Ford is an Assistant Professor in the Department of Community Health Sciences at the Fielding School of Public Health at UCLA. Her areas of expertise are in the social determinants of HIV/AIDS disparities, the health of sexual minority populations, and Critical Race Theory. She earned her Ph.D. from the Gillings School of Public Health at the University of North Carolina.



Q&A with Chandra Ford

Director of the Center for Public Health Critical Race Praxis talks about her research on social inequity and health disparities

What has your recent work on social inequity and health disparities revealed about the multiple roles that racism plays in affecting health outcomes related to HIV/AIDS? Is distrust of the medical establishment caused by knowledge of historical medical malpractice compounded by continuing institutional and structural racism?

To answer these questions, it's important to first have an understanding of the types of racism prevalent in today's world. For example, racism might occur everyday at work. Another, more pervasive type of racism may not be experienced firsthand but affects systems and processes. We can look

at a specific type of racism and then begin to assess how racism in that occurrence affects health outcomes. There already is a lot of work on the relationship between racism and non-infectious diseases—blood pressure, mental health outcomes, and adverse birth- or pregnancy-related outcomes, such as having a child prematurely. Much less work has been done on the effects of racism on the transmission of infectious diseases or on access to services to prevent the transmission of infectious diseases. My work helps to fill that gap.

That said, I have learned that the relationship between racism and HIV testing and other prevention-related outcomes is pretty complex, more complex than some data

would suggest. My work primarily examines preventive behaviors, but most HIV prevention work focuses on risk behaviors. This risk orientation emphasizes how behaviors increase risk. Based on my findings to date, I am beginning to consider the possibility that, when taking racism into account, preventive behaviors may function differently than risk behaviors. We do know that one of the factors that motivates behaviors is the knowledge that one is receiving a benefit. This is often obscured for those undertaking preventive measures.

Most of my work is focused on people who have very low incomes, who rely on public health clinics and resources, and who are in

high HIV-prevalence or -risk populations. Often, they have multiple health or social issues. Those who use clinics specializing in the treatment of sexually transmitted disease (STD) are considered at high risk for HIV for two reasons. First, if they're engaging in behaviors that place them at risk for an STD like gonorrhea, they are, by definition, engaging in behaviors that also place them at risk for HIV. Secondly, because HIV prevalence is higher in these networks, opportunities to acquire or transmit HIV are many.

My work to date offers several interesting findings. In some of my qualitative work, we found that people from these disadvantaged populations generally do not have racial preferences regarding their health provider's background. They do, however, feel very strongly about having a provider who treats them like a person. Many believe that providers may treat them poorly because they are minorities. A growing body of work suggests that racial concordance between the patient and provider may influence patient behaviors in clinical settings. In one small study I conducted, African American women seeking STD screening—a population the Centers for Disease Control and Prevention (CDC) recommends automatically undergo HIV testing during visits—were more likely to do so if they were seen by a

black provider. Even though African American providers in this context made up only one-fourth of the provider pool, approximately 80% of the African American women who obtained an HIV test were tested by an African American provider. We need to do more studies with larger, more representative samples to understand these relationships better and to determine if racial concordance might facilitate earlier diagnosis of any HIV infection among African Americans, whose rates of HIV/AIDS remain higher than any other U.S. racial/ethnic group.

Another interesting finding from my research has to do with how people, especially African Americans, respond when they perceive everyday kinds of racism (that is, "racial microaggressions"). Racial microaggressions are the little things that, by themselves, seem silly and insignificant, but derive meaning because they occur so regularly in one's life that they become chronic stressors. As an example, think of the black person who goes to a nice store and is followed by the sales people to make sure nothing is stolen.

We explored whether people perceive this kind of racism as pervasive in society. We then compared people who believe it pervasive and those who do not—to see how those perceptions related to their HIV-testing behaviors

in STD clinics. For African American STD clinic patients who believed this kind of racism is pervasive, the more they believe it, the more inclined they are to test for HIV infection during an STD clinic visit. That finding was consistent with other studies primarily focused on preventive outcomes. We conjectured that perceiving these microaggressions might be a marker of self-awareness or awareness of one's social environment. A higher level of awareness, including race consciousness, might actually help people respond more assertively, more proactively, to perceived potential threats if they believe they can do something to address the threats. We also thought that these people might be more proactive about HIV testing because they want to avoid becoming reliant on a system they don't completely trust or don't want to unknowingly contract HIV and pass it on to their loved ones.

Currently, I'm beginning to examine what happens when people experience racism, especially in a health care setting. I am asking the research question, "When controlling for other relevant considerations, does an experience of racism influence HIV testing in this high HIV-prevalence setting?" Our preliminary data suggest that it does and that this relationship might actually create a barrier, but that's a very preliminary conclusion.

Since 2010, when we first published our public health critical race praxis, we have begun to see marks of progress in the use of this model. One is that scientists are trying to standardize the approaches they use in quantitative and qualitative empirical research to address race, ethnicity, and/or racism-related factors. This, I think, is pretty exciting! It means we are placing a greater emphasis on explicitly naming racism. And, while explicitly naming racism is not new to what we are doing, we are now providing tools that allow researchers to do so in more refined and more nuanced ways.

What has your study of older (50+) adults and HIV testing shown about the effects of conspiracy theories and mistrust of the government?

Interestingly, the relationship we found between HIV testing and endorsement of HIV conspiracy theories among older adults was similar to the relationship we found between everyday pervasive racism and HIV testing. Both findings remind us that people exercise agency in their lives, that they have resilience, and that even socially marginalized communities have some resources. The findings remind us to pose our research questions such that they do not frame community perspectives as illogical. We need to understand that these communities may have important reasons for their concerns or for endorsing conspiracies. And, in their estimation, addressing these concerns and beliefs will protect and enhance their health.

To put this concept in context relative to other work on racism and health, this approach suggests we need to think in more nuanced ways about racism. To give you an example, members of focus groups I conducted several years ago had very negative *attitudes*, which appeared to be propelled by their personal experiences with racism. Their *behaviors*, however, were not affected in the same way.

For instance, several reported being treated very badly, but nevertheless declared that, despite feeling terrible because of how clinical staff treated them, “If I need services, I’m going to demand that I get what I need.”

As I mentioned earlier, much less is known about the role of racism on preventive behaviors vs. risk behaviors. It’s important that we begin or continue asking the questions: “How does experiencing racism relate to someone seeking HIV testing?” “What are the implications when we’re thinking about racism in high- versus low-HIV-prevalence populations?” This is important because we know that, although high-risk groups undergo HIV testing more than any other groups do, it still does not occur at the levels we would hope for, given the even higher levels of HIV in these populations.

So, thinking about whether racism limits HIV testing in a population is not enough. We need to think about it relative to HIV/AIDS rates in the population and with regard to how groups differ in their relationship to HIV testing in general.

How has critical race theory changed the conceptualization of racism in the field of public health? How can it help to develop more successful strategies for reducing health disparities and achieving health equity?

For generations, scientists in public health and biomedicine have conducted research to counter medical racism and address racial/ethnic inequities in health. I am fortunate to be able to draw on their findings, and the expertise of my colleague, Collins Airhihenbuwa, to continue the work on critical race theory and, specifically, our novel contribution, the public health critical race praxis (PHCR), which is not just a reduction and extraction of critical race theory. Instead, it is an engagement with both critical race theory as it exists outside of the public health context and as what Camara Jones at the Centers for Disease Control and Prevention calls “an organic public health critical race theory.”

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means we are placing a greater emphasis on explicitly naming racism. And, while explicitly naming racism is not new to what we are doing, we are now providing tools that allow researchers to do so in more refined and more nuanced ways.

In terms of the literature, in the past, it has often been difficult to publish peer-reviewed articles addressing racism. And, while we are gaining some momentum in scholarly publication, we continue to be challenged by the fact that critical race scholarship is not well understood within the mainstream of the field.

Yet, another positive thing is happening: researchers are beginning to incorporate explicit self-awareness, self-consciousness, and reflexivity in their quantitative research. This is really quite notable because objective science is not typically a place where researchers talk about how their own subjectivities influence the research questions they ask, the methods they use, the interpretations they make of the findings, or other considerations. So this, again, I find to be very exciting.

Several efforts are underway to shift how researchers investigate and address social determinants of health and health equity. For instance, the University of Maryland’s Center for Health Equity has called for a fourth generation of health disparities research to

be based entirely on the public health critical race praxis. They argue that three orientations to health disparities have existed; by pursuing their PHCR-based research they will capitalize on this critical race direction to study health disparities and to promote critical race praxis on the ground through public health practice in communities.

We’re also thinking about how to layer on more explicit, critical, racialized analyses into approaches that are already working in the field, such as community-based participatory research (CBPR). With a CBPR approach, communities and researchers partner in truly equal ways—at all levels of the research continuum—to conduct the study and then to use the findings to improve the community. This process is not driven by researchers coming up with ideas and then receiving community input on them. Rather, it is the whole community, including the researchers, that creates the ideas and drives the research effort.

Within this framework, we call for a more sustained and explicit consideration of how racialization might be at work in CBPR projects. To facilitate this, we help to provide a vocabulary grounded in critical race theory to draw public health efforts into conversation with critical race scholarship outside our field. I believe this can help to legitimate public health

critical race approaches. Our model emphasizes not only studying health disparities, but also studying ways that racialization within our field might inadvertently contribute to the disparities. This involves examining our methods and conventions. One paper that is now being referenced widely is one that Nina Harawa and I published in *Social Sciences and Medicine* on conceptualizing and measuring ethnicity in the United States. We talk about race all the time, but what does ethnicity mean in the United States? This question is fundamental to the field of public health because we routinely use these variables all the time. Given the social construction of ethnicity, we urge empirical researchers to define it in ways that underscore how specific social inequalities are linked to ethnicity.

What drew you to participating in the Life (Un)Ltd. working group?

I'm interested in engaging critical race theory and feminist theory relative to public health research and practice, and to exploring how critical scholarship might be applied to real-life public health problems. We often find a disconnect between applied scholarship and theory-based academic work. I'd like to marry the two to see if we can better our understanding of health disparities, improve people's wellness, and increase knowledge.

I'm also interested in how critical feminist scholarship, among other critical scholarships, can benefit from what's going on in public health. I am concerned that critical feminist and other critical studies do not sufficiently engage with and critique knowledge production occurring within biomedicine and public health. While there may be some engagement with it, failure to truly engage with these fields may leave them unchecked and may even reinforce presumptions that the fields are beyond critique from non-scientists.

Has having an M.L.I.S. in addition to an M.P.H. and Ph.D. affected your approach to research?

Absolutely. It informs how I think about the causes of disparities and how I go about my own research. My training in library and information studies was focused on health information, especially disparities in accessing health information. For many years, I also focused on how information tools, including the Internet and other media, might be used to reduce disparities. In terms of knowledge production, having an M.L.I.S. shapes how I carry out my own work. Moreover, it informs one of the central focuses of the public health critical race praxis—the role of racialization in knowledge production about disparities.

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