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What Do Schools of Public Health Have to Say About Diversity and Inclusion?

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Abstract

Objective. The purpose of this study was to understand how schools of public health (SPHs) define and operationalize diversity and inclusion. *Methods*. Data were collected in February 2017 from publicly available websites for each of the 59 Council on Education in Public Health–accredited SPHs, including mission/vision, goals/strategic plans, and diversity statements. Mentions of diversity were quantified to generate the proportion of SPHs that explicitly address diversity or inclusion. As a related secondary point, mentions of equity were also considered. *Results*. One third of SPHs do not mention diversity, inclusion, or equity as central tenets of the school. Twenty percent do not mention strategic plans or goals related to diversity, inclusion, or equity. Only 12 of the 59 schools define what they mean by diversity. *Conclusions*. Recently released Council on Education in Public Health accreditation competencies point to a need for increased attention by SPHs to inclusion and equity. Currently, however, most SPHs do not have a clear definition of how they define diversity. *Implications*. Additional research is needed into how SPHs will evolve their conceptualizations of diversity, inclusion, and equity to meet the training needs of the next generation of public health professionals.

Keywords

diversity and inclusion, workforce development, academic public health

Introduction

There is surprisingly little empirical attention devoted to diversity as part of training for public health students. The United States has long had a difficult relationship with the exclusionary practices that undergird its education system. Diversity initiatives, such as affirmative action policies that allow members of disadvantaged or minority groups to be given preferential admission to academic programs, are intended to counteract enduring structural barriers to education (Berrey, 2011). While diversity and inclusion issues are not exclusive to historically marginalized racial/ethnic groups, *diversity* as a term is often used as coded language in an academic setting referring to the presence or absence of people of color (Ahmed, 2012). Moreover, previous research has shown that campus climates that are inhospitable to people of color are strongly associated with feelings of exclusion for other marginalized groups (Garvey, Taylor, & Rankin, 2015). The present research question was conceptualized through the lens of historical racism while seeking to understand more broadly how schools of public health (SPHs) define diversity and inclusion.

As U.S. Justice Harry Backmun declared in the landmark 1978 Supreme Court ruling that led to affirmative action policies at many health schools, "In order to get beyond racism, we must first take account of race. We cannot, we dare not, let the equal protection clause perpetuate racial supremacy" (Cohen, Gabriel, & Terrell, 2002, p. 98). However, cultural competence and diversity efforts grounded in the notion of exposure to difference as sufficient to decrease prejudices have done little to address structural racism (i.e., broader systemic instances of disproportionally advantaging White students while simultaneously disadvantaging students of color) (Malat, 2013). Rather, even with diversity and inclusion initiatives in place at most colleges and universities, people of color continue to be underrepresented in academic health settings, both as instructors and as learners (Cohen et al., 2002). In the context of training health professionals, this underrepresentation can have rippling effects on the quality and equality of health services being provided (Institute of Medicine [IOM], 2003). As such, the IOM recently convened a panel of experts to propose a framework to improve how health professionals are trained to address structural

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racism and other forms of discrimination that contribute to persistent health disparities (IOM, 2016). Chief among these recommendations is the call to "increase the inclusivity and diversity of health professional student body and faculty" (IOM, 2016). These recommendations, however, do not define what constitutes a diverse or inclusive environment. Similarly, the framework proposed by the IOM sees improvements in the training of health professionals as a mechanism for improving health equity but does not articulate the parameters within which they measure equity.

Partly in response to U.S. federal recommendations for improved health professional education, the Council on Education in Public Health (CEPH), the U.S. accrediting body for schools and programs of public health, recently released new foundational competencies for public health professional trainees (CEPH, 2016). These new competencies include a more explicit focus on how structural racism, bias, and discrimination affect public health practice. This emphasis has many points of overlap with diversity and inclusion efforts already in place at most colleges and universities in the United States, including those in which schools and programs of public health are housed. However, as with most other areas of education (e.g., engineering, natural science, liberal arts), what we mean by *diversity* or *inclusion* in public health training remains unclear. Without explicit, standardized definitions of diversity and inclusion, it becomes difficult to assess the extent to which public health is achieving its stated training goals. Moreover, the term *equity* is sporadically used in conjunction with diversity and inclusion. The contribution of this term to how SPHs in the United States define diversity and inclusion also remains unclear.

Purpose

This article aims to understand how these terms are defined across different SPHs. This analysis does not begin with an a priori definition of these terms (*diversity, inclusion*, and *equity*), but instead, it seeks to look at how SPHs operationalize these terms in order to construct a normative definition of how schools broadly define diversity and inclusion (and to a slightly lesser extent, equity) across the schools. Moreover, a clearer understanding of what SPHs mean by diversity and inclusion are fundamental to establishing and assessing programmatic diversity and inclusion goals. This article provides a summary of publicly available statements (e.g., official college or university website content, public rendition of the school's strategic plans, diversity statements, etc.) provided by SPHs to identify trends across schools for how SPHs frame public health training as it relates to diversity and inclusion. Potential implications for public health practice and areas for future research are provided.

Method

College and university websites convey to multiple audiences their academic offerings, including how units within the school address noncurricular academic issues like diversity or equity (Dowd, Bishop, & Bensimon, 2015). Content analysis of school websites have proven useful in examining resources available at a school (Saichaie & Morphew, 2014) and underlying messages conveyed by the information schools choose to post on their official, public websites (Hayes-Smith & Hayes-Smith, 2009). This content analysis of the official websites of SPHs in the United States focuses on the 59 SPHs that had CEPH accreditation at the end of 2016. This sample was selected because schools have appreciably different capacity to create programming around diversity and inclusion specific to the training and practice of public health professionals (e.g., more staff, larger operating budgets, and more autonomy) than programs of public health situated within a larger college or university unit. The present analysis is somewhat unique in that it does not begin with a priori definitions of the terms under study (*diversity, inclusion*, and *equity*) as the central focus of the analysis is to understand how SPHs define these terms.

Data were collected in February 2017 from publicly available websites for each of the 59 CEPH-accredited SPHs. The present analysis was conducted at the school level, rather than at the university or department level, as the goal of the study was to understand how SPHs understand and operationalize these terms. The following documents were used for this analysis:

a. Mission, vision, and ideals statements
b. Objectives, goals, and strategic plans
c. Diversity statements and plans
d. Other publicly available information about diversity or inclusion within SPH webpages (e.g., webpages specific to diversity offices, summaries of inclusion initiatives, and reports on diversity self-studies)

Webpages were visited in the order listed above and described below. Mentions of diversity were counted to gain a sense of the proportion of SPHs in this study that explicitly address *diversity* or *inclusion*. As a related secondary point, mentions of equity were also considered (including references to inequity and inequality). Questions used to identify pages and documents for inclusion were "How does the SPH define diversity?" "What does the school indicate is the point of diversity?" "Who counts as diverse?" I began looking through SPH websites with the broadest webpages and documents that could be opened for inspection (i.e., mission and vision statements), then looking more narrowly through each school's objectives, goals, and strategic plans.

Review of strategic plans were confined to the most recent plan(s) created by the SPH. I then looked through each SPH website for content related to diversity offices, diversity plans, inclusion initiatives, and so on to collect additional data. I then started over at each SPH's landing page and searched the terms of interest (*diversity, inclusion, equity*) to search for pages that may have been missed in previous searches. Searches on each SPH website were conducted within a single 24-hour period to minimize the possibility of time effects on sampling. Using the three initial guiding questions as a basis, I conducted an initial round of coding. Following the first round of deductive coding, I performed another round of coding, this time using inductive codes I identified during the first round of coding. This included, but was not limited to, *research being conducted at the SPH on diversity and inclusion, explicit mentions of social justice or health disparities, and perceived institutional benefits of diversity*. After several weeks passed, I used the deductive and inductive codes to code the entire data set a second time, serving as my own second coder. I established before the second round of coding that codes that did not have at least 80% reliability between both rounds of coding would not be included in the analysis. Once the two rounds of coding were completed, both were combined into a single merged file for comparison. Sections of data that were coded the same for both independent rounds were considered to be in agreement. A single code was near the threshold for reliability (i.e., 82% agreement between rounds). Given that all other codes had 86% to 97% agreement, I chose a conservative approach and excluded the single code. Additionally, I created memos throughout the coding process as part of my analysis to systematically document emergent patterns I was observing. Finally, once all rounds of coding were conducted, I created a quantitative matrix of codes at each SPH in my sampling frame to generate percentages presented here. Atlas.ti 7 was used for all analyses.

Specific SPHs are not named in the presentation of findings, as the purpose of this review is not to measure SPHs against one another but rather to demonstrate the normative mechanisms of naming, operationalizing, and evaluating issues of diversity and inclusion in an aggregate form within the schools in this study. See Table 1 for a list of all SPHs that made explicit, public statements about how they address diversity, inclusion, and/or equity.

Results

Of the 59 CEPH-accredited SPHs at the time of this analysis, one third made no mention of diversity, inclusion, and/or equity in their public mission, vision, or values statements. Another third of SPHs explicitly mentioned diversity alone. Eleven percent mentioned equity alone, and the remaining 23% mentioned two or more of the terms under study. Many websites do not mention, and therefore do not operationalize, these terms. See Figure 1 for a summary of SPHs that mention diversity as a central tenet of the school.

Twenty percent of the SPHs analyzed made no mention of diversity, inclusion, or equity in their goals, objectives, or strategic plans. The majority (60%) mentioned only diversity as a goal, objective, or strategic plan. Five percent each specified diversity and inclusion or diversity and equity. Ten percent of the schools mentioned goals specific to all three. See Figure 2 for a summary of SPHs that mention diversity-related issues in goals or objectives at the school.

While the majority (31 of 59) of SPHs indicated that diversity (and to a lesser extent, inclusion) was a central tenet of the school, only 12 defined what they meant by *diversity*. Fewer still discussed the goals of diversity and inclusion efforts. Rather, all but one SPH defined diversity by providing a list of who was considered to be diverse vis-a-vis their identity(ies) (e.g., people of color, sexual minorities, etc.) as a proxy for a formal definition. Generally, diverse identities were defined as non-White racial/ethnic/color/nationality categories, gender or gender identities, sexual orientation, age, veteran status, disability, income/class/socioeconomic status, religion/creed, political perspective or associational preference, and family or parental status. Only one school explained why certain identities were named as constituting diversity, specifically stating that these identities were selected because of the systemic exclusion of historically marginalized groups. All other SPHs referred to underrepresented groups as being targeted for inclusion without providing an explanation for their underrepresentation. Table 2 summarizes the findings discussed above.

All the 21 SPHs that specified diversity and inclusion goals indicated that the measure of success was the recruitment of faculty, staff, and students from historically underrepresented demographic groups. Those SPHs that indicated a measure of the magnitude of success sought to either reflect local demographic compositions or increase representation from baseline by a specified percentage. Across SPHs, metrics focused more on matriculation of students than on retention of students, faculty, or staff. Secondary to the demographic composition of SPHs, one quarter of schools indicated that a goal of diversity and inclusion efforts was to create a civil or respectful environment. No school under study indicated how environment was measured or specified a threshold for success. Though no school stated so explicitly, six SPHs included brief discussions about community engagement in relation to diversity and inclusion goals, suggesting an implicit belief across schools that increasing diversity serves to improve community–university partnerships or advances a school's mission to serve local communities.

Table 1. Schools of Public Health That Made Explicit, Public Statements About How They Address Diversity, Inclusion, or Equity.

Council on Education in Public Health–accredited schools of public health included in the analysis	• Boston University • Brown University • Colorado School of Public Health • Columbia University • CUNY School of Public Health • Drexel University • East Tennessee State University • Emory University • Florida International University • George Washington University • Georgia Southern University • Georgia State University • Harvard University • Indiana University at Bloomington • Indiana University-Purdue University Indianapolis • Instituto Nacional de Salud Publica • Johns Hopkins University • Loma Linda University • Louisiana State University Health Sciences Center • Ohio State University • Oregon State University • San Diego State University • SUNY-Downstate Medical Center • Texas A&M Health Science Center • Tulane University • Rutgers, The State University of New Jersey • University at Albany-SUNY • University at Buffalo-SUNY • University of Alberta • University of Arizona • University of Arkansas for Medical Sciences • University of California, Berkeley • University of California, Los Angeles • University of Florida • University of Georgia • University of Illinois at Chicago • University of Iowa • University of Kentucky • University of Louisville • University of Maryland • University of Massachusetts Amherst • University of Memphis • University of Michigan • University of Minnesota • University of Nebraska Medical Center • University of North Carolina, Chapel Hill • University of North Texas Health Science Center • University of Oklahoma • University of Pittsburgh • University of Puerto Rico • University of South Carolina • University of South Florida • University of Texas Health Science Center at Houston • University of Washington • West Virginia University • Yale University
Council on Education in Public Health–accredited schools that did not have explicit, public statements about diversity, inclusion, and/or equity	• Kent State University • Saint Louis University • University of Alabama at Birmingham

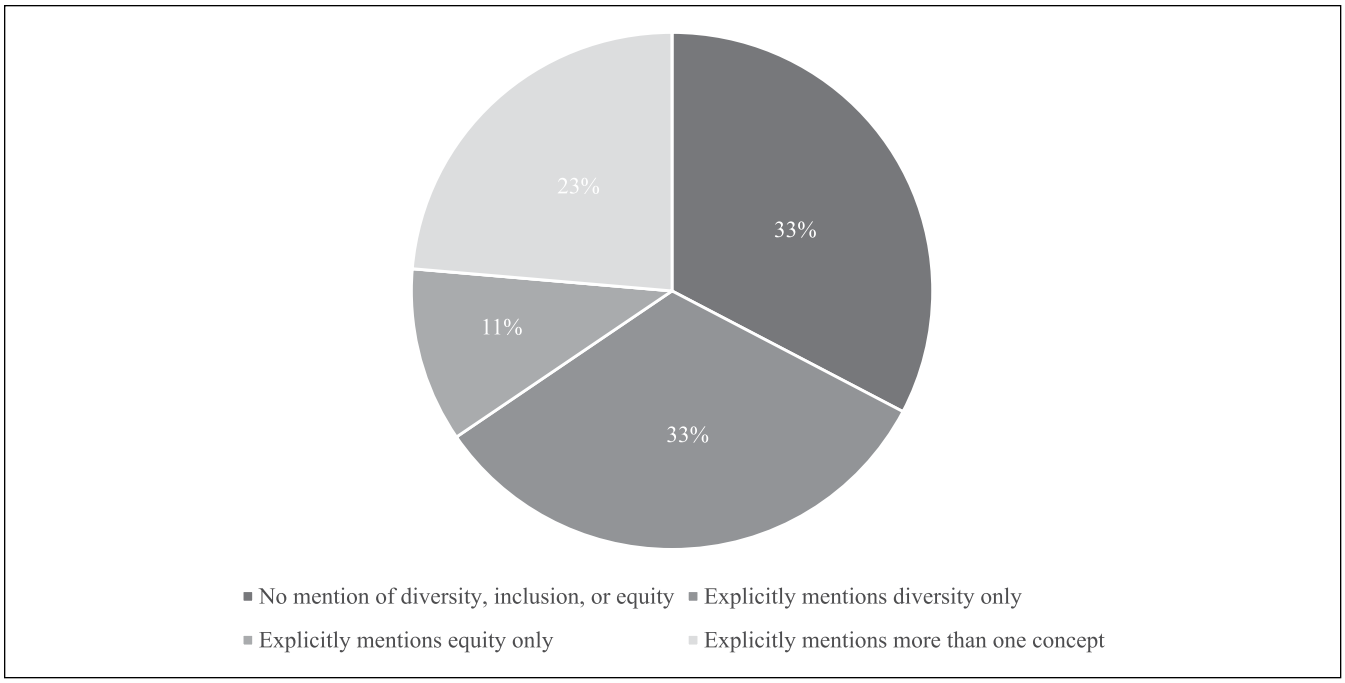

Figure 1. Schools of public health that mentioned diversity, inclusion, or equity in their mission, vision, or values.

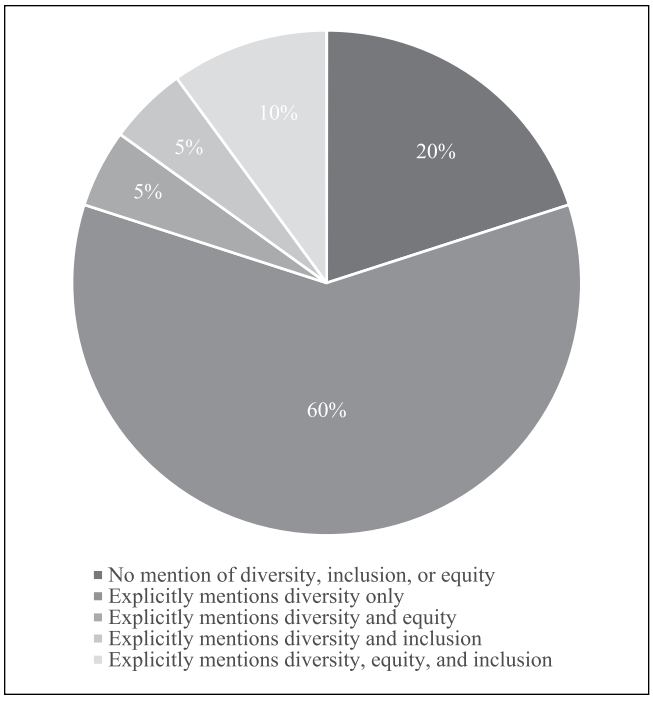

Figure 2. Schools of public health that specify diversity, equity, or inclusion in their goals, objectives, or strategic plans.

In addition to explicit mentions of diversity and inclusion within the school, several SPHs mentioned social justice, equity, and health disparities when discussing diversity and inclusion. Five schools indicated that their mission, vision, or values included a commitment to social justice. Four schools specified social justice as a component of strategic plans or goals. Of note, while there was some overlap, these four SPHs were not a subset of the five that mentioned social justice in their formal mission, vision, or values statements for the school. Of all the schools studied, two SPHs explicitly mentioned the conduct of health equity and health disparities research as a goal of diversity and inclusion efforts, with one school specifying that they were referring to faculty research. The benefits of diversity were explicitly stated by eight SPHs. Broadly, these schools stated the benefits included attracting further diversity, improving the learning environment, and better preparing trainees for public health practice.

Discussion

The majority of SPHs make public statements about the importance of diversity (and to a lesser extent, inclusion) in public health training. However, most do not provide a clear definition of what they mean by *diversity* or *inclusion* on their official websites. Additionally, almost no SPHs state why diversity and inclusion efforts are needed. Moreover, even fewer schools discuss the end goal of diversity and inclusion efforts. What is listed in the majority of diversity statements, rather, is a list of who SPHs are considering as diverse. Very few SPHs links stated commitments to diversity, equity, or social justice with measurable goals or objectives for the school.

Table 2. Summary of Findings by Inductive and Deductive Codes.

Question	Summary of Findings
Deductive codes	
How do SPHs define diversity?	31 schools included a list of identities that constituted diversity (with one providing an explanation as to why these identities were selected). These included • non-White racial/ethnic/color/nationality categories, • gender or gender identities, • sexual orientation, • age, • veteran status, • disability, • income/class/socioeconomic status, • religion/creed, • political perspective or associational preference, and • family or parental status.
What do schools feel is the point of diversity?	21 schools indicated that increasing representation of students, faculty, and staff is the primary goal of diversity and inclusion efforts. 6 schools mentioned working with communities when discussing diversity.
Who is counted as diverse?	Historically underrepresented groups are considered those who count as diverse (all but one SPH implied this rather than stating it explicitly).
Inductive codes	
Does the institution mention research being conducted on diversity?	2 SPHs mentioned the conduct of health equity or health disparities research as a goal of diversity and inclusion efforts.
Does the institution explicitly mention social justice or health disparities?	5 SPHs included social justice as a component of the mission, vision, or values.
What does the institution indicate as the benefits of diversity?	8 SPHs explicitly stated the benefit of diversity, generally stating that it would attract further diversity, improve the learning environment, and better prepare trainees for public health practice.

Note. SPHs = schools of public health.

Diversity and inclusion statements at SPHs typically consist of lists that delineate difference that qualifies as diverse and, therefore, merits inclusion. Both visible minorities (e.g., people of color, individuals with visible disabilities, etc.) and less easily identified minorities (e.g., religious minorities, sexual minorities, etc.) are included in most formal diversity and inclusion statements made by schools. As Ahmed (2012) states, a laundry list of who qualifies as diverse is one mechanism by which inviting inclusion maintains White supremacy in academic training. She states,

> When diversity becomes a form of hospitality, to be made to feel welcome by an explicit act of address works to reveal what is implicit: that those who are already given a place are the ones who are welcoming rather than welcomed, the ones who are in the structural position of hosts. Whiteness is produced as host, as that which is already in place at home. . . . People of color are welcomed on the condition that they return that hospitality by integrating into a common organizational culture, or by "being" diverse, and allowing institutions to celebrate their diversity. (Ahmed, 2012, p. 43)

If diverse others are commodified in such a way that their presence in public health training programs is valued for its marketing or aesthetic potential, rather than leveraging the ability of members of differing positions and viewpoints to enrich health professions (Martin, Heron, Moreno-Walton, & Jones, 2015; Parker et al., 2016), then the result may be a tokenization of diverse public health professionals and perpetuation of inequitable health practices (Bearman & Ajjawi, 2013; Meehan & Glover, 2007). There is only occasional mention of noncorporeal forms of diversity (e.g., political ideology, religious beliefs, personal values). I found no evidence of noncorporeal or intellectual diversity being measured as a metric for inclusion. Moreover, no mention of neurodiversity or other forms of diversity related to cognition were made, which stands out as a gap in normative conceptualizations of diversity as they relate to learning environments. The extent to which definitions of diversity and inclusion (or lack thereof) affect how public health trainees approach work with underserved and marginalized populations requires further study. Moreover, the extent to which these assertions play out specifically in SPHs have not been tested empirically to date.

Empirical studies of curricular interventions to combat institutional racism in health professional education have largely been limited to individual-level interventions to reduce bias (Boscardin, 2015), but formative education

and organizational studies have suggested that it is necessary to also intervene on faculty and administrators who develop and deliver curricula as well (Theodorakopoulos & Budhwar, 2015). The introduction of revised accreditation competencies has created a unique opportunity for public health academicians to introduce more radical changes to their curriculum that might otherwise be discouraged by colleagues (Barbosa & Cabral-Cardoso, 2007). This could include moving more public health professional training to community-based settings rather than classroom-based learning, centering the knowledge of marginalized communities over those of academic experts, and more critically examining paternalism as a foundation of public health practice. Among the many changes to curricular competencies introduced by CEPH in 2016, there is a more explicit focus on how structural racism, bias, and discrimination affect public health practice. This evolution of public health training requirements has many points of overlap with diversity and inclusion efforts already in place at most colleges and universities in the United States, including those in which schools and programs of public health are housed. Moreover, it mirrors recommendations made by federal agencies to more directly address how health professional training contributes to social and structural determinants of health (IOM, 2016). To maximize the impact of substantive changes to the training of health professionals of all kinds, improvements must be made across the educational system, with particular attention being paid to areas like community and public health (Cuff, 2014). Additional research is needed to explore how curricular interventions in health professional training may affect the inclusivity and equity of health professionals.

Limitations

This study is not without its limitations. Given that the sole author conducted both rounds of coding, it is possible that there are systematic errors present as the sole coder that would be remedied by replicating this analysis with multiple researchers. Additionally, it may be worthwhile to explore further how increased resources devoted to diversity and inclusion in SPHs (e.g., diversity offices, high-level administrators devoted to diversity and inclusion full-time, etc.) may shape how schools think about and seek to address diversity issues within their schools. Moreover, as each school had different ways of presenting web content, including varied documents (i.e., there is no standardized way to approach diversity and inclusion in SPHs), comparing documents intended for different purposes or varied audiences may have led to unbalanced comparisons. For example, a SPH interested in increasing recruitment of diverse students, faculty, or staff may highlight even small diversity initiatives, whereas a school that has a long-standing history of enrolling a representative student body may not highlight its well-developed inclusion efforts. Finally, this is a descriptive study and does not make any normative judgments as to how well the schools commit to diversity, inclusion, and/or equity. As mentioned above, a school could explicate diversity-related terms at a high level and do little in practice, and, conversely, a school could not have much evidence of a commitment to inclusion in its web content and in practice make strong efforts to ensure inclusive excellence. Limitations notwithstanding, this study presents a starting point for future research on how the field of public health continues to adapt training practices in order to meet the needs of communities throughout the nation and tackle inequitable practices that plague myriad health professions, including, but not limited to, public health.

Conclusion

This analysis is the first step in an in-depth discourse analysis to explore how SPHs define and operationalize issues of diversity and inclusion as part of public health training. Understanding how SPHs talk about diversity and inclusion can help administrators refine how they operationalize these concepts, help instructors more clearly teach the importance of diversity and inclusion in public health practice, and help emerging professionals integrate issues of diversity and inclusion into public health research and practice. By improving diversity and inclusion efforts through public health professional education, we can begin to train a public health workforce that thinks more critically about difference in social systems and works more explicitly toward improving health equity for diverse populations.

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