POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Impact of Racism on Child and Adolescent Health

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The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

STATEMENT OF THE PROBLEM

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[1] Racism is a social determinant of health[2] that has a profound impact on the health status of children, adolescents, emerging adults, and their families.[3–8] Although progress has been made toward racial equality and equity,[9] the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear.[10] Failure to address racism will

abstract

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continue to undermine health equity for all children, adolescents, emerging adults, and their families.

The social environment in which children are raised shapes child and adolescent development, and pediatricians are poised to prevent and respond to environmental circumstances that undermine child health. Pediatrics as a field has yet to systematically address the influence of racism on child health outcomes and to prepare pediatricians to identify, manage, mitigate, or prevent risks and harms. Recognizing that racism has significant adverse effects on the individual who receives, commits, and observes racism,[11,12] substantial investments in dismantling structural racism are required to facilitate the societal shifts necessary for optimal development of children in the United States. The American Academy of Pediatrics (AAP) is committed to reducing the ongoing costs and burden of racism to children, the health care system, and society.[13,14]

Today's children, adolescents, and emerging adults are increasingly diverse. Strategies to address health and developmental issues across the pediatric life span that incorporate ethnicity, culture, and circumstance are critical to achieving a reduction in health disparities. Accordingly, pediatrics should be at the forefront of addressing racism as a core social determinant. The inclusion of racism is in alignment with the health equity pillar of the AAP strategic plan.[15] In a series of workshops in 2016 during national meetings of pediatricians, 3 strategic actions were identified: (1) development of a task force within the AAP to address racism and other forms of discrimination that impact the health status and outcomes of minority youth, (2) development of a policy statement on racism, and (3) integration of evidence-based anticipatory guidance about racism into *Bright Futures*.[16]

The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. This policy statement will allow pediatricians to implement recommendations in practice that will better address the factors that make some children more vulnerable than others.[13] The statement also builds on existing AAP policy recommendations associated with other social determinants of health, such as poverty, housing insecurity, child health equity, immigration status, and early childhood adversity.[9,17–19]

RACISM AS A CORE DETERMINANT OF CHILD HEALTH

Racism is a core social determinant of health that is a driver of health inequities.[20–22] The World Health Organization defines social determinants of health as "the conditions in which people are born, grow, live, work, and age." These determinants are influenced by economic, political, and social factors linked to health inequities (avoidable inequalities in health between groups of people within populations and between countries). These health inequities are not the result of individual behavior choices or genetic predisposition but are caused by economic, political, and social conditions, including racism.[23]

The impact of racism has been linked to birth disparities and mental health problems in children and adolescents.[6,24–30] The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level. Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease.[31] As an example, racial disparities in the infant mortality rate remain,[32] and the complications of low birth weight have been associated with perceived racial discrimination and maternal stress.[25,33,34]

Investments in policies to address social determinants of health, such as poverty, have yielded improvements in the health of children. The Food Stamp Program, a War on Poverty initiative first developed in the 1930s during the Great Depression and later revived in the 1960s, is linked to improvements in birth outcomes.[35] Efforts in education, housing, and child health insurance have also led to improved health outcomes for issues such as lead poisoning, injuries, asthma, cancer, neurotoxicity, cardiovascular disease, and mental health problems.[20,36,37] Expansion of child health insurance has improved health care access for children, with significant gains for African American and Hispanic children in terms of access to well-child, doctor, and dental visits.[38] Despite these improvements, it is important to recognize that children raised in African American, Hispanic, and American Indian populations continue to face higher risks of parental unemployment and to reside in families with significantly lower household net wealth relative to white children in the United States, posing barriers to equal opportunities and services that optimize health and vocational outcomes.[39–45]

Juvenile justice involvement is also a critical social determinant of health. Because racial inequity continues to shape the juvenile justice system, this area is a modern example of race being an important determinant of short- and long-term outcomes. The AAP published a statement in 2011[46] focusing on key health issues of justice-involved youth, which was recently revised to include an in-depth discussion on racial and ethnic inequalities for this population.[47] Although the overall rates of youth incarceration have decreased, African American, Hispanic, and American

Indian youth continue to be disproportionately represented.[48] While incarcerated, youth experience additional adverse experiences, such as solitary confinement and abuse, that have the potential to undermine socioemotional development and general developmental outcomes.[49–51] Differential treatment of youth offenders on the basis of race shapes an individual's participation and ultimate function in society. This type of modern racism must be recognized and addressed if the United States seeks to attain health equity.[52]

THE DEVELOPMENT OF RACE AS A CONSTRUCT

Race as a social construct is rooted in history and remains a mechanism through which social class has been controlled over time. Flawed science was used to solidify the permanence of race, reinforce the notions of racial superiority, and justify differential treatment on the basis of phenotypic differences as people from different parts of the world came in contact with each other.[53] Race emerged as a social classification used to assign dominance of some social classes over others.[53] Scientific, anthropologic, and historical inquiry further solidified race as a social construct.[54] Modern science, however, has demonstrated that there is only 1 biological race and that the clines (phenotypic differences in skin and eye color, hair texture, and bone structure) at the core of early anthropologic research were insufficient to establish different races among human beings. Dr Francis Collins, former director of the National Human Genome Project and presently the director of the National Institutes of Health, has affirmed that humans are 99.9% the same at the level of their genome.[55] Despite this, efforts to collect, organize, and categorize individuals on the basis of the plausibility of the 0.01% human variation remain a force of scientific discovery, innovation, and medical-pharmaceutical collaborations.[56] Rather than focusing on preventing the social conditions that have led to racial disparities, science and society continue to focus on the disparate outcomes that have resulted from them, often reinforcing the posited biological underpinnings of flawed racial categories.[57] Although race used in these ways has been institutionalized, linked to health status, and impeded our ability to improve health and eliminate health disparities,[58,59] it remains a powerful measure that must be better measured, carefully used, and potentially replaced to mark progress in pediatric health disparities research.[60,61]

As such, it is important to examine the historical underpinnings of race used as a tool for subjugation. American racism was transported through European colonization. It began with the subjugation, displacement, and genocide of American Indian populations and was subsequently bolstered by the importation of African slaves to frame the economy of the United States. Although institutions such as slavery were abolished more than a century ago, discriminatory policies, such as Jim Crow laws, were developed to legalize subjugation. As the United States expanded west in North America and into Alaska and the Pacific Islands, the diversity of populations encompassing the United States also expanded. Native Hawaiian and Pacific Islander, Alaskan native, Asian American, and Latino American populations have experienced oppression and similar exclusions from society.[62–65] Although some racial and/or ethnic groups have received reparations[66] and fared better than others over time, remnants of these policies remain in place today and continue to oppress the advancement of people from historically aggrieved groups.[67–72]

Through these underpinnings, racism became a socially transmitted disease passed down through generations, leading to the inequities observed in our population today. Although the endemic nature of racism has powerful impacts on perceived and actual health outcomes, it is also important to note that other forms of discrimination (eg, sex, religion, sexual orientation, immigrant status, and disability status) are actively at play and have created a syndemic with the potential to undermine child and family health further. It is important to address racism's impact on the health and well-being of children, adolescents, and emerging adults to avoid perpetuating a health system that does not meet the needs of all patients.[52] Pediatricians are uniquely positioned to both prevent and mitigate the consequences of racism as a key and trusted source of support for pediatric patients and their families.

CHILDHOOD EXPERIENCES OF RACISM

Children can distinguish the phenotypic differences associated with race during infancy[73–75]; therefore, effective management of difference as normative is important in a diverse society. To identify, address, and manage the impacts of racism on child health, it is critical that pediatricians understand 3 key levels through which racism operates: (1) institutional, (2) personally mediated, and (3) internalized. The experience of race is also impacted by other identities that people have related to ethnicity, sex, religious affiliation, immigrant status, family composition, sexuality, disability, and others that must be navigated alongside race. Much of the discussion to date related to the historical underpinnings of race deals with institutionalized (or structural) racism, expressed through patterns of social institutions (eg, governmental organizations, schools, banks, and courts of law) that implicitly or

explicitly discriminate against individuals from historically marginalized groups.[22,52,76,77] Children experience the outputs of structural racism through place (where they live), education (where they learn), economic means (what they have), and legal means (how their rights are executed). Research has identified the role of implicit and explicit personally mediated racism (racism characterized by assumptions about the abilities, motives, or intents of others on the basis of race)[78] as a factor affecting health care delivery and general health outcomes.[79–86] The impacts of structural and personally mediated racism may result in internalized racism (internalizing racial stereotypes about one's racial group). A positive racial identity mediates experiences of discrimination and generates optimal youth development outcomes.[12,87,88] The importance of a prosocial identity is critical during adolescence, when young people must navigate the impacts of social status and awareness of personally mediated discrimination based on race.[89–91]

Although children and adolescents who are the targets of racism experience the most significant impact, bystanders are also adversely affected by racism. As an example, young adults who were bystanders to racism and other forms of victimization as youth experience profound physiologic and psychological effects when asked to recall the memory of a past anchoring event as a victim or bystander that are comparable to those experienced by first responders after a major disaster. Three core features that characterized the abusive event(s) were as follows: (1) an individual gets hurt psychologically or physically, (2) a power differential exists (eg, age, size and/or stature, or status) versus the target individual resulting in domination and erosion of the target's self-esteem, and (3) the abuse is repetitive, causing stress levels to increase because of anticipation of future events.[11] Internalized negative stereotypes related to race can unconsciously erode self-perception and capacity and may later play out in the form of stereotype threat or the fear of confirming a negative stereotype of one's race.[91] Stereotype threats can undermine academic and vocational attainment, key developmental milestones for the victim. Underachievement then reinforces the stereotype held by both the perpetrator and victim, further enhancing the vulnerability of the victim and the bystander to repeated acts of overt or covert victimization. These observations suggest that universal interventions to eliminate racism (experienced as a victim or bystander) from the lives of children and to engage in active societal antiracism bystander behavioral intervention may optimize well-being for all children and the adults who care for them. For individual intervention to occur, however, bystanders must identify critical situations, view them as an emergency, develop a sense of personal responsibility, have self-efficacy to succeed with the intervention, perceive the costs of nonintervention as high, and consciously decide to help.[11,92] Research has demonstrated that racism has an effect on health across racial groups in communities reporting high levels of racism[93] but that racially diverse environments, such as schools, can benefit all youth by improving cognitive skills such as critical thinking and problem-solving.[94]

RACISM AT THE INTERSECTION OF EDUCATION AND CHILD AND ADOLESCENT HEALTH

Educational and vocational attainment are key developmental outcomes that pediatricians monitor to assess for successful growth and development. After accounting for sleep and time spent at home, children spend a significant portion of their time in educational settings.[95–97] Educational achievement is an important predictor of long-term health and economic outcomes for children. Adults with a college degree live longer and have lower rates of chronic disease than those who did not graduate from college.[98] It is critical for pediatricians to recognize the institutional, personally mediated, and internalized levels of racism that occur in the educational setting because education is a critical social determinant of health for children.[99]

Disparities in educational access and attainment, along with racism experienced in the educational setting, affect the trajectory of academic achievement for children and adolescents and ultimately impact health. Chronic absenteeism, defined as missing ≥10% of school days in an academic year, is a strong predictor of educational achievement. Chronic absenteeism disproportionately affects children of color, children living in poverty, children with disabilities, and children with chronic diseases.[100] In high school, 21.2% of Hispanic, 23.4% of African American, and 27.5% of American Indian children were chronically absent in 2013–2014 compared with 17.3% of white children.[101] Immigration enforcement and the fear of apprehension by authorities can negatively affect school attendance for Hispanic and black immigrants, thereby perpetuating inequalities in attendance.[102] According to the National Center for Education Statistics, the graduation rate for white students nationally in 2015–2016 was 88% compared with 76% for African American students, 72% for American Indian students, and 79% for Hispanic students.[103] Disparities in chronic absenteeism and high school graduation rates prevent children from realizing the full benefits of educational attainment

and can increase the development of chronic disease and reduce overall life expectancy.[104]

Although the landmark US Supreme Court case *Brown v Board of Education* banned government-sponsored segregation and laid a foundation for equal access to a quality public education, the US Department of Education continues to report institutional or structural inequality in educational access and outcomes,[105] even in the most diverse and well-resourced communities in the United States. Students from historically aggrieved groups have less access to experienced teachers, advanced coursework, and resources and are also more harshly punished for minor behavioral infractions occurring in the school setting.[105] They are less likely to be identified for and receive special education services,[106] and in some states, school districts with more nonwhite children receive lower funding at any given poverty level than districts with more white children.[107]

Children may also experience personally mediated racism early in their schooling, which may be internalized and ultimately affect their interactions with others.[108] Early teacher-child interactions are important for long-term academic outcomes. The relationship of teacher to student across ages and grade levels influences school adjustment, literacy, math skills, grade point average, and scholastic aptitude test scores.[109–111] Given the critical nature of the student-teacher relationship, it is important to explore how racism and implicit bias affect this dynamic. Student-teacher racial mismatch can impact academic performance, with studies showing that African American children are more likely to receive a worse assessment of their behavior when they have a non-Hispanic white teacher than when they have an African American teacher.[112] This finding may result from racial bias in teachers' expectations of their students, with data demonstrating that white and other non–African American teachers are more likely than African American teachers to predict that African American students would not finish high school.[113] Similarly, data indicate that teachers may underestimate the ability of African American and Latino students, which can lead to lower grade point averages and fewer years of schooling.[114] African American students who have 1 African American teacher in elementary school are more likely to graduate from high school and enroll in college than their peers who do not have an African American teacher; the proposed mechanism for this improved long-term educational outcome is the exposure to a role model early in the educational experience.[115] These findings indicate the importance of ensuring a diverse teacher workforce, particularly as the population of students in US schools continues to diversify.[116] School racial climate, which refers to norms, curricula, and interactions around race and diversity within the school setting, also impacts educational outcomes for students.[117] Students who had a positive perception of school racial climate had higher academic achievement and fewer disciplinary issues.[118] Racial inequities in school discipline begin early, and school discipline has long-term consequences for children. Although federal civil rights laws prohibit discrimination in the administration of discipline in public schools, the US Government Accountability Office found that African American and American Indian students are overrepresented among students experiencing suspension.[119] Data from the US Department of Education confirm that a disproportionate number of African American children receive more than 1 out-of-school suspension in preschool and overall in kindergarten through grade 12 are suspended 3 times more and expelled 1.9 times more than white students.[120] To mediate the effects of institutional and personally mediated racism in the educational setting and prevent internalized racism, studies show that a positive, strong racial or ethnic identity and parental engagement in families is protective against the negative effects of racial discrimination on academic outcomes.[121–123]

HOW PEDIATRICIANS CAN ADDRESS AND AMELIORATE THE EFFECTS OF RACISM ON CHILDREN AND ADOLESCENTS

Pediatricians and other child health professionals must be prepared to discuss and counsel families of all races on the effects of exposure to racism as victims, bystanders, and perpetrators.[124–126] Pediatricians can implement systems in their practices that ensure that all patients and families know that they are welcome, that they will be treated with mutual respect, and that high-quality care will be delivered regardless of background using the tenets of family- and patient-centered care.[127] To do this, it is critical for pediatricians to examine their own biases.[128] Pediatricians can advocate for community initiatives and collaborate with government and community-based organizations to help redress biases and inequities in the health, justice, and educational systems. These strategies may optimize developmental outcomes and reduce exposure to adverse events that dramatically alter the lived experiences, health, and perceived self-value of youth.[48,129,130]

Optimizing Clinical Practice

In practice, pediatricians and other child health care providers encounter children every day who have experienced racism. There are interventions available for use in the medical home that can identify and potentially ameliorate inequities.

- Create a culturally safe medical home[131] where the providers acknowledge and are sensitive to the racism that children and families experience by integrating patient- and family-centered communication strategies and evidence-based screening tools that incorporate valid measures of perceived and experienced racism into clinical practice.[132–136]
- Use strategies such as the Raising Resisters approach during anticipatory guidance to provide support for youth and families to (1) recognize racism in all forms, from subversive to blatant displays of racism; (2) differentiate racism from other forms of unfair treatment and/or routine developmental stressors; (3) safely oppose the negative messages and/or behaviors of others; and (4) counter or replace those messages and experiences with something positive.[137,138]
- Train clinical and office staff in culturally competent care according to national standards for culturally and linguistically appropriate services.[139,140]
- Assess patients for stressors (eg, bullying and/or cyberbullying on the basis of race)[141] and social determinants of health often associated with racism (eg, neighborhood safety, poverty, housing inequity, and academic access) to connect families to resources.[9,142,143]
- Assess patients who report experiencing racism for mental health conditions, including signs of posttraumatic stress, anxiety, grief, and depressive symptoms, using validated screening tools and a trauma-informed approach to make referrals to mental health services as needed.[144]
- Integrate positive youth development approaches,[145] including racial socialization,[123,146] to identify strengths and assess youth and families for protective factors,[9] such as a supportive extended family network, that can help mitigate exposure to racist behaviors.[138]
- Infuse cultural diversity into AAP-recommended early literacy–promotion programs[147] to ensure that there is a representation of authors, images, and stories that reflect the cultural diversity of children served in pediatric practice.
- Encourage pediatric practices and local chapters to embrace the challenge of testing best practices using Community Access to Child Health grants and participation in national quality-improvement projects to examine the effectiveness of office-based interventions designed to address the impact of racism on patient outcomes.
- Encourage practices and chapters to develop resources for families with civil rights concerns, including medicolegal partnerships and referrals to agencies responsible for enforcing civil rights laws.
- Encourage pediatric-serving organizations within local communities, including pediatric practices, hospitals, and health maintenance organizations, to conduct internal quality-assurance assessments that include analyses of quality of care and patient satisfaction by race and to initiate improvement protocols as needed to improve health outcomes and community trust.

Optimizing Workforce Development and Professional Education

- Advocate for pediatric training programs that are girded by competencies and subcompetencies related to effective patient and family communication across differences in pediatric populations.[148,149]
- Encourage policies to foster interactive learning communities that promote cultural humility (eg, self-awareness, lifelong commitment to self-evaluation, and commitment to managing power imbalances)[150,151] and provide simulation opportunities to ensure new pediatricians are competent to deliver culturally appropriate and patient- and family-centered care.[152–155]
- Integrate active learning strategies, such as simulation[156] and language immersion,[157] to adequately prepare pediatric residents to serve the most diverse pediatric population to date to exist in the United States[158] and lead diverse and interdisciplinary pediatric care teams.[159]
- Advocate for policies and programs that diversify the pediatric workforce and provide ongoing professional education for pediatricians in practice as a strategy to reduce implicit biases and improve safety and quality in the health care delivery system.[160–162]

Optimizing Systems Through Community Engagement, Advocacy, and Public Policy

- Acknowledge that health equity is unachievable unless racism is addressed through interdisciplinary partnerships with other organizations that have developed campaigns against racism.[163,164]
- Engage community leaders to create safe playgrounds and healthy food markets to reduce disparities in obesity and undernutrition in neighborhoods affected by poverty.
- Advocate for improvements in the quality of education in segregated urban, suburban, and rural communities designed to better optimize vocational attainment and educational milestones for all students.

- Support local educational systems by connecting with and supporting school staff. The AAP Council on School Health provides resources to help physicians engage and interact with their school system and provides guidelines around the role of school physicians and school health personnel.[165,166]
- Advocate for federal and local policies that support implicit-bias training in schools and robust training of educators in culturally competent classroom management to improve disparities in academic outcomes and disproportionate rates of suspension and expulsion among students of color, reflecting a systemic bias in the educational system.[167]
- Advocate for increased access to support for mental health services in schools designed to help teachers better manage students with disruptive classroom behaviors and to reduce racial disparities in school expulsion.[144,168,169]
- Advocate for curricula that are multicultural, multilingual, and reflective of the communities in which children in their practices attend school.[170]
- Advocate for policies and programs that diversify the teacher workforce to mitigate the effects of the current demographic mismatch of teachers and students that affects academic attitudes and attainment for all students.[115,171]
- Advocate for evidence-based programs that combat racism in the education setting at a population level.[172–174]
- Encourage community-level advocacy with members of those communities disproportionately affected by racism to develop policies that advance social justice.[19,175]
- Advocate for alternative strategies to incarceration for management of nonviolent youth behavior.[50,176,177]
- Collaborate with first responders and community police to enhance positive youth engagement by sharing expertise on child and adolescent development and mental health, considering potential differences in culture, sex, and background.[178]
- Advocate for fair housing practices, including access to housing loans and rentals that prohibit the persistence of historic "redlining."[179]

Optimizing Research

- Advocate for funding and dissemination of rigorous research that examine the following:
  1. the impact of perceived and observed experiences of discrimination on child and family health outcomes[180];
  2. the role of self-identification versus perceived race on child health access, status, and outcomes[52];
  3. the impact of workforce development activities on patient satisfaction, trust, care use, and pediatric health outcomes[161];
  4. the impact of policy changes and community-level interventions on reducing the health effects of racism and other forms of discrimination on youth development; and
  5. integration of the human genome as a way to identify critical biomarkers that can be used to improve human health rather than continue to classify people on the basis of their minor genetic differences and countries of origin.[55]

CONCLUSIONS

Achieving decisive public policies, optimized clinical service delivery, and community change with an activated, engaged, and diverse pediatric workforce is critically important to begin untangling the thread of racism sewn through the fabric of society and affecting the health of pediatric populations. Pediatricians must examine and acknowledge their own biases and embrace and advocate for innovative policies and cross-sector partnerships designed to improve medical, economic, environmental, housing, judicial, and educational equity for optimal child, adolescent, and emerging adult developmental outcomes.

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