

Environmental Justice in Asheville

State of Black Asheville, Dr. Dwight Mullen

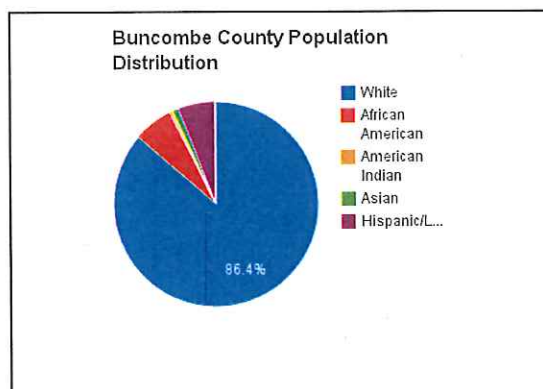
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I. Introduction

Asheville, North Carolina prides itself in its local produce, fresh mountain air, and wide-array of healthy dining options, especially vegan and vegetarian. Out of the 100 counties in North Carolina, Buncombe County ranked third in the category of “Clinical Care”, seventh for “Health Behaviors”, and eleventh for “Social and Economic Factors” in the *2012 Buncombe County Community Health Assessment*. While Buncombe fostered optimal scores for three of the five categories, it received thirty-second in “Morbidity” and fifty-ninth in “Physical Environment”. The parameters utilized to rank county Morbidity include citizens of poor or fair health, number of poor physical and mental health days, and instances of low weight births. Physical Environment encompasses the accessibility to recreational facilities, limited accessibility to healthy foods, number of fast food restaurants, and air pollution, including both ozone and particulate matter levels.¹

II. Racial Distribution



According to the last U.S. Census in 2010, Buncombe County is home to 238,318 inhabitants with 208,192 residents identifying as White^o (86.4%), 15,211 as African American^o (6.31%), leaving the remaining 17,619 residents identifying as Hispanic/Latino, Asian,

and American Indian, respectively (7.31%). Of the Buncombe County total, Asheville harbors 83,393 residents with a 79.3% White, 13.4% African American, 0.34% American Indian, 1.4%

¹<http://www.buncombecounty.org/common/health/CHA/CHA2012.pdf>(Page 45)

^oIt is implied that all references to the African American and White sector are both non-Hispanic.

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Asian, and 6.5% Hispanic population.² Of all the cities in Buncombe, Asheville has the largest African American community, though it has been steadily declining for years; for example the population has dropped 6% in just two decades. (19.7% in 1990)³

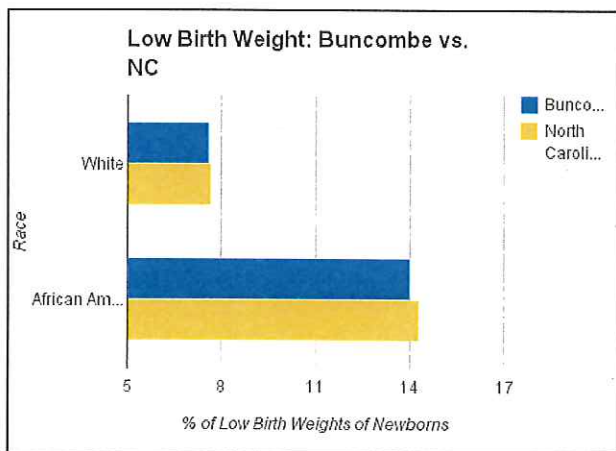
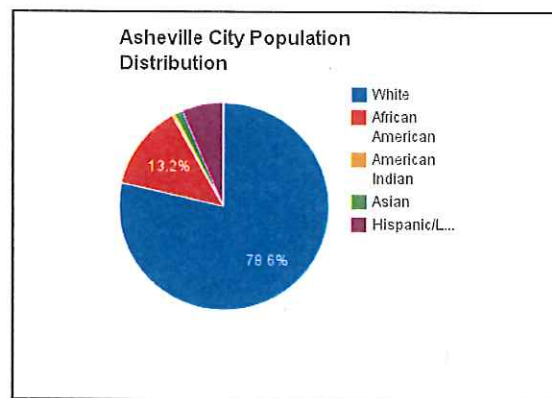
III. Health Outcomes

i) Infant Health: Prenatal/Neonatal

In Buncombe County, racial inequities begin to appear in the months prior to birth, with

African American babies having a 9.5 fetal death rate per 1,000 deliveries compared to 5.4 of White babies.⁴ Upon birth, African American babies experience double the rate of low birth weight (<2500 grams) than White babies.⁵ This is congruent to the North Carolina rates of 7.7% and 14.3% of low-weight births of White and African American newborns, respectively.

Similarly, the African American neonatal death rate was double the White rate and three times



the post-neonatal.⁶ Although mortality rates decline in both neonatal (<28 days) and post-neonatal (>28 days to 1 year) infants, the gap still persists within the racial sectors. However disparate the Buncombe outcomes, the inequities are not nearly as large as in Alexander County,

² <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

³ <http://censtats.census.gov/cgi-bin/pl94/pl94data.pl>

⁴ <http://www.schs.state.nc.us/SCHS/data/databook/CD11%20fetal%20death%20rates.html> (Rate from 2007-2011)

⁵ <http://www.schs.state.nc.us/SCHS/data/databook/CD4-6%20LBW%20&%20VLBW%20by%20race.html>

(Rate from 2007-2011)

⁶ <http://www.schs.state.nc.us/SCHS/data/databook/CD12A%20neonatal%20death%20rates.html> (Rate from 2007-2011)

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where the White post-neonatal mortality rate is 2.4 per 1,000 births while the African American infants spike an alarming rate of 11.9.⁷

ii) Sexual Health: Teen Pregnancy/Sexually Transmitted Infections

Relating to prenatal and neonatal health, a vast racial gap exists among teen pregnancies in Buncombe County. Unintentional pregnancies are less likely to receive adequate prenatal care,

thus developing a higher risk of low birth weight or prematurity in babies.

In 2011, the pregnancy rate per 1,000 girls between ages 15-17 differed substantially within the teen

populations: 18.7 for White, 50.5 for

African American, only to be exceeded by a rate of 51.3 for Hispanic teens.⁸ As demonstrated in Table 26, expanding the age demographic by two years spikes the overall rate of pregnancies while maintaining an alarming separation between White and African American girls. Although credible, this data lacks a complete account of all teen pregnancies due to the limited age of reproduction determined by the *2012 Buncombe County Health Assessment*.

Additionally among sexual health, rates per 100,000 cases of Gonorrhea (a common sexually transmitted infection) were considerably asymmetrical among racial populations. From 2006-2010, 528 reported cases were White and 542 cases were African American, fostering

Table 26. Pregnancy Rate, Ages 15-19, by Race, Pregnancies per 1,000 Women (2010)

| County | Total | | White Non-Hispanic | | African American Non-Hispanic | | Other Non-Hispanic | | Hispanic | |
|--------------------------|--------|------|--------------------|------|-------------------------------|------|--------------------|--------------|----------|------|
| | # | Rate | # | Rate | # | Rate | # | Rate | # | Rate |
| Buncombe County | 275 | 40.0 | 184 | 32.7 | 47 | 75.3 | 8 | 57.1* | 36 | 74.5 |
| Regional Total | 990 | n/a | 740 | n/a | 86 | n/a | 51 | n/a | 113 | n/a |
| Regional Arithmetic Mean | 62 | 46.3 | 46 | 42.2 | 5 | 72.2 | 3 | 50.3 | 7 | 73.0 |
| State Total | 15,957 | 49.7 | 6,525 | 34.4 | 6,292 | 70.2 | 609 | 48.9 | 2,456 | 82.7 |

* A figure in **bold italics** indicates an unstable county rate based on a small number of events
 Note: There is some instability in the regional mean rates indicated by **italics** because each includes one or more unstable county rate.

⁷ <http://www.schs.state.nc.us/SCHS/data/databook/CD12B%20postneonatal%20death%20rates.html>
 (Rate from 2007-2011)

⁸ <http://www.schs.state.nc.us/SCHS/data/databook/CD9A%2015-17%20Preg%20rates%20by%20race.html>
 (Rate from 2007-2011)

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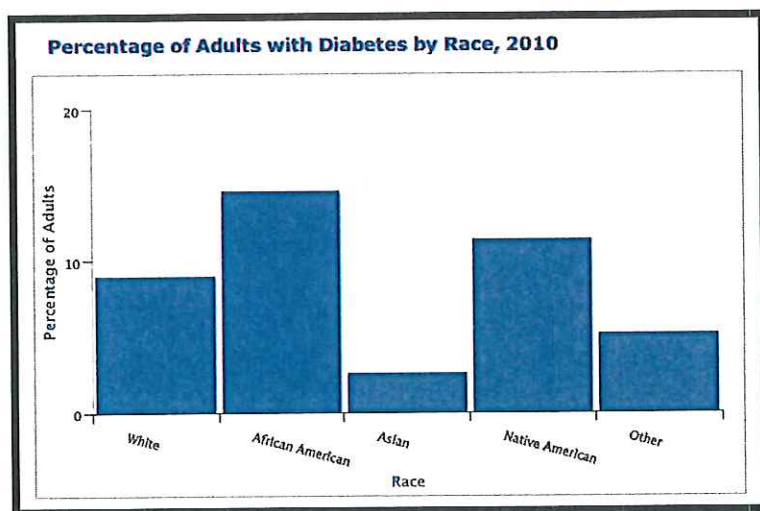
infection rates of 53.1 to 649.3, respectively.⁹

African Americans made up 48.3% of the reported Gonorrhea cases in Buncombe while only 6.3% of the total county citizenry. Considering the proportionality of the two percentages, it is deeply disturbing to see a minority population exceed case

numbers, especially with the high risks of problematic medical conditions if left untreated, including various forms of inflammation and prenatal/neonatal complications.¹⁰

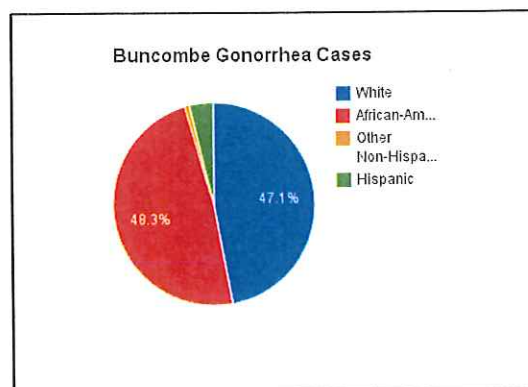
iii) Disease: Diabetes/Cancer

In North Carolina, 14.6% of African American adults were diagnosed with diabetes in 2010, followed by 11.4% Native American, 9.0% White, and 2.6% Asian adults.¹¹ In a July 2010



report, the State Center for Health Statistics and the Office of Minority Health and Health Disparities positioned diabetes as the fourth leading cause of death of African Americans in North Carolina with 747 recorded deaths in 2008. Additionally,

the report examines the rates of cancer among African American residents, the number-two killer that resulted in 3,459 deaths in 2008. Whilst the rates of breast, cervical, colon, and bladder



⁹<http://www.schs.state.nc.us/SCHS/data/databook/CD16%20gonorrhea%20rates.html> (Rate from 2006-2010)

¹⁰<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943790/>

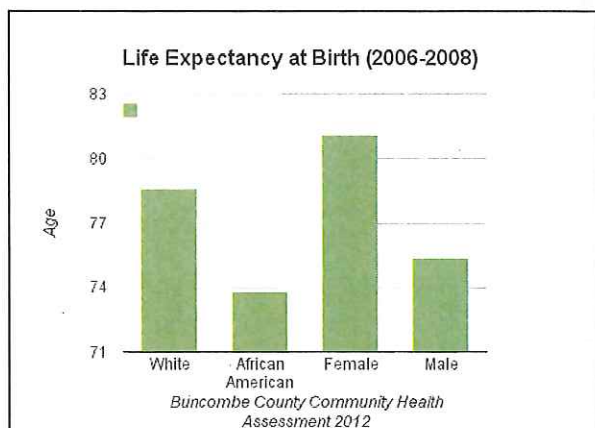
¹¹http://healthstats.publichealth.nc.gov/indicator/view_numbers/Diabetes.Race.html

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cancers among racial sectors were relatively equitable, the rate of prostate cancer among per 100,000 of the African American demographic was 242.5 while only 136.8 among the White.¹²

iv) Life Expectancies

This data can merely scratch the surface to explain the 5-year gap between the life expectancies of Whites and African Americans in North Carolina. Given the mortality rates and



health conditions of the specific racial and gender populations, the life expectancy is 78.6 for White residents in Buncombe County, 73.8 for African Americans, 75.4 for males and 81.1 for females.¹³ Life expectancy rates, as well as other health related statistics, can be related to a

wide web of causal changes, including education, income levels, residence location, etc.

IV. Data Analysis

Throughout this analysis, there will be implications to a type of racism recognized as *institutional racism*. Institutional racism differs from intentional racism in that the problematic outcomes do not stem from a specific source or person, but rather multiple formalities and policies within an institution or multiple institutions. Within the processes involved in situations of institutional racism, it can seem that some areas exhibit intentional racism, specifically in crafting policies, mapping electoral districts, and other arenas where there is a lack of racial

¹²http://www.schs.state.nc.us/schs/pdf/AfricanAmer_FS_WEB_080210.pdf

¹³<http://www.buncombecounty.org/common/health/CHA/CHA2012.pdf> (Page 100)

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diversity in leadership within the decision-making process (Walker, 2012). The difficulty in beginning to solve instances of institutional racism is pinpointing and reforming the vast web of potential causal factors.

i) Environmental Justice: History/Definition

As a result from governments locating hazardous waste sites proximal to low-income neighborhoods, the Environmental Justice Movement emerged throughout local communities during the 1980s. Correlating poverty, race, and environmental hazards mobilized racial minority communities to protest against *environmental racism*: a term alluding to intentional racial inequity in the exposure to environmental hazards. The initial movement highlighted the environmental discriminations among socioeconomic and racial classes and how these inequalities affected living conditions. The recent civil rights activism paved a favorable atmosphere for the emerging community grassroots organizations. Like many movements in history, this movement began to encompass a broad spectrum of environmental discriminations and took a more “positive” outlook by seeking environmental justice. (Walker, 2012)



A demonstration in Warren County, NC against the location of a toxic waste site. Led by both religious and civil rights leaders. (1982)

Environmental Justice is not exclusive to addressing the detriments to human health from waste site pollution and the exploitation of natural resources; it also incorporates the limited access to fundamental environmental resources such as healthy food and clean air. Being that Buncombe County is 59th in the Physical Environment category in the 2012 *Buncombe County*

¹⁴ Picture obtained from an article written by Cheryl Katz in *Environmental Health News*.
<http://www.environmentalhealthnews.org/ehs/news/2012/pollution-poverty-people-of-color-day-9-qa-with-environmental-justice-pioneers>

Community Health Assessment, these health disparities begin to suggest the role of poor environmental conditions among African American residents.

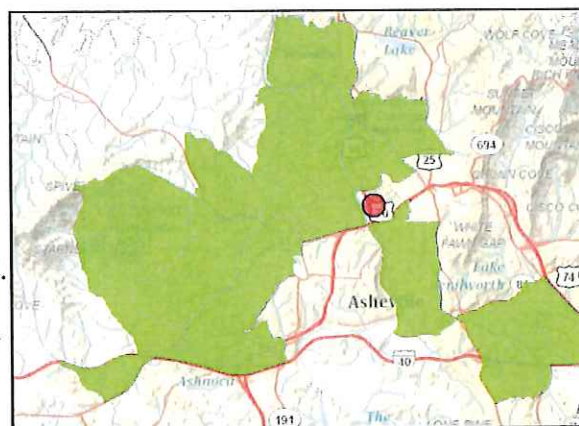
ii) “Physical Environment”: Access to Healthy Food

“Food Deserts and Health”

Food deserts are defined by the United States Department of Agriculture as “areas with limited access to affordable and nutritious food”.

¹⁵ Consequences of limited food accessibility by these food deserts can result in detrimental and expensive health problems, such as diabetes and even fetal malfunctions. Dr. Dean Ornish, Clinical Professor of Medicine at UC San Francisco, has analyzed the positive effects of a healthy diet full of mostly fresh produce among patients diagnosed with prostate cancer.¹⁶ The quality of food that one consumes directly contributes to the quality of one’s health. People can become trapped into paying expensive costs of pharmaceuticals to maintain their health when poor or limited access to healthy food was unavailable to them in the first place. Considering the disparity among instances of prostate cancer in North Carolina (see page 5), Dr. Ornish’s research should reemphasize the necessity of access to healthy food, especially among minority and low-income sectors.

Figure 1 Food Deserts in Asheville (1 mile or greater)

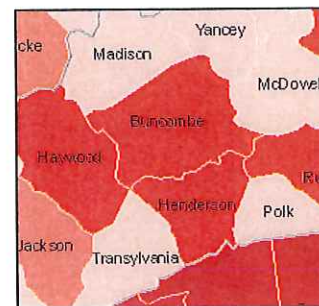


¹⁵ <http://www.ers.usda.gov/publications/ap-administrative-publication/ap-036.aspx#.UXawnqI3tRY>

¹⁶ http://www.youtube.com/watch?feature=player_embedded&v=ECaI1XwonN0

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The USDA provides interactive maps on their website with many layers highlighting areas of food deserts, low-income, and limited vehicle access. These food maps consider the accessibility to large chain grocery stores rather than local stores or farmers markets. Although Buncombe is home to more farmers markets than many other counties, it experiences a greater low-access population than four of its seven surrounding counties.¹⁷



Darker shade = greater concentration

From the interactive Food Environmental Atlas, Buncombe County fostered both positive and negative data. Due to the abundant agriculture of the area, Buncombe served fairly well in the number of farms, including Community Supported Agriculture and vegetable farms. However, the latest record of “Farm to School” programs in 2009 brought a dismal reality of only a single program. This directly affects the impoverished children in Buncombe (at a rate of 24.20%) and the 12,670.83 children with low access to a grocery store (2010). Additionally in 2009, 38.75% of Buncombe students were free-lunch eligible and 8.55% eligible for a reduced price.¹⁷

“Progress in Food Accessibility”

In 2012 the USDA extended funding to increase the farmers market accessibility of people who relied on the government-funded Supplemental Nutrition Assistance Program (SNAP).¹⁸ This funding could very well aid the 20,608.28 Buncombe inhabitants with low-income and low-access to grocery stores as well as the 16.47% of the 2011 population that

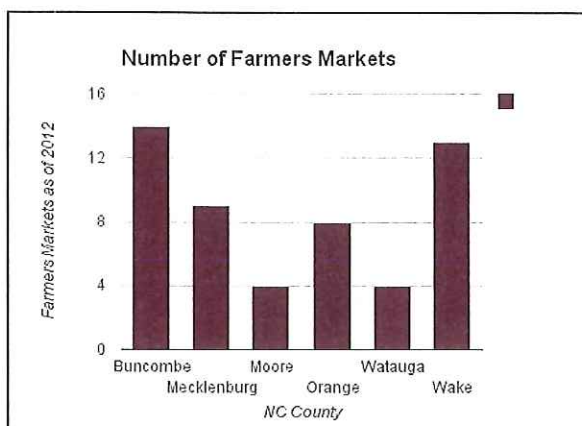
¹⁷ <http://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas.aspx#.UXasW6I3tRY>

¹⁸ http://www.fns.usda.gov/snap/rules/Memo/2012/FM_051112.pdf

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participates in SNAP. Since 2008, Buncombe County fostered a 63% increase in the number of SNAP-authorized stores, bringing the total amount to 211 in just three years. Additionally, a specialized SNAP program designated for Women, Infants, and Children (WIC) also

experienced slight growth in Buncombe, bearing 42 WIC-authorized stores in 2011.



iii) “Physical Environment”: Levels of Ozone and Particulates

“Air Pollution Data”

In addition to the Physical Environment category, the substandard ozone and particulate levels could possibly affect the quality of health of Buncombe inhabitants. GoodGuide, a private third-party research organization, provides an online community scorecard determining pollutant type, location, and concentration and analyzing any racial, financial, or educational disparities pertaining to environmental burdens.¹⁹ Using their team of chemists, toxicologists, nutritionists, etc., GoodGuide analyzes counties’ environmental quality and provides a percentile rank based on the comparison of other U.S. counties. Buncombe County’s 1996 emissions data was ranked among the worsts counties in the United States: 80th percentile for added cancer risk from hazardous air pollutants (HAP) and 90th percentile for the number of people living in these areas with high cancer and HAP risks.²⁰ Based on EPA air quality estimates and chemical toxicity

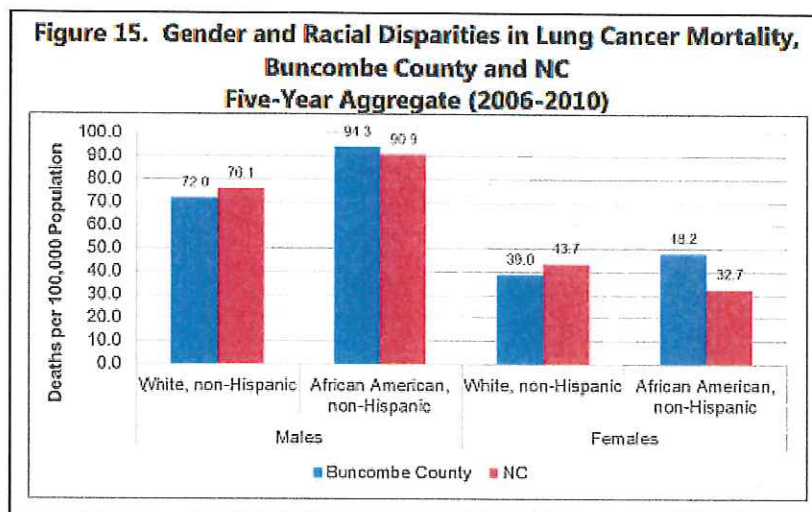
¹⁹ <http://www.goodguide.com/>

²⁰ http://scorecard.goodguide.com/env-releases/hap/county.tcl?fips_county_code=37021#maps

data, GoodGuide calculated the risk of cancer from HAP to be almost double for People of Color than Whites in Buncombe.^{21 22}

“Lung Cancer Data”

Although less than 10% of the Buncombe population, African Americans surpass Whites with a ratio of 9 to 22 lung



cancer deaths per 100,000 persons. The mortality rate for both African American males and females were higher in Buncombe County than statewide, with the largest gap existing among African American females. On the contrary, the number of lung cancer deaths of the county's White population was lower than state levels.²³ Dissimilar to the rate of mortality, the age-adjusted rate of diagnosed lung cancer is lower for African Americans (69.9) than White (76.9) North Carolina residents. Based on survey data from the North Carolina Behavioral Risk Factor Surveillance System (BRFSS), the current rates of adult smokers were relatively similar percentages among White and African American North Carolinians: around 22%. Lacking deviation among cigarette smokers, the dissimilar racial outcomes between the diagnosis and mortality rates bring to question the accessibility and/or quality of health care among the African American population. Similar BRFSS survey data estimated that 23.1% of African Americans in

²¹ http://scorecard.goodguide.com/env-releases/def/ej_burdens.html#hap

²² http://scorecard.goodguide.com/community/ej-summary.tcl?fips_county_code=37021&backlink=cap-co#dist

²³ <http://www.buncombecounty.org/common/health/CHA/CHA2012.pdf> (page 67: Figure 15)

North Carolina had no current health insurance, 20.6% could not see a doctor due to cost, and 21.2% did not have a personal doctor.²⁴

V. The Necessity of Environmental Justice

The United States has had a deep history of racial disparities in health care outcomes (along with many others) simply because of the second-class citizenship hoisted upon Native American tribes, African slaves, and other immigrant and minority groups. These sectors did not receive equal or adequate health care and the number of deaths can only begin to account for these disparities. Living in 2013, where these second-class standards are no longer permissible by law, it seems contradictory to find that these outcomes still exist if these explicit discriminatory laws are no longer upheld.

Currently, policies in the United States often differentiate citizens based on socioeconomic status rather than by race, despite that many members of the impoverished community identify with racially minority groups. It seems permissible and non-racist to simply rely on the “free market”, thus creating an accepted notion of “societal Darwinism” to account for the disparate outcomes. When racial disparities do occur, it becomes easy for policy-makers to blame the economy or even the work ethic of poor individuals rather than blaming the policies that persist these overt racial inequities.

Similar to a Hindu caste system, people in America are not born with equal opportunities to live an optimal quality of life. Despite Thomas Jefferson’s claim that “all men are created equal” in the *Declaration of Independence*, federal policies have made, and have continued to

²⁴ http://www.schs.state.nc.us/schs/pdf/AfricanAmer_FS_WEB_080210.pdf (page 2: Table 3) (page 5: Table 4, Figure 5)

make, second-class citizenship and unequal opportunities permissible by law. For example, “owning” an African American slave as property was permissible until the Thirteenth Amendment of the U.S. Constitution was ratified. Until 1920, women were legally suppressed from their right to participate in their own democracy. Today in North Carolina, the law prohibits equal treatment between civil unions (both hetero and homosexual) and married couples. Similarly, various local policies can affect the adequate accessibility and equal opportunity for its citizenry. For example, the Asheville city bus does not run on Sundays, thus limiting the opportunity for people without the luxury of a car to travel to grocery stores, medical appointments, or any other location to maintain a safe and healthy lifestyle.

VI. Conclusion

Based on the breakdown of this data, racial inequalities still exist within health outcomes despite governments dismantling recognizably racist policies. While this analysis correlates environmental inequities with health disparities, there are several components within public policies that contribute to these outcomes. To combat institutional racism, citizens and lawmakers must demand change in the policy areas that continue to generate racially inequitable results.

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