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Executive Summary

At the Robert Wood Johnson Foundation, we believe New Jersey—our home state—should be a place where everyone can live the healthiest life possible, regardless of who they are, where they come from, or how much money they have. The state’s demographic, social, and economic characteristics, paired with significant investments in health-promoting efforts from various sectors, should position New Jersey to attain this vision of a more equitable and just place.

However, health and wellbeing have never been fairly distributed in the state. Health inequity—the uneven distribution of social and economic resources that affect an individual’s health—persists in New Jersey despite renewed attention to and investment in addressing disparities. That is because investment alone cannot achieve equity; a growing body of research places structural racism—the unjust and unfair policies, practices, and norms underlying every aspect of our society—at the core of persistent inequity.

Structural racism is not long-ago history. It remains embedded in our society, manifesting in the reality of present-day racial inequity and disparities for the state’s people of color. To achieve health equity—where everyone is assured of the conditions that provide the opportunity to be their healthiest self—we must also strive for racial equity by treating the root cause of disparities.

About This Report

This document highlights three sections explored in our 2019 publication, Building a Culture of Health: A Policy Roadmap to Help All New Jerseyans Live Their Healthiest Lives. Here, we focus strategically on housing, the health of women and pregnant people, and public health infrastructure. We also added one area of focus, equity-informed decisions and power-building. These areas are ripe for action in the state, align with RWJF-wide priorities, receive significant state investments, and have great potential to advance equity for the people of New Jersey. This document provides context and data to support informed decisions to address structural racism in policies, practices, and systems and to empower communities and individuals so that each person in New Jersey can thrive.

We identified a broad list of specific policy recommendations in each area that could address immediate needs or change policies, practices, and norms that drive inequity. The primary criterion for inclusion was how a recommendation could advance racial equity and, as a result, advance health equity and racial justice. The aim is for New Jersey to be a place where a person’s race or ethnicity no longer predicts their ability to live a healthy life. In each case, we considered historical and systemic racism and bias that situate populations differently and perpetuate racial inequity. We also examined the most complete and current data and available evidence base for each recommendation. We engaged various experts in the state via feedback sessions, interviews, and a survey.

Actions to Support Equity-Informed Decisions and Power-Building

The ongoing COVID-19 pandemic exacerbated the number and scope of disparities in New Jersey. There has been significant investment from federal and state levels targeting specific disparities and urgent needs. However, this alone will not create the transformative change needed to achieve equitable outcomes. Research shows that achieving equitable outcomes requires more than robust investment. It requires an equity lens in all matters, building and sharing power with communities, targeted implementation strategies, and effective enforcement and accountability mechanisms.
Recommended Policy Options:

- Establish a state task force to assess how New Jersey’s Black residents have been harmed throughout state history and propose actionable steps to the state Legislature, agency officials, and other officials as appropriate.
- Create and fund an interagency equity working group to provide leadership on cross-sector collaboration.
- Assess the impact of significant new legislation and regulations on racial equity within New Jersey.
- Acknowledge the presence and effects of structural racism and identify opportunities to repair harm and plan action.

Ensure New Jerseyans Have Equitable Access to Affordable Housing in Communities Where They Choose to Live

Our homes and neighborhoods play significant roles in shaping our health and wellbeing. The challenges of the housing landscape in New Jersey are many and complex. They remain influenced by a history of overt exclusion of Black and Hispanic residents via redlining and restrictive covenants. Rising home prices and rental costs have compounded challenges to stable housing in the U.S. and New Jersey. The situation is especially acute for the state’s Black and Latino residents, who face continued inequity and discrimination. Investments in developing and maintaining affordable, safe, and stable housing and neighborhoods can be a catalyst for healthier, more equitable communities.

Recommended Policy Options:

- Invest in producing more affordable and safe homes across all communities.
- Promote racially-equitable land use and zoning policy to provide opportunities for more people to live in neighborhoods that support good health and wellbeing.
- Strategically implement and leverage innovative strategies to facilitate racially-equitable homeownership.
- Establish and fund a right-to-counsel for low-income renters.

Birth and Reproductive Justice: Improve Maternal and Infant Health Outcomes by Enhancing Care, Supports, and Prevention

New Jersey has among the most significant racial disparities in the nation for birth and infant outcomes. These disturbing trends and inequities result from many complex factors, including discrimination, sexism, and racism. State officials have made significant investments to make New Jersey the safest place to give birth, but more must be done to set the stage for transformative change. Implementation efforts must keep equity as a core tenet, and strategies must be targeted to account for how Black women and pregnant people are situated within the state.

Recommended Policy Options:

- Continue to support and invest in a diverse workforce aware of bias and provide appropriate care across the maternal and infant care and education continuum.
- Implement new Medicaid policy in a way that supports racial equity.
- Enhance access to comprehensive reproductive health, including abortion care.
- Enhance enforcement of the existing paid leave benefit and increase uptake.
Public Health Infrastructure: Centering Equity in a Modern Public Health System

Public health agencies are increasingly on the front lines of addressing existing and emerging health threats. Compounding these stressors, New Jersey entered the pandemic with a drastically underfunded public health structure, ranking 31st in the nation in state funding per capita for public health. There is a unique opportunity amid additional, albeit temporary, federal COVID-19 funding to bolster public health systems. With deliberate coordination, investment, and the persistent pursuit of equity in all actions, we can work to transform New Jersey’s public health system into a robust and modern one that can help all people thrive.

Recommended Policy Options:

- Provide adequate and flexible funding and maximize existing assets to support public health services and capabilities.
- Establish a state Public Health Institute to facilitate collaboration within and across sectors to improve health equity.
- Increase state investments to transform public health data systems to center equity and include practical, flexible data-sharing processes.

Conclusion

Nearly 250 years of intentional policy, practices, and norms systematically excluded people of color from opportunities to thrive in this country and the state of New Jersey. This history and the persistence of structural racism in the status quo result in our residents experiencing some of the worst racial inequities in the nation.

However, we are optimistic that relentlessly intentional policy and practices and shifting norms can lead us to a more inclusive system that centers on racial equity in both processes and expected outcomes.

This process of reimagining and shifting structures will not be easy, quick, or easily measured. RWJF is committed to broadly sharing these recommended policy options and bringing together a wide range of interested and affected parties, including policymakers, philanthropy, community leaders of color, academics, and advocates. Deliberate collaboration to share knowledge and power, to honor lived experience, and explore evidence-based solutions alongside bold but nascent ideas can help bring us closer to achieving racial equity.

Acknowledgement

The Robert Wood Johnson Foundation wishes to thank Samantha Vargas Poppe, principal at Equity Matters, LLC, for her work researching and writing this report in collaboration with Foundation staff.
Introduction
At the Robert Wood Johnson Foundation, we believe New Jersey—our home state—should be a place where everyone can live the healthiest life possible, regardless of who they are, where they come from, or how much money they have.

The state’s demographic, social, and economic characteristics, paired with significant investments in health-promoting efforts from various sectors should position New Jersey to attain this vision of a more equitable and just place where:

■ all people, regardless of race or ethnicity, geographic location, income, ability, sexual orientation, or gender identity, are situated in a way that supports good health;
■ all babies are equally likely to see their first birthday;
■ all mothers and pregnant people can give birth and care for their infants safely;
■ all residents are well-positioned to weather a health or economic crisis.

But persistent inequity—the uneven distribution of social and economic resources that worsens the health of individuals and communities—stands in the way of realizing this vision.

Wellbeing and health have never been evenly distributed in New Jersey. The COVID-19 pandemic exacerbated inequity, but the pre-pandemic status quo never led to a stable, healthy situation for many, especially people of color in the state.

Health inequity results from several determinants, including poverty, income, housing, and discrimination.1 Racism is at the core of these inequities, as evidenced in a growing body of research over the past 20 years.2 In 2021, the Centers for Disease Control and Prevention declared racism a public health issue, affecting the health and wellbeing of millions of people directly.3

Racism is more pervasive than many people think. It is embedded in unjust and unfair policies, practices, and norms—the structures or systems underlying every aspect of our society.4 The structural racism inherent in these systems, at first overtly and legally sanctioned and, later, de facto, led to accumulated disadvantages that became barriers to good health for residents of color,5 while at the same time offering accumulated advantages and boosts to good health for White residents.

In New Jersey, structural racism has been present since the state’s earliest days in such forms as the enslavement of Black people, targeted disenfranchisement of Black people after emancipation, and exclusionary housing policies and practices. But structural racism in New Jersey is not long-ago history. It continues today, manifested in the reality of present-day racial inequity and disparities for people of color.6,7

So, to achieve health equity—where everyone is assured the conditions that provide the opportunity to be their healthiest self—focusing on disparities is not enough. New Jersey must strive for racial equity by treating root causes and recognizing that health equity cannot be achieved without racial equity.8

Imagining a racially equitable system and how to implement it is challenging. Attaining that system might seem out of reach because truly equitable structures have never existed in New Jersey or the nation. Even after the most egregious forms of structural racism were abolished, the long-term harm from lost opportunity and the underlying policies, practices, norms, and power structures continues.

Addressing these factors requires raising awareness and then transforming underlying structures in a reparative way that addresses systemic harms and sets the foundation for good health for all.
No single organization or group can build this system. Everyone has a role to play. This document provides context and data to enable state and local leaders and the public they serve to make informed decisions that address structural racism in policies, practices, and systems and empower communities and individuals to thrive.

**Objective/Scope/Methodology**

**Objective:** Using *Building a Culture of Health: A Policy Roadmap to Help All New Jerseyans Live Their Healthiest Lives* as a guide, we aim to bring attention to what a state of racial health equity would look like, what stands in the way, and what actions can help achieve the goal of health and wellbeing for all New Jersey residents. This document provides context and data to enable the public, community-based organizations, philanthropy, the private sector, state and local policymakers, and other decisionmakers to arrive at informed decisions that can address structural racism in policies and practices and empower communities so that each person in New Jersey can thrive.

**Scope:** This document builds on the 2019 RWJF publication *Building a Culture of Health: A Policy Roadmap to Help All New Jerseyans Live Their Healthiest Lives*. That document listed 13 priority areas for state action. This report strategically focuses on three of those areas: housing, the health of women and pregnant people, and public health infrastructure.

These areas are ripe for action in the state and align with RWJF-wide priorities. It should be noted that New Jersey has made significant investments in these areas and still falls short of achieving equity. As such, we explored additional areas, including equity-informed decisionmaking and building community power, which have the potential to address the structural racism that persists in policies, practices, and norms. Targeted action to attend to these areas has great potential to advance equity for the people most affected in New Jersey. In many cases, recommendations aim to enhance existing policies or improve their implementation. In other cases, developing policies that show potential in advancing equity in other locations are included for consideration.

**Methodology:** We examined the 2019 report’s recommendations and actions taken at the state and local levels since then, identifying where disparities remain and considering what factors drove those outcomes. Based on this additional research on policies and the evidence that supports them, we identified a broad list of recommendations that could help address immediate needs, plus policies, practices, and norms that drive inequity.

Our primary criterion for inclusion was how a recommendation could advance racial equity—where people’s race or ethnicity no longer predicts their ability to live a healthy life. In each case, we considered historical and systemic racism that perpetuates inequity. We also examined the most complete and current data and available evidence for each recommendation.

For each recommendation, we also considered who is best situated to act—community-based organizations, philanthropy, the private sector, state and local government, elected officials, and more. And we engaged experts, including leaders of community-based service providers, state associations, advocacy organizations, academia, and health systems in New Jersey, through feedback sessions, interviews, and a survey. The individuals we engaged represent organizations that have a relationship with RWJF, are members of the Jegna Council, or are grantees. The Jegna Council is a 15-member advisory group dedicated to providing guidance to the RWJF grantmaking team as it strives to more effectively center equity in its work and advance health equity in the State of New Jersey. Additionally, the Jegna Council helps to advance the Foundation’s efforts...
to benefit those most threatened by health disparities. Everyone brought expertise in one or more of our focus areas of housing, birth and reproductive justice, and public health infrastructure.

The resulting recommendations make up a broad, balanced portfolio of short- and longer-term policy solutions and promising approaches to promote better health and wellbeing across the state.

**Background**

**New Jersey Demographics**

New Jersey is increasingly diverse (see Figure 1). In 2021, 54.6% of residents identified as non-Hispanic White, 20.9% Latino, 15.1% Black, 10% Asian, and 0.6% American Indian/Native Alaskan.\(^9\) Latino and Asian residents drove much of the state’s population growth since the 2010 Census.

**Figure 1: Percentage of Population by Race/Ethnicity, 2010 through 2020**

<table>
<thead>
<tr>
<th>Year</th>
<th>White Alone</th>
<th>Hispanic</th>
<th>Black</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>59.30%</td>
<td>17.70%</td>
<td>12.80%</td>
<td>8.20%</td>
</tr>
<tr>
<td>2011</td>
<td>58.80%</td>
<td>18.20%</td>
<td>12.90%</td>
<td>8.60%</td>
</tr>
<tr>
<td>2012</td>
<td>58.30%</td>
<td>18.50%</td>
<td>12.90%</td>
<td>8.70%</td>
</tr>
<tr>
<td>2013</td>
<td>57.80%</td>
<td>18.80%</td>
<td>12.90%</td>
<td>8.90%</td>
</tr>
<tr>
<td>2014</td>
<td>57.30%</td>
<td>19.20%</td>
<td>12.90%</td>
<td>9.00%</td>
</tr>
<tr>
<td>2015</td>
<td>56.70%</td>
<td>19.50%</td>
<td>12.90%</td>
<td>9.20%</td>
</tr>
<tr>
<td>2016</td>
<td>56.20%</td>
<td>19.90%</td>
<td>12.90%</td>
<td>9.40%</td>
</tr>
<tr>
<td>2017</td>
<td>55.60%</td>
<td>20.20%</td>
<td>12.90%</td>
<td>9.60%</td>
</tr>
<tr>
<td>2018</td>
<td>55.10%</td>
<td>20.60%</td>
<td>12.90%</td>
<td>9.70%</td>
</tr>
<tr>
<td>2019</td>
<td>54.60%</td>
<td>20.90%</td>
<td>12.90%</td>
<td>9.80%</td>
</tr>
<tr>
<td>2020</td>
<td>51.90%</td>
<td>21.60%</td>
<td>12.40%</td>
<td>10.20%</td>
</tr>
</tbody>
</table>

Source: United States Census Bureau Data 2020 and 2010

**Defining Race and Racism**

*Race* is a social construct distinct from ethnicity, genetic ancestry, or biology. Yet, race has been and still is used as a proxy for biology or genetics in medical education, research, and clinical practice. ([American Medical Association](https://www.ama-assn.org))

*Racism* is the belief that *race* is a fundamental *determinant* of human traits and capacities and that racial differences produce an inherent superiority of a particular race. As such, racism influences where and how people live and the resources and opportunities they have, directly affecting health. ([Merriam-Webster](https://www.merriam-webster.com) and [APHA](https://www.apha.org)).

The broadest and most ingrained understanding of racism in the U.S. tends to focus on “the personal prejudice and intentional bias in our individual interactions across different races.” But, as the definition and understanding of racism evolves, a growing number of scholars and advocates believe that interpersonal
New Jersey also had a significant increase over a decade in residents identifying as “some other race” (155% increase) or “more than one race” (115% increase). This apparent shift in identity for many residents, similar to nationwide trends, suggests that current Census categories for race and ethnicity may lead to limited data that masks the true extent of indicators, including disparities across and within certain population groups.

Overall, immigrants are increasing as a share of New Jersey’s population. In 2019, nearly one in four New Jerseyans was born in another country, a 50 percent increase since 1990. Over half of the foreign-born population in New Jersey are naturalized citizens. The most significant share of foreign-born individuals in New Jersey is from Asian and Latin American countries. Many major federal programs exclude most immigrants, among all immigration statuses, from eligibility. State programs play an important role in helping to provide support for immigrants and their children, many of whom are U.S. citizens.

Foundations of Structural Racism in New Jersey

Health inequity today stems from a long history of exclusionary and oppressive policies, practices, and norms at the federal, state, and local levels. Modern policy debates typically focus on decisions made at the federal level. As one of the nation’s 13 original colonies, New Jersey has long sustained destructive racism. For example:

Leaders of the original colony provided 150 acres of land to each White settling family and granted an additional 150 acres for each enslaved Black person a White family brought to the colony.

New Jersey held over two-thirds of all enslaved Black people in the North in 1830.

New Jersey was the first northern state to legally disenfranchise Black residents by restricting the right to vote to White men.

The state Legislature passed a resolution opposing the Emancipation Proclamation.

New Jersey was the last northern state to abolish slavery.

Racially exclusionary covenants, redlining, exclusion of Black veterans from GI Bill benefits for home purchases, and economically exclusionary zoning policies continued well into the 20th century.

Other New Jersey residents also suffered a long history of racism-influenced harm, including the descendants of Indigenous people. The state formally recognizes three tribes: the Nanticoke Lenni-Lenape Tribe, Powhatan
Renape Nation, and Ramapough Lenape Indian Nation.26

These tribes have a history in the land that is now New Jersey going back nearly 10,000 years. Since the mid-17th century, New Jersey’s Indigenous communities have been subject to trauma, genocide, segregation, forced migration, and other harm by European colonizers and past state leaders. Indigenous people report continued discrimination and harassment that affect their health and wellbeing.27 For example, almost one in four Native Americans (23%) reported discrimination in clinical encounters and 15% said that they avoided seeking healthcare for themselves or family members due to anticipated discrimination. Additionally, nearly 40% of Native Americans reported being victims of violence, and 34% reported being threatened or harassed. Further, the structural challenges affecting New Jersey’s tribes continue; as recently as 2018 their status as state-recognized tribes was in question, resulting in a loss of opportunity and government funds.

Though their status was reaffirmed in 2018 following a lawsuit, inequity continues.28 For example, over half (54%) of all Native American/Native Alaskan households in New Jersey live at or near the federal poverty level and struggle to make ends meet.29 Today, their number has dwindled to just 0.6% of the state population.30 Like many states, New Jersey’s databases do not include robust or disaggregated data for these communities, continuing the legacy of erasure and inadequate representation for Indigenous people.31, 32

Latino history in the state began with people moving from the Spanish-speaking countries of the Caribbean to Latin America in the late 1800s.33, 34 Significant growth of the state’s Latino population began in the 1950s with migration from Cuba, followed by Puerto Rico in the 1960s. Today, Latinos are the second-largest racial/ethnic population in the state.35, 36 Latinos in New Jersey were not subject to the same overt and codified racism, discrimination, and separation as those living in the American Southwest in the late 1800s and early 1900s or, more recently, in Southeastern states.37

Ten examples of systemic racism that contribute to health inequities

1. Disenfranchisement through voter suppression and gerrymandering
2. Racial residential segregation
3. Discriminatory public and private lending policies
4. Systemic inequities in education
5. Widespread and entrenched employment discrimination
6. Environmental injustice
7. Systemic injustice in the criminal justice system: policing, sentencing, mass incarceration
8. Race-based forcible displacement policies
9. Inequity in healthcare access and quality
10. Insufficiently disaggregated data obscuring the needs of disadvantaged populations

Source: https://www.rwjf.org/content/dam/farm/reports/reports/2021/rwjf467812

Figure 2: Life Expectancy Across Mercer County

However, the data and patterns evident in New Jersey show that the structural racism embedded in the state also harms Latino communities. For example, as the Latino population of New Jersey grew, individuals moved to municipalities in the New York metropolitan area that were historically redlined and home to many Black people. Over time, some of those communities became majority Latino and subjected to the same modern-day discriminatory practices that affect the health and wellbeing of other people of color. Nationally, 20% of Latinos report experiencing discrimination in medical encounters, and 17% report avoiding medical care because of anticipated discrimination.38

**Ongoing Structural Racism Affects Black and Latino Residents**

Over time, the above examples embedded systematic disadvantages in the lives of Black and Latino residents in New Jersey.39 While the most egregious forms of structural racism—those legally sanctioned—were overturned, the structures remain essentially unchanged. New Jersey is home to some of the nation’s most significant racial and ethnic inequities in health, income, and wealth. For example:

**Health:** Good health is not evenly distributed throughout the state; in fact, life expectancy varies by place. In Trenton, the average life expectancy is 73 years, but just 13 miles away in Princeton, it is 87 years.40 See Figure 2.

The health and wellbeing of New Jerseyans also varies by race and ethnicity. Black babies born in New Jersey are three times as likely to die before their first birthday than White babies, and Black people in the state are seven times more likely than White people to die due to childbirth or pregnancy issues.41,42 Black residents are more likely to develop such chronic health conditions as heart disease, diabetes, cancers, and high blood pressure.43 Black and Latino communities in New Jersey experienced some of the most harmful health effects of the COVID-19 pandemic because of living and work conditions and often limited access to healthcare.44,45

**Poverty:** New Jersey had a statewide poverty rate in 2019 of 9.2%—below the national average of 12.3%. But there are large disparities by race. The poverty rate in New Jersey was 15.8% for Black residents, 15.6% for Latinos, and 5.6% for White residents.46 Income is strongly associated with illness and mortality, with income-related health disparities growing over time. The effects of low income and poor health often reinforce each other.47 Further, another 27% of New Jerseyans are employed and earning above the poverty line but have trouble affording basic needs.48 This population in New Jersey is increasing due to stagnating wages and rising costs of living.

**Figure 3: How Systemic Racism Harms Health**

<table>
<thead>
<tr>
<th>Systemic Racism</th>
<th>Different Opportunities</th>
<th>Harms to Health</th>
<th>Biological Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial residential segregation</td>
<td>Economic disadvantage, including lack of access to wealth, homeownership, &amp; educational opportunity</td>
<td>Chronic stress</td>
<td>Neuroendocrine processes</td>
</tr>
<tr>
<td>Unfair financial systems/structures</td>
<td>Inadequate housing</td>
<td>Environmental hazards</td>
<td>Inflammation</td>
</tr>
<tr>
<td>Gerrymandering &amp; voter suppression</td>
<td>Unhealthy food &amp; exercise environments</td>
<td>Mass incarceration</td>
<td>Immune system dysfunction</td>
</tr>
<tr>
<td>Biased policing &amp; sentencing</td>
<td>Exposure to violence</td>
<td>Inadequate housing</td>
<td>Infection</td>
</tr>
<tr>
<td>Environmental injustice</td>
<td>Unhealthy behaviors</td>
<td>Unhealthy environments</td>
<td>Vascular mechanisms</td>
</tr>
<tr>
<td>Pervasive discrimination in employment, housing, education</td>
<td>Obesity</td>
<td>Epigenetic effects (gene-environment interactions)</td>
<td>Premature aging</td>
</tr>
</tbody>
</table>

**Income inequality:** New Jersey had the 12\textsuperscript{th} state highest income inequality in 2019—up from 2016 when the state was ninth.\textsuperscript{49} Essex County has the most significant inequality and is also one of the most economically segregated counties.\textsuperscript{50} For example, Millburn has among the state’s highest median household incomes, at $214,449 a year, while—just 11 miles away—Newark has a median income among the state’s lowest, at $37,642.

**Wealth inequality:** Wealth represents the assets an individual or family has (e.g., bank accounts, retirement savings, homes, automobiles) minus debt (e.g., credit cards, mortgages, student loans) There is a well-documented racial wealth gap in the United States: Median net worth by race in 2018 was $127,390 for White households; $8,050 for Black households; and $16,610 for Latino households.\textsuperscript{51} In New Jersey, the gap is even larger. Median net worth in 2018 was $309,396 for White households; $5,900 for Black households; and $7,020 for Latino households.\textsuperscript{52} Research shows that the racial wealth gap persists across educational attainment levels, employment status, and other factors, evidence that policies to close gaps that focus on individual education and choices are not enough.\textsuperscript{53}

Extensive research finds that diverse experiences and exposures produced by systemic racism contribute to racial/ethnic disparities in health by setting in motion sequential causal chains whose complexity and length often make it difficult to detect underlying but unseen causes. Figure 3 depicts (in greatly simplified form) a series of general sequential steps (represented by boxes) through which systemic racism is thought to produce racial health disparities, listing examples of factors often involved at each step.

**Priority Area 1**

**Actions to Support Equity-Informed Decisions and Power-Building**

The COVID-19 pandemic required leaders in federal, state, and local government, community organizations, healthcare systems, advocacy, philanthropy, and other sectors to respond to unmet needs innovatively to help protect against the most devastating health and economic effects. Most pandemic-related relief was transactional—that is, to address urgent needs within the confines of the existing systems and structures.\textsuperscript{54} These types of solutions may narrow disparities—the effects of systemic racism—but will fall short of facilitating the transformation of underlying structures and systems in a reparative way that addresses systemic harms and sets the foundation for all New Jerseyans to thrive.\textsuperscript{55}

State government officials and policymakers in New Jersey have recently taken action to design state-funded policies and programs to achieve better health for more children, women, and pregnant people, among others.\textsuperscript{56} The effects of these investments are not yet known fully but available data does not show a significant shift toward equitable outcomes.\textsuperscript{57} Research shows that achieving equitable outcomes requires more than robust investments. It requires using an equity lens in each step and building and sharing power with the community.\textsuperscript{58} An equity lens, at its core, involves a series of reflective questions and analyses that enable decisionmakers to consider and assess the needs of various communities when planning a program, service, or policy. Community power is a community’s ability to act together to drive structural change and hold decisionmakers accountable.\textsuperscript{59}

Both of these approaches are essential to transforming systems because the people most directly affected by systemic barriers and inequities are best positioned to identify the solutions and actions needed to drive change. However, they have been kept from involvement in making decisions on policies and practices that impact their health and prosperity, through generations of systemic exclusion and disinvestment. There is an opportunity for New Jersey leaders across sectors—government, communities, healthcare, and others—to maximize these investments by developing community-informed, diverse, and targeted implementation strategies and effective enforcement and accountability mechanisms.
Recommendation 1

Establish a state task force to assess the harm to New Jersey’s Black residents throughout state history and propose actionable steps to the state Legislature, agency officials, and other officials as appropriate

In 2008, the New Jersey Legislature passed a resolution apologizing for past leaders’ “perpetuating the institution of slavery,” an important acknowledgment of systemic racism and resulting harm. There is a need for continued action to repair generations of harm and provide an opportunity to residents who were denied access and harmed by discriminatory processes throughout the state’s history, from slavery to today.

A deeper understanding of the root causes of disparities and an in-depth analysis of the state’s racialized legacy and enduring effects will help inform New Jersey of its often-forgotten state history and provide a starting point to identify policy-driven solutions.

Bringing history to light can help shape a more accurate narrative for the role that structural racism has played and continues to play in New Jersey residents’ health and wellbeing. The membership of the task force should include a diverse group of people, including community leaders and affected residents. To promote meaningful engagement, the task force should have authority to make recommendations to the Legislature, Governor, and agencies. For example, the task force could be charged with reviewing the state’s fiscal situation and tax structure to identify from where funds can be drawn and make recommendations on how to reinvest those funds in affected communities. Cities and the state of New Jersey should also consider adopting resolutions supporting a federal reparations study commission.

California state lawmakers are implementing the nation’s only reparative justice task force. A nine-member task force was charged with studying and developing reparative proposals to benefit Black residents,

RWJF Health Equity Principles for State and Local Leaders

The COVID-19 pandemic brought a dual threat to health equity in the United States, with over one million deaths disproportionately affecting Black and Latino communities and a severe economic downturn that resulted in tens of millions of people losing jobs—the highest numbers since the Great Depression. This experience underscored what communities of color already knew: the nation’s healthcare, public health, and economic systems do not adequately or equitably protect people’s wellbeing. For all communities and residents to recover fully and fairly, state and local leaders must center on health equity when designing and implementing pandemic responses and post-pandemic efforts. To do this, RWJF urges state and local leaders to consider the following principles to assess whether their efforts will help lead toward an equitable and lasting recovery:

- Collect, analyze, and report disaggregated data.
- Include in decisionmaking those most affected and benchmark progress based on their outcomes.
- Establish and empower teams of decisionmakers and other interested parties dedicated to racial equity.
- Fill policy gaps while advocating for more federal and state support.
- Invest in public health, healthcare, and social infrastructure.

recommending ways to educate the California public about the task force’s findings, and suggesting a course of action to remedy inequities the group finds.64

The California Department of Justice was charged with supporting the task force with administrative, technical, and legal assistance over two years.65 The task force released a 500-page report detailing how the actions of state leaders have harmed Black residents for over 150 years. Each chapter also details harm done by the federal government. This report includes draft recommendations spanning a wide range of topics, including proposals to help address inequity in such areas as education, housing, wealth opportunities, and the criminal justice system. The report notes that the draft recommendations aim to be reparative and the final recommendations, due to the California state Legislature in July 2023, will include a separate recommendation on compensation. That proposal is under development by the task force and by a team of economic consultants examining existing guidelines for reparative proposals from the United Nations and other entities.66,67

**Recommendation 2**

**Create and fund an interagency equity working group to provide leadership on cross-sector collaboration**

The many structural drivers of inequity create distinct, yet related, disparate outcomes. Past efforts across the nation and within the state have often focused on one manifestation of structural racism at a time without addressing the root cause of disparity: interrelated systems that do not support or undermine wellbeing. New Jersey should advance plans to join other states that have adopted cross-agency collaborative efforts to promote equity.68

Developing a “Health in All Policies” agenda—a strategy that strengthens the link between health and other policies, including education, housing, and transportation to support health and wellbeing—was in New Jersey’s 2020 State Health Improvement Plan.69 It is unclear how much progress on this agenda has been made amid the COVID-19 pandemic and associated state response. As the Governor’s office updates future iterations of this plan, it should make a Health in All Policies approach the cornerstone. Evidence shows that programs embedding this approach raise awareness of the social determinants of health and create opportunities to embed such considerations in everyday policy decisions throughout state government.70

In alignment with recommendations from the American Public Health Association, the Governor’s office should establish and lead an inter-agency workgroup to develop, govern, and create collaborative opportunities to help all New Jersey residents reach their best health.71 New Jersey officials should coordinate with state systems outside of health, human services, and child and family sectors to include the state Departments of Education, Transportation, Community Affairs, Labor and Workforce Development, and Corrections.72

The state should also provide sustainable funding for operations and pilot projects and develop performance metrics and accountability mechanisms. This workgroup should also develop a community-driven, jurisdiction-wide racial equity and social justice action plan.73 Such a plan should outline action to monitor progress toward goals. The plan should also advise how technical assistance will be provided for state entities to consider structural racism and transform operations, while pledging to continue to seek meaningful community input and respond, as appropriate, in real time to address needs. Action at this level can help “normalize, organize, and operationalize” racial equity and efforts to transform government systems.74 Several jurisdictions across the nation have developed and implemented racial equity action plans and can serve as a model of presenting robust guidance to city departments.75,76
Assess the impact of significant new legislation and regulations on racial equity within New Jersey

Racial or minority impact statements have emerged in various states as a tool to help inform the policy process. Racial impact statements are a relatively new strategy to inform legislators on the effects bills would have on communities of color so they can avoid increasing disparities. To do this, legislative staff systematically analyze how racial and ethnic groups are affected by an existing or proposed action, policy, or practice and typically focus on criminal justice. New Jersey was one of the first states to implement a requirement for racial and ethnic impact statements for specific proposed criminal justice bills. Notably, New Jersey is the only state to also require state agencies to prepare racial and ethnic impact statements for proposed rule-making. Specifically, “in proposing a rule for adoption, the agency involved shall issue a racial and ethnic impact statement setting forth the nature and extent of the impact of the proposed rule on pretrial detention, sentencing, probation, or parole policies in this state and how the rule would affect racial and ethnic minorities. This statement shall be included in the notice of a proposed rule as required by subsection.”

However, as of 2022, there has been only one such statement in New Jersey.

Impact statements have long been used in other contexts, such as legislation that could affect the environment, health, or the state’s fiscal situation. Given the still-emerging status of racial impact assessments, there are few evaluations of their use and effectiveness. One recent evaluation of racial impact statements for criminal justice legislation in Iowa—which in 2008 became the first state to implement this tool—suggests the statements have the potential to advance equity. But there are limitations to the current process. Researchers identified 176 criminal justice-related bills that went to the Iowa House or Senate floor from 2009 to 2019. Their analysis of these bills found a need for standard definitions and methodologies to ensure a comprehensive analysis takes place instead of short reports of general census data. They also noted the need for increased transparency by adding a public reporting requirement on the number and outcome of assessments and resulting legislative actions. Finally, this analysis noted that several racial impact assessments warned of a negative effect on communities of color, yet the bills were still passed; researchers recommend the need for additional scrutiny of legislation with potential negative effects on communities of color.

There is an opportunity for New Jersey legislators and other officials at the state and local levels to expand upon the existing racial impact statement process in New Jersey. For example, legislators could broaden the requirement for racial impact assessments for legislative and regulatory proposals in other core areas, including housing and health policy development and implementation.

For each core area, legislators should also consider looking back at past effects of existing legislation on various populations. The New Jersey Legislature did this by pairing the criminal justice requirement with a state sentencing commission to look back at existing harmful policies and develop solutions. This comprehensive review can provide valuable context for past harm and help orient future assessments. Additionally, staff developing the racial impact assessment must have adequate resources, including time, staffing, and technical support. Finally, the process and resulting racial impact statements should be transparent and available to all interested parties—including constituents—early in the legislative process.

At the municipal level, officials should examine how to use racial impact assessments. For example, the cities of Seattle and New York, and Montgomery County, Maryland implemented racial impact assessments in land use and zoning decisions. The assessments vary, but all have the aim of considering how new land developments or rezonings will affect residents of color. As more racial impact assessments take place across governments, continued evaluation will be essential to help make this tool effective in preventing worsening inequity.
Recommendation 4

Acknowledging the presence and effects of structural racism and plan action

Declaring that the harms from past practices are important in achieving equity because they help shift attention to the root cause of inequity: systems and structures, rather than individuals. In 2021, for example, the CDC took the extraordinary action in declaring racism a public health threat. A first step that state officials can take is to issue gubernatorial executive orders, legislative and local government resolutions, and declarations of racism as a threat to public health.

A growing number of state and city leaders in the U.S. have declared racism a public health crisis. New Jersey has no state-level declaration. Two entities in the state have made resolutions declaring racism a health threat. The Borough of Leonia in 2020 became the first jurisdiction in New Jersey to do so, with a resolution listing actions the Mayor and Council pledged to take to help dismantle racism. Also in 2020, the Elizabeth School Board passed a resolution naming systemic racism and its effects, as well as actions the Board would take to address them.

Declarations and resolutions alone will not advance equity. Still, state and local leaders can use them to start or continue meaningful engagement and partnership with community leaders and advocates. According to the American Public Health Association, many entities include specific actions in their plans. Most often, these actions involve an "equity in all policies" approach for future actions and programs or a commitment to review existing policies and programs through a racial equity lens. Any action around declarations should also include sufficient resource allocation.

Policy Ideas to Explore: Actions to Democratize Decision-making

New Jersey’s 219th Legislature was the “most diverse” in state history, but still fell short of being fully representative of the state population, which was 54.6% non-Hispanic White, 20.9% Latino, 15.1% Black, and 10% Asian in 2021. Of the 120 state senators and Assembly members, 70% are non-Hispanic White and about 66% are men.

To help achieve more representative decision-making in the short term, New Jersey leaders should explore and implement meaningful avenues for diverse community members, experts, and leaders to provide input and influence state decisions. Efforts to do this in other states include community advisory boards to state agencies with authority to make decisions, participation in the budgeting process, and community inclusion in redistricting efforts. Community advisory boards and similar bodies have the potential to advance equity. Intentional design of a board must include those experiencing health inequities, communities of color, those in poverty, and immigrants. Meaningful engagement beyond intermittent information gathering can help ensure that programs and efforts are created with—not just for—these communities. The process must aim to be inclusive to attract members from a wide area of backgrounds, qualifications, experiences, and communities.

Participatory budgeting efforts are increasing, with Chicago, Boston, New York City, San Francisco, and Seattle taking this approach in various forms. Participatory budgeting aims to engage people who have been traditionally excluded from government or budget processes and allows community members to directly decide how to spend part of a public budget. Some New Jersey municipalities have implemented participatory budgeting, including the Borough of Freehold and Jersey City. This strategy can provide
Priority Area 2

Ensure New Jerseyans Have Equitable Access to Affordable Housing in Communities Where They Choose to Live

Homes and neighborhoods play significant roles in shaping people’s health and wellbeing. The health influences are many, including the physical condition of a person’s home (i.e., presence of lead or allergens); the safety and viability of the communities where they are located; and affordability—all of which affect financial stability, educational opportunities, availability of jobs, and a family’s overall ability to make healthy choices. As such, investments in developing and maintaining affordable, safe, and stable housing and neighborhoods can be a catalyst for healthier, more equitable communities.

Today’s housing challenges in New Jersey are influenced by a history of such overt exclusion as redlining and restrictive covenants. Discrimination and resulting exclusion and segregation did not disappear with enactment of the federal Fair Housing Act of 1968—intended to provide equal housing opportunities for residents of every race, ethnicity, and religion. Black and Latino residents continued to be disproportionately rejected for loans, discouraged from buying homes in certain places, and more likely to live in racially and economically segregated neighborhoods with lower educational investments, food deserts, less access to transit and good jobs, and environmental challenges.

Today, rising home prices and costs associated with housing compound the challenges to homeownership and rentals in the U.S. and New Jersey. In addition to challenges to becoming and remaining homeowners, a general lack of affordable rental homes has worsened racial inequity in the state. For these reasons, accessing affordable, stable, and safe housing is a challenge across communities in New Jersey, but is especially acute for Black and Latino residents who face continued inequity and discrimination.

Recommendation 1

Invest in producing more affordable and safe homes across all communities

Recent polling shows that most New Jersey residents are very concerned about high housing costs. Available data help illustrate why this sentiment persists: A household must earn $31.96 per hour, significantly more than the state minimum wage of $14 per hour, to afford a two-bedroom apartment. In New Jersey, nearly three-quarters of very-low-income families—those earning only 30% to 50% of the area median income—spend more than half of their income on housing. The high costs of affordable homes is exacerbated by a longstanding inadequate supply, especially for families earning poverty-level incomes, which disproportionately affects Black and Latino or Hispanic people.

After many years of inadequate funding, New Jersey leaders are working to make investments toward affordable housing. The state budget that took effect July 1, 2022, continues recent efforts to increase state investment in affordable housing. The budget includes full funding for the state’s Affordable Housing Trust Fund (AHTF), intended to help finance construction of affordable homes in New Jersey. Research shows that trust funds can increase the supply of affordable, high-quality housing. However, until 2020, NJ AHTF residents with significant influence over how public funds are allotted. As these approaches are still new and evolving, their use should be carefully tailored to the needs of a particular community, ensure meaningful participation and adequate resources, and include rigorous evaluation to build an evidence base for what works.
funding—drawn from realty transfer fees—had been repurposed to support the states’ other commitments, including rental assistance, which supports nearly 4,000 households. Rental assistance is an urgent need for many residents, but it should not come at the expense of state and municipal officials meeting their affordable housing goals. Both must be adequately funded to address the affordability crisis.

In addition to full funding for the AHTF, the budget allocates $305 million from American Rescue Plan funds to produce over 3,300 affordable homes required by municipal fair housing settlements but previously stalled due to a lack of dedicated funding.

Though these two investments are a significant improvement from past years, making progress on overcoming the significant shortage of affordable homes in the state requires that this investment be sustained, if not increased, to keep pace with inflation.

In addition, state officials should develop a transparent regulatory and enforcement process regarding the requirement that affordable housing is produced when state-owned lands or state funds are used for development. This obligation, created under the state Fair Housing Act of 2008, applies to such state agencies as the Department of Community Affairs, Department of Transportation, NJ Transit, the Economic Development Authority, and the Department of Environmental Protection.

Policy Ideas to Explore: Several experts support reparative efforts to address structural challenges that keep Black and Latino New Jerseyans out of homeownership. Reparative solutions for housing injustices are thought to have the potential to narrow persistent health disparities and gaps along racial lines in other areas of life. Housing-specific reparative solutions include, for example, allocating more money to state housing trust funds to target investment in communities of color or individuals living in once redlined areas. These targeted investments could take various forms, including a dedicated sub-fund within the trust fund for grants for home down payments or revitalizing homes of existing homeowners who have experienced inequity. In another example, New Jersey already has a down payment assistance program available to certain first-time home buyers and subject to some income limits but would need additional funding to meet current demand.

With existing limited funds, New Jersey can center racial equity by strategically targeting funds to first-generation homebuyers as this group is more likely to be Black or Latino. These targeted strategies within a broad program could help stabilize housing, support healthier communities, and move the needle on longstanding gaps in homeownership and wealth.

To be effective, housing reparations programs should be carefully designed and implemented. For example, integration of previously racially exclusive communities may only redistribute where people live but not address underlying systemic racism. And, moving individuals will not provide investment in communities that were intentionally marginalized. Efforts to improve property value and equity and infrastructure of existing neighborhoods can help ensure more people live in neighborhoods that can support wellbeing. Additionally, enhanced resources to enforce fair lending laws that combat ongoing discrimination in the housing market can help address ongoing systemic challenges. Together, these efforts can help mitigate continued harm that perpetuates fear, stress, and unequal treatment for people of color. It should be noted that there is a lack of evidence about the outcomes of such efforts, mainly because so few entities have developed and implemented reparative actions. As more jurisdictions implement these programs, careful evaluation should follow.
Recommendation 2

Promote racially-equitable land use and zoning policy to provide opportunity for more people to live in neighborhoods that support good health and wellbeing

Racial and economic segregation in New Jersey stems from decades of racially restrictive covenants that prohibited Black people from buying or renting property based on race, redlining, and other discriminatory practices. The U.S. Supreme Court in 1948 struck down court enforcement of restrictive racial covenants because it violated the 14th amendment. However, racially restrictive covenants themselves persisted until 1968 when the federal Fair Housing Act prohibited discrimination on the grounds of “race, color, national origin, religion, and sex.”

Still, covert exclusionary practices followed. For example, many communities began to adopt such income-based zoning requirements as large minimum lot sizes and the exclusive construction of single-family homes. In 1975, the New Jersey Supreme Court made a landmark decision in *South Burlington County NAACP v. Mt. Laurel*, holding that “developing municipalities must provide a realistic opportunity for a fair share of the area’s present and prospective housing needs to accommodate low- and moderate-income families.” This and a later decision form the Mount Laurel Doctrine, which prohibits ongoing economic discrimination by municipalities through the use of zoning ordinances to price out low-income residents from their municipality and requires prioritizing space for affordable homes and apartments. The decisions were met with significant pushback from municipal leaders and implementation of the Doctrine was slow.

When enforced, the Doctrine is a valuable tool against continued exclusion and oppression of people of color in New Jersey. Unfortunately, the Doctrine went unenforced for 15 years, when enforcement was transferred to the New Jersey Legislature. In 2015, enforcement returned to the courts. Since then, almost all of the 350 municipalities that sought court approval for their housing plans have reached settlement agreements to comply with their fair housing obligations, paving the way for the construction of tens of thousands of new homes for working families in safe neighborhoods that are close to jobs and good schools. Enforcement efforts in the state are largely led by the Fair Share Housing Center, a nonprofit founded in 1975 that is the only group in the state committed to pursuing enforcement of the Mount Laurel Doctrine.

State lawmakers should continue to explore ways to compel municipal compliance with robust enforcement of the state’s fair housing laws to provide opportunities for more families. For example, the Governor and legislators could provide full funding in future budgets for the Department of Community Affairs so it can have the staff needed to gather and provide data to promote enforcement of Mount Laurel and related requirements.

Due in large part to the Mount Laurel Doctrine, New Jersey municipalities are designing and implementing inclusive zoning and housing measures. Inclusive zoning measures are “regulations or incentives to include units within a development for low- and moderate-income families.” Also referred to as inclusionary housing, these policies dedicate affordable housing units by requiring or encouraging developers to include a specified share of below-market units as part of market-rate rental or homeowner developments. The most recent comprehensive study identified 886 jurisdictions with inclusionary housing efforts across 25 states and Washington, D.C. In 2016, New Jersey was home to nearly half of those efforts (45%). Examples of inclusionary zoning policies include rescinding zoning rules that allow only single-family homes, removing minimum lot sizes, and allowing accessory dwelling units. The study found inclusionary housing programs to be an effective tool for producing affordable housing.

While community investment and revitalization often are positive, low-income people or residents of color may face displacement in the absence of affordable options amid rising costs when areas undergo revitalization that
attracts higher-income residents. A racial equity lens is critical when considering inclusionary zoning efforts to avoid such unintended consequences in historically underserved neighborhoods. Municipalities can explore right-to-return and other policies that provide preference for people with ties to displaced communities to come back and live there.

Some localities are exploring how to set aside affordable units in gentrifying markets to mitigate against displacement. For example, in Austin, 28 units developed in a Community Land Trust were tied to a preference policy. Only people who meet the criteria and are accepted will be able to rent or purchase those properties, ensuring that current efforts are reparative to those directly affected by past policy. This type of strategy can help people stay in a neighborhood where improvements support good health.

**Recommendation 3**

**Strategically implement and leverage innovative strategies to facilitate racially-equitable homeownership**

For decades, paying no more than 30% of gross income toward housing was the accepted standard of affordability in academic, research, and advocacy settings. Recently, researchers and advocates have questioned it, noting that the formula “oversimplifies the issue of housing affordability.” For example, it does not take into account cost-of-living differences from state to state; such tradeoffs families may make to afford housing as living farther from where they work; neighborhood crime; and threats to health from their home’s physical environment. Additionally, surveys asking respondents to self-report this information likely limit the validity of housing burden, missing complex nuances in income, expenses, and income swings year to year. Still, even a simplified measure shows that affordability is a challenge and a barrier to attaining and maintaining homeownership and wealth, especially for Black and Latino residents of New Jersey.

In addition to facing home prices higher than the national median, Black and Latino families are more likely to earn lower wages and have limited intergenerational wealth due to structural racism. While there are many supports to help families buy homes, those efforts do nothing to change how the housing system functions, combat discrimination in housing appraisals, or solve the challenges that come with the traditional aim of owning a single-family home in a high-cost state.

Other states and localities are exploring alternatives to traditional homeownership pathways. One example is shared-equality homeownership, an effort to balance wealth-building for families who would otherwise be unable to afford and preserve their investment. Examples are found in cities across the country. Community Land Trusts (CLT) are among the most popular shared-equity models, with 260 operating across the country in 2021, including one in Essex County, New Jersey. CLTs are usually operated by private, not-for-profit corporations. The CLT purchases land, builds a home on the land and then allows a low- or middle-income individual to purchase the home but not the land, reducing the cost of a home to these buyers. CLT agreements have varying restrictions to ensure continued affordability of the home. For example, all CLT agreements limit the price at which a house can be sold and require that any profit is shared between the owner of the home and the owner of the land (CLT). CLTs have shown the potential to advance equity, especially when residents of communities of color are engaged and have a leadership role in creating the CLT. An in-depth evaluation of CLTs in Minneapolis suggests that CLTs helped increase prices of nearby homes and finds strong evidence that the CLT homes in an area could help stabilize neighborhoods because they are less likely to go into foreclosure.

CLTs are just one example of innovative ways to move toward equity and should be considered as part of a comprehensive plan that includes other strategies. For example, some advocates suggest that they be used in
combination with Community Land Banks. Land Banks are typically “public nonprofit or governmental entities that specialize in the conversion of vacant, abandoned and foreclosed properties into productive use.” With targeted coordination, land banks and CLTs may be used together to promote more equitable development that helps mitigate the effects of fluctuating private capital by placing otherwise inaccessible land into land trusts for public benefit. This could help provide more stock of affordable homes and associated equity for more families.

**Recommendation 4**

**Establish and fund a right-to-counsel for low-income renters**

It is estimated that there are 3.6 million evictions filed annually in the U.S., indicating that the threat of eviction significantly affected individuals and families before the COVID-19 pandemic. Data shows that Black renters received a disproportionate share of eviction filings in the country, and Black and Latino female renters faced higher eviction rates than their male counterparts.

While pandemic-related emergency provisions and funding have kept many from eviction, those supports were temporary. New Jersey resumed eviction hearings in September 2021. Evictions do not lead only to a loss of a stable home; studies show that eviction can harm physical and mental health, employment, educational prospects, and credit scores. Evictions also affect communities as a whole: Neighborhoods with a high incidence of evictions are likely more unstable, eroding community cohesion and civic empowerment.

Tenants are often at a disadvantage when faced with eviction or other loss of housing stability because there is no constitutional right to counsel such as that available to criminal defendants. Nationally, 90% of landlords have legal counsel, and 90% of tenants do not. State policymakers should expand and affirm tenants’ rights by establishing and funding a right to counsel for low-income renters to help keep people in their homes and protect them from discriminatory practices. Legal support in eviction proceedings could include a variety of services from full representation by an attorney in court or such limited legal assistance as help to complete paperwork or preparing tenants to represent themselves.

Recently, 15 cities and three states enacted a right to counsel for tenants facing eviction. Newark passed an ordinance in 2019 to establish an Office of Tenant Legal Services to provide free legal services to residents with incomes below 200% of the federal poverty level, becoming the third city in the nation to launch such a program. In 2021, three states—Washington, Maryland, and Connecticut—enacted laws establishing statewide right to counsel programs. These programs have a data and evaluation component, but data is not yet available. Still, they can serve as a blueprint and offer lessons for New Jersey’s leaders who seek a more uniform approach to ensuring the right to legal counsel for more renters in their state.

**Priority Area 3**

**Birth and Reproductive Justice**

Despite progress over the past half-century, the United States still falls behind other industrialized countries in maternal and infant health. Recently, preterm births and maternal mortality rates have been rising. In New Jersey, while the infant mortality rate is lower than the national average, the maternal death rate is nearly twice the national average. New Jersey also has among the most significant disparities in the nation for these outcomes: Black infants are more than three times as likely to die before their first birthday than White infants; and Black mothers are more than seven times as likely as White mothers to die from pregnancy-related complications.
These disturbing trends and inequities result from many factors. Disparities in outcomes for Black women persist at higher education and income levels, suggesting that discrimination and racism are at play. Specifically, Black women and pregnant people experience the intersection of racism and sexism in healthcare practice and systemic racism that inhibits access to adequate and appropriate care, safe and supportive environments, and causes related stressors.

State officials have made significant investments aimed at making New Jersey the safest place to give birth, including the Nurture NJ program. This initiative spans state agencies and aims to provide enhanced services to women and pregnant people to improve outcomes. These necessary investments and broad goals are an admirable start. To be effective and begin to set the stage for transformative change, though, implementation efforts must keep equity as a core tenet and strategies must be targeted to account for how Black women and pregnant people are situated within the state.

**Recommendation 1**

**Support and invest in a diverse workforce that is aware of bias and can provide appropriate care across the maternal and infant care and education continuum**

Data from the CDC shows that about 60% of maternal deaths in the United States are preventable. One strategy to help reduce maternal deaths among Black women and pregnant people is bias training for healthcare providers. Many health systems commit to equity, but research shows this is not enough to counter discriminatory behaviors that stem from implicit bias, which often manifests as “inadvertent discriminatory behavior” that can “co-exist alongside deeply held personal commitments to equity.”

Effective training can help healthcare providers identify and acknowledge their implicit biases and be an effective measure to counter their impact. In 2021, New Jersey enacted a law, making the state one of a few that require “all healthcare professionals who provide perinatal treatment and care to pregnant persons at a hospital or birthing center undergo explicit and implicit bias training.” The training is mandatory for licensing, and the training curricula is subject to approval by the state Department of Health. To ensure that training effectively addresses bias, the approval criteria should be evidence based and informed by Black practitioners, patient advocates, and policy and research communities. The implicit bias training should be patient centered and include a focus on the lived experiences of Black women and pregnant people to help increase provider awareness of bias and how it affects care and outcomes.

Another proven way to help reduce racial health disparities is to engage a diverse workforce that proportionally reflects the population. Today’s obstetrics-and-gynecology, doula, and midwife workforce in the United States is overwhelmingly White. Given the disproportionate impact of the maternal health crisis on Black women and pregnant people in New Jersey, policymakers should aim to increase the number of Black providers.

New Jersey leaders could explore prioritizing these professions in existing programs, like the recently enacted and first-of-its-kind Pay It Forward initiative. This initiative brings together funding and expertise from New Jersey state officials and Chief Executive Officers to provide interest- and fee-free loans for low-income career seekers who participate in approved training programs for midwives, doulas, and community health workers.

Further, there is an opportunity to better understand and support career progression of doulas and community health workers. This information can help support doulas and health workers in their day-to-day practice and also provide valuable information to help connect them to additional training and opportunities. A mentorship program—with adequate support and a paid stipend to honor expertise and time—can help support doulas, health workers, and midwives of color.
Recommendation 2

Implement new Medicaid policy in a way that supports racial equity

Medicaid is an essential safety-net program, contributing to improved outcomes for many people. Still, the program was inherently borne out of structural racism, where low-income Black and Latino people were, and still are disproportionately left out of employer-sponsored health insurance coverage in the United States. There is growing evidence that Medicaid reinforces, rather than eliminates, systemic racism. Over the program’s lifetime, expansion of eligibility or services has been driven by, and often limited by, political debates that adversely affect people who have been traditionally underserved by the nation’s healthcare system. This is important to the health of women and pregnant people in New Jersey because Medicaid finances nearly one in three births in the state. As such, Medicaid policy profoundly affects the choices a woman or birthing person has in their care.

Recently, New Jersey officials have taken several steps to enhance Medicaid coverage for women and pregnant people. For example, the state is using funds from the American Rescue Plan to expand Medicaid coverage for women and pregnant people for up to one year following birth. New Jersey was the second state to do this. Additionally, state officials recently decided to provide coverage for doula services, which have been shown to improve outcomes but are often inaccessible for Black or low-income women and pregnant people. As New Jersey continues to implement this policy and others aimed at racial equity, it must intentionally center on racial equity and consider how the design and implementation of policies and requirements can inadvertently limit access. Early lessons from Oregon’s and New York’s implementation of doula services under Medicaid can help inform New Jersey. This includes, for example:

- Taking advantage of all opportunities available to advance equity within the Medicaid program parameters. New Jersey Medicaid officials should continue to lead in implementing evidence-based services that help support enrollees’ health. For example, recent guidance from the Centers for Medicaid and Medicare Services on section 1115 waivers allows states to apply to use funds to address social determinants of health. New Jersey intends to use this waiver authority to offer housing assistance to those served through NJ FamilyCare, including pregnant people.

- Ongoing engagement and assistance to diverse and new providers ensure that administrative burdens in filing for payment or other technical aspects of program participation do not undermine the ability to provide services.

- Ensuring that reimbursement reflects fair rates for services that indicate the full, comprehensive time and care provided or the administrative time to bill. As most doulas are independent contractors, they incur additional costs for time and materials. Data show that doulas typically spend much more time with clients than other providers; Medicaid reimbursement rates may not always amount to a living wage.

- Carefully considering requirements that may provide unintentional barriers to provider participation. For example, doula advocates in New Jersey point to challenges posed by requirements in other states’ doula coverage, including state certification requirements in addition to doula training services certification. In New Jersey, a doula must be certified through a state-approved program. Officials should ensure that approved programs are high quality, including those led by Black and other people of color. As this program is implemented, state officials should work with community providers and other interested and affected parties to ensure that quality and participation requirements are not overly burdensome or a barrier to participation for qualified practitioners.
Spotlight on Real-Time Implementation: Nurture NJ

Nurse NJ is a statewide initiative aiming “to make New Jersey the safest and most equitable place in the nation to give birth and raise a baby.” It acknowledges that systems in New Jersey must be transformed to achieve the desired outcomes for mothers and infants. In 2021, a robust and wide-reaching strategic plan was developed by state experts with input from 100 interested and affected parties in the state.242 Several of the recommendations have been implemented, including the provision of universal maternal health home visits and women’s health services between pregnancies.

As this potentially promising campaign continues, decision-makers must keep racial equity centered and target the factors that continue to harm Black women and pregnant people. While community engagement is a core recommendation of Nurture NJ, officials should make it a priority to fully incorporate the voices of women and pregnant people from communities that have been marginalized, starting with Black communities. There should be efforts to integrate full participation, from the beginning through all phases, of Black women and pregnant people.243

Individuals with strong community ties and expert understanding of the factors perpetuating inequity for Black pregnant people, such as Black-led community health leaders, should also be heavily engaged to avoid unintended consequences of implementation decisions. For example, New Jersey was the second state to adopt a universal voluntary home visit program for all newborns to support the health of women and babies in the perinatal period.244 A visiting nurse will check the health of the parent and baby and screen for postpartum depression, child abuse or neglect, or other situations that could be dangerous for the family. But there is a potential downside to the structure of the program: The program is operated by the state’s Department of Children and Families—an association that could inadvertently keep participation low among families of color due to distrust and fear that the visit could result in children being removed from the household.

This feedback and related solutions would come to light with more community engagement. Such engagement could include hosting listening and learning sessions in places where women and families live, work, learn, and get care; engaging state agency leaders in these sessions along with frontline staff; using plain language and clear processes to involve residents in prioritizing issues; identifying solutions and shaping all stages of policy and program design; and reporting to communities on how their input was used to inform decision-making.245

Additionally, the makeup of boards, commissions, and task forces under or aligned with the Nurture NJ plan and other maternal health initiatives in the state should review their membership, recruitment, and appointment processes to ensure diverse perspectives and inclusive participation and decisionmaking. Such inclusion can lead to more effective, practical, and tailored solutions while facilitating a shift toward a longer-term agenda to change traditional power dynamics within the state.246
Recommendation 3

Enhance access to comprehensive reproductive health, including abortion care

Access to comprehensive reproductive and sexual health services, including contraception, depression and cancer screenings, and domestic partner abuse assessments, has broad benefits for a person’s health and wellbeing. Abortion care is an essential health service for any person who can get pregnant and is particularly important to support the health of Black women and pregnant people as they experience higher incidences of pregnancy-related morbidity and mortality. Research shows that unintended pregnancies increase the risk of maternal mortality and morbidity, depression, physical violence during pregnancy, and poor birth outcomes, including infant mortality and preterm birth.

New Jersey’s policies support reproductive health and bodily autonomy. Legislation enacted in January 2022 codified reproductive rights into state law, notably including the right to access contraception and the right to abortion. But it does not guarantee equal access because a person’s income, insurance coverage, or immigration status can be a barrier. For example, though New Jersey Medicaid covers family planning—including abortion-related costs for enrollees—access to over-the-counter preventive family planning services including emergency contraceptives, Plan B and condoms, remains limited because the state requires a prescription for coverage. Obtaining a prescription costs beneficiaries additional time and resources. Use of federal matching funds for these services also requires a prescription, but a state could drop the prescription requirement for over-the-counter products by using state funds for this coverage. Others with private insurance coverage may encounter cost-sharing requirements that hinder access. And uninsured individuals are responsible for the full cost. The Department of Health Service’s Reproductive Health Care Fund currently covers prenatal care and contraception services for those with no path to health insurance due to immigration status. Abortion care is not covered under this program, but state officials can administratively expand the fund to include this service.

In addition to fees, hidden costs of taking time off work, travel, and childcare can undermine access to abortion care in New Jersey. Cost barriers to abortion services were identified in a study by the NJ Department of Banking and Insurance, and immediate action was taken to mandate coverage for abortion on all state-regulated health insurance plans. Policymakers should now consider expanding the mandate to require coverage without out-of-pocket costs, like all other reproductive health care services.

Recommendation 4:

Enhance enforcement of the existing paid leave benefit and increase uptake

New Jersey was the second state in the country to pass and implement legislation establishing a statewide family leave insurance (FLI) plan. An analysis by the Board of Governors of the Federal Reserve found that the program had a positive effect on employment and wages for women and helped narrow the gender wage gap from 38% in 1996 to 27% in 2014. They noted an increased drop in the gap after 2009, when the state’s FLI program went into effect. Still, advocates and researchers point out that many New Jerseyans who pay into the program through payroll deductions assessed on all working people were unable to use the benefit when needed. The state expanded the program in 2020 to respond to these concerns by increasing wage-replacement rates, expanding maximum coverage to 12 weeks and extending coverage to survivors of domestic violence and sexual assault.
The program is a significant achievement and serves as a model for other states, but implementation can be improved. Research shows low public awareness of New Jersey FLI and confusion about benefits, as well as workplace stigma and fear of retaliation due to a lack of enforcement mechanism—all of which contribute to significant underutilization of FLI.\(^{196}\) Notably, investment in outreach activities tapered off after the launch of FLI in 2009.\(^{197}\)

The New Jersey Department of Labor should make full use of the $1.2 million appropriated annually under the 2020 legislation to increase FLI program awareness—half of which must go to community-based organizations.\(^{198}\) As of late 2021, the funds had not been released. The state Department of Labor should consider targeting outreach based on program data.\(^{199}\) For example, an assessment of enrollment demographics, geography, leave length, and denials can help identify groups underserved by the program. These efforts may also uncover challenges facing certain groups and provide information for program adjustments. If this data is unavailable, state officials must design regular reports for use in providing data useful in evaluating FLI to enhance efficacy.

New Jersey also should increase enforcement of paid leave benefits for eligible workers. For example, the Department of Labor could devise a monitoring mechanism or other enforcement activity to enable workers—especially those who work for low pay and people of color—to take leave without fear of retaliation. Today the law does not provide for this.\(^{200}\) But action still could be taken to partner with legal advocates and workers’ rights organizations to call attention to and address noncompliance among businesses taking legal actions as needed.\(^{201}\)

### Policy Ideas to Explore: Guaranteed Income

Some states and localities are seeking ways to help support good health through targeted income-stability support.\(^{247}\) Several vehicles exist, including provision of a guaranteed level of income, Universal Basic Income, and the temporarily expanded federal Child Tax Credit. New Jersey recently enacted its own Child Tax Credit, which provides to families below a certain income level a refundable tax credit of up to $500 for each child under age 6.\(^{248}\) Several states continued state stimulus payments to certain families to offset financial stress during the COVID-19 pandemic.\(^{249}\) These programs all have in common that they offer a stable monthly income, which helps families afford healthcare, maintain safe housing, and purchase nutritious food.\(^{250}\) These payments may also promote a sense of greater financial autonomy, which can help a person arrive at better pregnancy and physical and mental health.\(^{251}\) Additionally, preliminary research shows the potential for a positive economic boost to the nation or state and local jurisdictions that provide such income, given that recipients are likely to spend the money rather than be able to save it for future needs.\(^{252}\)

Several cities provide some form of guaranteed income to various individuals, with largely positive results, including two in New Jersey. Newark in 2021 launched a two-year pilot that aims to provide $6,000 per year for two years to 400 adult residents who earn at or below 200% of the federal poverty level. More than 1,200 people applied for the 400 spots. Also in 2021, Paterson started a pilot that guarantees a yearlong income to 110 financially disadvantaged residents chosen via a lottery.\(^{254}\)

California is the first state to fund a Universal Basic Income for certain residents,\(^{255}\) in the form of $35 million to community organizations over five years that will be used to provide regular cash payments to individuals to cover basic needs. California prioritizes funding for pilot programs and projects serving people who aged out of foster care or are pregnant.\(^{256}\) The statewide action followed one of the nation’s first UBI pilots, in Stockton. An analysis of the Stockton pilot showed that the first year produced such beneficial results as reduced income volatility, increased full-time employment, less anxiety and stress, and more financial stability and empowerment.\(^{257}\)
Priority Area 4:

Public Health Infrastructure—Centering Equity in a Modern Public Health System

Public health agencies are increasingly on the front lines of addressing existing and emerging health threats that stretch and challenge the longstanding structure of local delivery of public health services. These threats include a global pandemic, changing climate conditions, extreme weather events, and systemic racism. Compounding these stressors, New Jersey entered the pandemic with a drastically underfunded public health structure, ranking 31st in state funding per capita for public health. New Jersey ranks last (51st among 50 states and the District of Columbia) in grant funding from the Centers for Disease Control and Prevention.

The nation once had robust public health systems that improved living and working conditions through cleaner water, better sanitation, and other advances over the years. But services have been splintered over the past few decades and delegated to other local and state offices, and public budgets have been slashed. The result is a disjointed system with gaps in service—despite public health workers’ dedication and hard work—that places people of color in direct harm because they are most likely to experience conditions that do not support health and wellbeing. There is a unique opportunity amid additional, albeit temporary, federal COVID-19 funding to bolster public health systems.

Recommendation 1:

Provide adequate and flexible funding and maximize existing assets to support public health services and capabilities

New Jersey public health officials report that the inadequacy of unrestricted funding is the biggest challenge to delivering a 21st-century public health infrastructure in the state. Since 1966, the Public Health Priority Fund (PHPF) has been the only source of state-appropriated and unrestricted funds for local health departments. However, since 2011, the PHPF has been unfunded in the state budget. As a result, local public health departments over rely on local property taxes as the main source of funding, leaving some departments underresourced and others with more money than they need. Other funding sources include federal dollars that are often earmarked for specific uses and cannot be used flexibly by public health officials to meet communities’ emergent needs.

To enable New Jersey’s public health system to respond to existing and future needs, the state should reinstate dedicated state funding. To be most effective, the funding should be adequate, sustainable, and flexible so health professionals can direct it to where the greatest health challenges emerge and where disparities exist. The New Jersey Public Health Associations Collaborative Effort (NJPHACE) estimates adequate funding would start at $11.2 million annually—the 2010 level adjusted for today’s economy.

Others suggest a higher amount, to meet basic needs and begin the work needed to transform the public health system. Further, funding should be flexible. Together, this funding will provide for a more comprehensive and modern approach to public health. This should include the ability to address emerging public health challenges, such as the effects of systemic racism.
**Recommendation 2:**

**Establish a state public health institute to facilitate collaboration within and across sectors to improve health equity**

People’s health depends on far more than the capacities of any state agency or healthcare sector. Meeting public health needs in New Jersey is complicated by a fragmented “home rule” system that spans 565 municipalities and over 600 school districts. It is hard to imagine that this arrangement does not contribute to the state’s persistent health inequities. A state public health institute—a nonprofit organization that would aim to advance public health practice and capacity—could help enable a more stable and robust public health infrastructure in New Jersey. The institute could help promote coordination across sectors to complement the work of the state, local, and regional public health departments in being more responsive to health and social needs. There is a well-demonstrated precedent for this type of entity, with public health institutes serving people in 33 states.

The benefits of such an organization can be seen in California’s Public Health Institute, whose Tracing Health initiative early in the COVID-19 pandemic quickly designed, deployed, and sustained protocols for case investigation and contact tracing, vaccine support services, resource coordination, and epidemiology among local health jurisdictions, school districts, community health centers, and other partners. The initiative sought to advance racial equity by hiring from within the communities served and strengthening trust and impact with culturally and linguistically appropriate services.

The Robert Wood Johnson Foundation recognizes the key role that a New Jersey public health institute would play in a reimagined public health system and has partnered with a community-based organization to help establish one. The Foundation engaged in a 10-month planning process that involved a wide range of leaders and interested parties from various sectors, including public health, healthcare, social services, and the faith community to explore how a public health institute could advance equity in the state. The culminating report, *Seizing the Moment: How a Public Health Institute would Advance Health Equity in New Jersey*, suggests four potential goals for a public health institute in New Jersey:

- Collaborate within communities to advance health equity through authentic relationships and support capacity-building, using a social justice framework.
- Function as an assertive, responsive, nimble fiscal and administrative entity to support public health initiatives and health equity.
- Serve as a community-driven, trusted, and independent convener that leads the administrative, operational, and strategic efforts in the development of a public health institute.
- Support and use an accessible, easy-to-use, modern data infrastructure.

A New Jersey public health institute would be the first in the nation to include achieving health equity as a founding principle. To operationalize that principle, the institute should prioritize addressing root causes that perpetuate disparities and support community engagement and empowerment in advancing equity and quality of life. The institute should be a nonprofit entity independent of state or local government.
Recommendation 3:

The state should invest in transforming public health data systems to center equity and include practical, flexible data-sharing processes

The COVID-19 pandemic brought into focus serious gaps in New Jersey’s public health and health data infrastructure and exposed their role in perpetuating vast health inequities. The Robert Wood Johnson Foundation established the National Commission to Transform Public Health Data Systems to explore how to modernize public health infrastructure. Specifically, this group works to develop better ways to collect, share, and use data and identify the investments needed to improve health equity.

As the work of the Commission continues, New Jersey can begin work to ensure that state policies for public health data collection, sharing, and analysis are centered in equity and will enable exploration of the influence and consequences of structural racism on health and wellbeing. One example: Examine community-relevant metrics on structural factors that influence health outcomes, particularly “upstream” causes of inequity, by measuring the extent to which systems segregate, discriminate, and exclude. The California Department of Public Health adopted a framework from the Bay Area Health Inequities Initiative to help guide analysis, planning, and decision-making efforts in public health practices and health equity work.

New Jersey does not consistently or uniformly collect data critical to begin to understand a person’s health, wellbeing, and lived experience in the state. This limitation constrains the ability to understand the scope and reach of inequity and to develop data-driven solutions. Efforts to collect self-reported race, ethnicity, income, education, gender identity, sexual orientation, and disability are necessary. Complete data that can be disaggregated could be used to better identify areas of inequity where investment and action are needed.

Additionally, state public health officials can lead multisector collaboration around public health data sharing to improve the timeliness and quality of data to strengthen local decision-making. This can include partnering with local health departments and other departments that provide public health data (e.g., social services) to consider new collaboration models to improve the efficiency and timeliness of decision-making and action at state and local levels.

Conclusion

There is momentum to build on recent progress toward equity through a mutual commitment to the health and wellbeing of all New Jerseyans.

These efforts must address urgent and unmet needs with short-term and targeted policy solutions at the same time New Jersey shifts focus toward transformative change to counter the effects of nearly 250 years of intentional and de facto policy, practices, and norms that systematically excluded people of color from opportunities to thrive.

If policy led us to the status quo, relentlessly reforming policy, practices, and norms can help bring about a more inclusive system that centers on racial equity in processes and desired outcomes.

Arriving at this system will require leadership, collaboration, and engagement across all sectors and communities. Working toward racial equity will require deliberate, meaningful inclusion of residents in communities that have been marginalized, underserved, or excluded by policies and practices in the state. Much can be learned from them toward co-creating solutions to help make sure all New Jerseyans have what they need to achieve their best health. Reaching that goal will require governmental investment in resources targeted to respond to and repair the damage done by generations of underinvestment and poorly directed resources.
Reimagining, let alone shifting, structures will not be easy, quick, or simple to measure. The Robert Wood Johnson Foundations commits itself to broadly share these recommended policy options and bring together a wide range of interested and affected parties—including policymakers, philanthropy, community leaders of color, academics, and advocates. Deliberate collaboration to share knowledge and power, honor lived experience, and explore evidence-based solutions alongside bold but nascent ideas can help bring us closer to achieving racial equity. We will also explore ways to support the adoption and implementation of the recommended policy options, including through research, communications, advocacy, and technical assistance.

Finally, we are committed to measuring progress toward racial equity in New Jersey. Part of that will involve observing engagement levels of organizations and communities across the state in championing equity-promoting policies and assessing their impact on health. Traditionally, the reduction of racial disparities is seen as a measure of success. That may be a useful measure, but we should explore other measures that might more accurately detect changes in structures that perpetuate disparities.

We invite state and local policymakers and leaders from healthcare, nonprofits, businesses, communities, and other sectors to consider and advance the recommendations in this report with us. We urge investment in what the evidence and experience of others demonstrates can work, as well as a willingness to explore visionary ideas emanating from various communities, individuals, and sectors to fuel transformative change. Together, we can push toward equity across New Jersey and serve as a model for the nation.
Endnotes


5 To the extent possible, we specifically state which communities are most affected by a particular inequity based on available data. In some cases, we may use the broad phrase “people of color” or other similar terms to refer to Black, Indigenous, Latino or Hispanic, Asian, Native Hawaiian and other Pacific Islander people. The use of broad terms is intended to reflect the collective impact of structural inequity and is not intended to erase the unique experiences of any one group.


8 The American Public Health Association defines racial equity as “a state where a person’s racial identity does not predict their outcomes because everyone is assured the conditions that provide the opportunity for best health and wellbeing.”

9 This document focuses on racial and ethnic inequities and resulting disparities in health: We acknowledge that structural inequity and disparities co-exist and affect individuals along other planes, including gender, sexual orientation, disability, economic status, geography, and more.


13 The foreign-born population includes naturalized U.S. citizens, lawful permanent immigrants, refugees and asylees, individuals in the United States with student, work, or some other temporary visas, and people residing in the country without authorization.


16 ibid.

17 ibid.

18 National Academies of Sciences, Engineering, and Medicine, 2017.


U.S. Census Bureau, 2021.


ibid.

U.S. Census Bureau, 2021.

Green and Vargas Poppe, 2021.

Finding MG, Casey LS, and Fryberg SA, et. al.

This section and most of this report focuses on the Black and Latino experience in New Jersey because of the unavailability or limitations of existing state data for other racial and ethnic groups. This focus does not intend to erase or otherwise discount the experience of Indigenous, Asian American, Native Hawaiian and other Pacific Islander communities. Recommendations to improve data collection ensure all populations and experiences are seen are included in the last section of this report.


74. ibid.


80. ibid.


82. RWJF, 2019.


84. Researchers also considered and analyzed analogous legislation from Connecticut, New Jersey, and Oregon.

85. ibid.


92. ibid.


97. APHA, 2021.

98. ibid.


136 Ibid.


150 Gromis, 2019.


153 Ibid.


156 Ibid.


158 Ibid.
We use the term “women and pregnant people” when referring to people who are pregnant or recently gave birth to acknowledge that not all people who can become pregnant or give birth identify as women. In some cases, “maternal” is used to describe this population to be consistent with data sources.


RWJF, 2019.


Ibid.


198 ibid.


200 Center for Women and Work, 2021.


204 Herb and Lowrie, 2021.

205 ibid.

208 Herb and Lowrie, 2021.


210 Herb and Lowrie, 2021.

211 ibid.

212 RWJF, 2019.


218 ibid.

219 ibid.

220 Simmons and George, 2022.


222 ibid.


235 County Health Rankings & Roadmaps. 


243 Othering & Belonging Institute, 2018.


246 County Health Rankings & Roadmaps. Universal Basic Income.


