Senator Osten, Representative Walker and Members of the Appropriations Committee of the Connecticut General Assembly:

My name is Thomas Buckley, I am a professor at the UConn School of Pharmacy and taught the public health and health policy course. I am also the co-chair of the healthcare team of the Greater Hartford Interfaith Action Alliance (GHIAA) and I live in Avon. I stand in support of H.B. 6662: An Act Declaring Racism as a Public Health Crisis and Establishing the Commission on Racial Equity in Public Health.

I want to applaud the committee for declaring racism as a public health crisis in Connecticut. I would like to offer thoughts on how the commission created in this bill can avoid lacking accountability. There have been many commissions and reports over the past 20 years that have documented how structural racism has created barriers to care and poor health outcomes. Perhaps one of the most famous is the 2003 Institute of Medicine report, commissioned by Congress, titled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare." This report clearly connected racism in mortgage lending, access to housing, employment, and criminal justice to racial health disparities.

The COVID pandemic has pulled back the curtain on disparities that many have known for years. I want to highlight a few data reports in Connecticut from before the pandemic and from now which struck me as conspicuously similar. The Connecticut Health Foundation released a report in 2018 which stated that Connecticut ranked as the 5th healthiest state in the country, but we were 43rd in health disparities. In its January 2020 report, it described this data as reasons why we have that ranking: Black residents are 5 times more likely than white residents to visit the emergency department for asthma, black residents are 4 times as likely and Hispanic residents twice as likely than white residents to be hospitalized for diabetes, babies born to black women are 3 times as likely and Hispanic babies 2 times likely to die than babies born to white women.

Access HealthCT released a report in February 2021 showing nearly similar disparities in COVID-19 cases, hospitalizations and deaths. Last month we learned that Connecticut had the 4th highest rate of COVID vaccinations in the nation, but also last month we learned that Connecticut has the highest disparity in vaccination rates between its richest and poorest communities — a difference of 65%. Other states are not close, New Jersey has the 3rd highest gap and it's only 28%. Any gap in vaccinating rich versus poor inevitably exacerbates racial divides. Black and Latino people are far more likely to live in poverty than white people, and despite having died at higher rates throughout the pandemic, they are receiving fewer vaccines than white people.

In this past month we also learned that the Governor didn't follow the recommendations of his vaccine allocation sub-committee when he rolled out vaccine criteria by just age. Focusing on areas with high co-morbidities would identify underserviced communities, and these are communities of color. Last week we learned that Connecticut again did not reach its vaccine equity target goal.

Because of historical and current data in Connecticut I urge the committee to look at the report from The Justice Collaborative Institute at St. Louis University, “Racism is a Public Health Crisis. Here’s how to respond”, which I have included with my testimony. It states governments declaring racism as a public health crisis is an important first step. Then it suggests five best practices a law or policy should include: (1) Define racism as a system that impacts all the key areas of the social determinants of health, which must be dismantled to achieve racial equity; (2) Provide material, institutional, and social supports to redress the historical and current practices of racism; (3) Require the use of a racial equity tool to determine whether government laws reinforce racism; (4) Give racial and ethnic minorities the power to participate in the decision-making process; and (5) Incorporate a healing process, such as a Truth and Reconciliation process, to address the trauma of experiencing racism.

Again, I applaud the committee for declaring racism a public health crisis, and I urge you to consider any one of these best practices, preferably all of them, be incorporated in the bill.

Thank you for the opportunity to present before your committee.

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DATA FOR PROGRESS

THE JUSTICE COLLABORATIVE INSTITUTE

RACISM IS A PUBLIC HEALTH CRISIS.

Here's how to respond.

Ruqaiijah Yearby *Professor of Law and Executive Director, Institute for Healing Justice and Equity, Saint Louis University*

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September 2020

EXECUTIVE SUMMARY

Racial disparities in health and wellbeing are well documented. In 2003, the Institute of Medicine issued the landmark report Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, which connected racism in mortgage lending, access to housing, employment, and criminal justice to racial health disparities. This report and the World Health Organization's 2008 report on health equity led to the U.S. Department of Health and Human Services' Social Determinants of Health Framework (SDOH), which recognized that racial health disparities are a result of inequalities in education, employment, healthcare, housing, and law enforcement.

Ten years after the SDOH framework was published, racial health disparities persist and have a significant impact on healthcare costs and lost life. For example:

- Between 2007 and 2016, Black, Native, and Alaska Native women were two to three times more likely to die from pregnancy-related causes than white women—and this disparity increases with age.
- Black people had higher death rates than white people for all-cause mortality in all age groups <65 years between 1999 and 2015.
- Black, Native, Alaska Native, and Latina women were more often diagnosed with stage 3 breast cancer than white and Asian or Pacific Islander women, which was tied to a lack of health insurance.
- Racial health disparities are estimated to cost the United States $175 billion in lost life years (3.5 million lost years at $50,000 per life year) and $135 billion per year in excess healthcare costs and untapped productivity.

In the past, most governments attributed racial health disparities only to specific instances of racism, such as redlining or residential segregation. But the COVID-19 pandemic and recent police violence have laid bare a system of racism that drives inequality in all aspects of American life, including education, employment, healthcare, housing, and law enforcement.

Racism in the United States can be traced back over 400 years to the arrival of the first slave ships and remains deeply embedded in the structure of American culture and society. It has led to recent public health crises like the Flint water crisis and the opioid epidemic, which have had a devastating and disproportionate effect on communities of color, particularly Black communities.[1] Anti-discrimination laws, such as the Civil Rights of Act of 1964 and the Equal Protection Clause of the 14th Amendment, prohibit institutional and some interpersonal racism, as defined below, but are too narrow in scope to fully combat the systemic racism that causes racial health disparities. They focus on individual perpetrators and victims, not the system as a whole.

1. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J. of L. Med. & Ethics 518-526 (September 2020)

Across the country, some jurisdictions have started to formally recognize the connection between racism and the SDOH, mostly in response to police violence against Black people and nationwide demands for racial justice. Between March and July 2020, 84 cities and towns as well as 42 counties declared racism a public health crisis. Only four cities and two counties passed the same laws between January 2019 and February 2020. Two state governors have issued executive orders and several federal bills have been proposed, including the Anti-Racism and Public Health Act of 2020, sponsored by Senator Elizabeth Warren and Representative Ayanna Pressley, which would house a national public health response to racism within the Centers for Disease Control and Prevention (CDC).

Declaring racism as a public health crisis is an important first step. Doing so acknowledges that racism exists and that government has a duty to dismantle the system of racism, instead of leaving the burden on individual victims of racism to file lawsuits. This is a critical shift in how to see racism and craft solutions to address it. Yet a declaration, without more, is not enough. Building on our past work, the health justice framework, and the W.K. Kellogg Foundation's Truth, Racial Healing & Transformation process, we suggest that laws and policies declaring racism a public health crisis:

1. Define racism as a system that impacts all the key areas of the SDOH, which must be dismantled to achieve racial equity, thereby ending the public health crisis;
2. Provide material, institutional, and social supports to redress the historical and current practices of racism that have harmed racial and ethnic minorities;
3. Require the use of a racial equity tool to determine whether government laws, policies, and practices reinforce racism;
4. Give racial and ethnic minorities the power to participate in the decision-making process as well as craft laws, policies, and practices that will address their current needs and redress past harms; and
5. Incorporate a healing process, such as a Truth and Reconciliation process, to address the trauma of experiencing racism.

While some governments (state and local) have included definitions of racism, funding to address racism, and evaluation of community engagement measures, none of the current laws and policies include all these best practices.

RACISM AS A SYSTEM

Our inability to adequately address racism in American society is due in part to our failure to accurately define and conceptualize it. Racism is a byproduct of the social construction of what we know as "race." It is a social system where a racial group in power creates a racial hierarchy in which other racial groups are deemed inferior. In the United States, this hierarchy is reinforced by social norms and institutional practices. The system of racism includes four different types of racism.

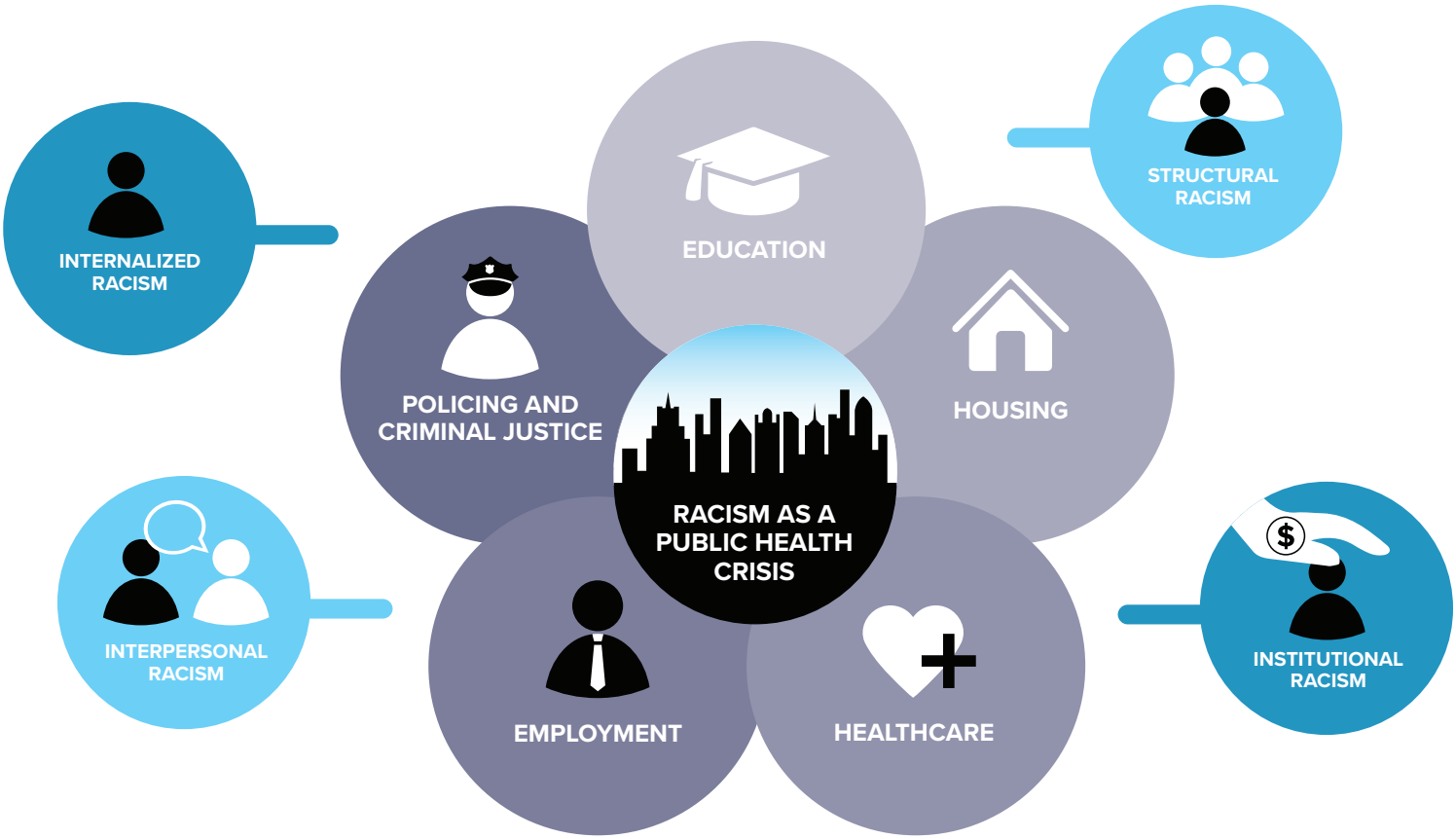
- **Structural racism** is the way key areas (education, employment, healthcare, housing, and law enforcement) are structured to advantage the group in power and disadvantage racial and ethnic minorities.[2]

2. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J. of L. Med. & Ethics 518-526 (September 2020).

Law is one of the tools used to structure key areas in this manner.

- **Institutional racism** operates through institutions' "neutral" practices and policies that establish separate and independent barriers for racial and ethnic minorities. These barriers not only impose substantial material harm, but also reinforce the racial hierarchy that racial and ethnic minorities are inferior to white people.
- **Interpersonal racism** operates through individual interactions, where an individual's conscious (explicit) and/or unconscious (implicit) racial prejudice restricts equal access to the key areas of the SDOH.
- **Intrapersonal or internalized racism** is when racial and ethnic minorities accept stereotypes about themselves and those who share the same racial identities, while believing that members of other racial groups are superior, which can be harmful to the psychological wellbeing and physical health of racial and ethnic minorities.

Shown in Figure 1, the system of racism causes racial inequalities in the key areas of the SDOH (education, employment, healthcare, housing, and law enforcement), which are associated with racial health disparities. Examples of how different types of racism impact each of the key areas of SDOH are discussed below.



Racism in Education

Funding education through property taxes is an example of **structural racism** because it is tied to the historical practices of redlining and over-valuing white residential property and neighborhoods. And even when racial and ethnic minorities pay more property taxes than white people, they still receive fewer public services, including educational funding. **Institutional racism** in education includes the seemingly "neutral" zero tolerance policies that have been disproportionately applied to racial and ethnic minority children. As a result, Latinx, Native, and Black children—especially Black girls—are more often expelled from school or receive more out of school suspensions compared to white children. Although the policies are, on the face of it, race "neutral," disparate enforcement reinforces the narrative that racial minorities are inferior because they cannot comply with school policies. **Interpersonal racism** is illustrated by the drawing of school district boundaries to keep out racial and ethnic minority students. Even after *Brown v. Board of Education*, racial segregation in education is perpetuated by, among other things, wealthy white communities that intentionally separate from larger, racially diverse school districts.

Racism in Employment

In employment, **structural racism** is illustrated by Jim Crow era (1875-1964) laws that expanded collective bargaining rights while either explicitly excluding racial and ethnic minorities or allowing unions to discriminate. This disproportionately excluded racial and ethnic minority workers from paid sick leave, forcing them to work even when they were sick, a problem that today has caused racial disparities in COVID-19 infections and deaths. **Institutional racism** includes the "neutral" decision to use salary history to determine wages, even though it results in racial and ethnic minorities being paid less than white men who do the same work. This process, while neutral on its face, reinforces the racial hierarchy because competency and work ethic are associated with pay. **Interpersonal racism** is at work when Black employees are penalized for negotiating their pay rate. A 2018 study found that Black "job seekers are expected to negotiate less than their white counterparts and are penalized in negotiations with lower salary outcomes when this expectation is violated." Hence, an individual's conscious and/or unconscious prejudice limited racial and ethnic minorities' pay, even when they tried to negotiate an equal salary. Research shows that experiencing racism at work has also been linked to lower psychological wellbeing for Black women, including "higher job stress and post-traumatic stress symptoms," in part because of internalizing the feelings of inferiority. Workplace discrimination and harassment combined with **Intrapersonal racism** has also been linked to problem drinking, including alcoholism and drinking to intoxication, and substance abuse in racial and ethnic minorities.

Racism in Healthcare

Structural racism is seen in the provision of healthcare based primarily on a patient's ability to pay, rather than on medical needs. Racial and ethnic minorities, who are disproportionately poor, have less access to affordable healthcare and health insurance. Unable to also afford the full cost of, or pay upfront for, healthcare, these individuals often forego needed treatment, resulting in racial disparities in mortality. According to law professor Vernellia R. Randall, **institutional racism** in healthcare "manifests itself in (1) the adoption, administration, and implementation of policies that restrict

admission; (2) the closure, relocation, or privatization of hospitals that primarily serve racially disadvantaged communities; and (3) the continued transfer of unwanted patients (known as "patient dumping") by hospitals and institutions to underfunded and overburdened public care facilities. Such practices have a disproportionate effect on racially disadvantaged groups; banishing them to distinctly substandard institutions or to no care at all."[3] These "neutral" policies and practices reinforce the racial hierarchy that Black lives do not matter. **Interpersonal racism** in healthcare is illustrated by research showing that physicians provide less than the recommended care to Black people, including being less likely to refer Black patients compared to white patients to specialists and high quality hospitals. Black men who experience racism and internalize it have shorter telomeres, which is linked to accelerated aging and is an example of **intrapersonal racism**.

Racism in Housing

In the housing arena, steering Black and Latinx borrowers to subprime loans is an example of **structural racism**. From 2004 to 2009, some banks disproportionately steered Black people and Latinxs into subprime loans when they qualified for conventional loans, leading to racial inequalities in foreclosures during the mortgage crisis. **Institutional racism** affects many communities where race "neutral" zoning laws were passed to prohibit affordable housing and keep property values high, disproportionately shutting out Black residents. Moreover, current research shows that landlords are still less likely to rent to applicants with Black-sounding names, and a recent investigation found that real estate agents steer Black home buyers into integrated neighborhoods and away from white neighborhoods, both examples of **interpersonal racism**. As a result of racism, housing segregation persists and predominantly Black neighborhoods continue to have substandard housing, poor schools, few job prospects, lack access to healthy foods, and unsafe streets.

Racism in Law Enforcement

Structural racism in law enforcement leads to different types of policing in different neighborhoods. While the police protect white neighborhoods, their approach in Black and Brown communities is to dominate. Racialized police violence is an example of **institutional racism** as it utilizes racially "neutral" statistics about crime, poverty, and health to surveil communities that have been marginalized by racial residential segregation and have limited or no access to education and employment opportunities. **Interpersonal racism** is illustrated by racial profiling, which leads to racially skewed and inflated crime data, thereby supporting policing that targets poor, Black, and Latinx neighborhoods. Living in over-policed neighborhoods results in higher rates of chronic conditions for racial and ethnic minorities. Experiences of police brutality are also associated with a lack of trust in healthcare facilities. The spillover effects of these acts of violence have gendered consequences: Black men are more likely to be incarcerated and removed from neighborhoods, while Black women are more likely to remain in these neighborhoods and be subjected to police sexual violence, which increases stress and their risk for obesity and heart disease.

3. Vernellia R. Randall, *Race, Health Care and the Law Regulating Racial Discrimination in Health Care*, United Nations Research Institute for Social Development Conference Paper, Sept. 2001, at 6.

RACISM AS A PUBLIC HEALTH CRISIS

Given that systemic racism drives the racial inequalities that cause racial health disparities, racism should be defined—and responded to—as a public health crisis. The current public health (SDOH framework) and legal (anti-discrimination laws)[4] responses are inadequate because they focus only on a specific action or perpetrator rather than the system of racism.[5] This legitimizes the existing social system of racism, leaving in place a racial hierarchy that is reinforced by social norms and institutional practices.

To achieve racial equity—to achieve, that is, a new reality where race can no longer predict life outcomes and where outcomes for all groups are improved—governments must dismantle the system of racism. They must provide support, consistently evaluate whether government actions reinforce racism, partner with racial and ethnic minorities to craft solutions, and incorporate a healing process to address the trauma of experiencing racism.

Current Laws and Policies

Laws recognizing racism as a public health crisis have been enacted or introduced at the local, state, and federal levels. As of July 30, 2020, 88 cities and towns and 44 counties across the United States had policies recognizing racism as a public health crisis, with most adopted after recent episodes of police violence (**see Appendices A and B**).

These declarations have been enacted through local government legislation, such as city council resolutions, and mayors in 10 cities have issued executive orders acknowledging that racism is a public health crisis. County policies have typically passed through county commissioner and/or County Board of Health resolutions.

State leaders have also recognized racism as a public health crisis. In 2017, the University of Wisconsin's Population Health Institute and the Wisconsin Public Health Association held a convening of grassroots groups, community-based organizations, government agencies, and academic leaders. Participants were urged to acknowledge the deep impact of racism on health disparities and the community's role in addressing it. One year later, the Wisconsin Public Health Association passed a resolution declaring that racism is a public health crisis and committed to taking action. This created a domino effect for other community partners to join the declaration and provided a model for the city, town, and county resolutions being enacted today.

On August 5, 2020, Michigan became the first state to declare racism as a public health crisis.[6] Michigan Governor Gretchen Whitmer's executive order declared racism a public health crisis, mandated a state advisory council centered around Black leadership, and required the Michigan Department of Health and Human Services to ensure that all state employees complete implicit bias training in an effort to "make health equity a major goal." That same day, Nevada Governor Steve Sisolak signed an

4. Alan David Freeman, *Legitimizing Racial Discrimination Through Antidiscrimination Law: A Critical Review of Supreme Court Doctrine*, 62 Minn. L. Rev. 1049-1053 (1978).
5. Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J. of L. Med. & Ethics 518-526 (September 2020).
6. Reports show that Wisconsin was the first state to issue a law declaring racism as a public health crisis, however, we were unable to find evidence beyond a statement at this time. Thus, we noted that Michigan was the first state to issue a law or policy declaring racism as a public health crisis.

executive proclamation declaring racism a public health crisis, and highlighting racial inequality in mental health services, education, and career opportunities.

Currently, there is state-wide legislation pending in five other states (**see Appendix C**).

At the federal level, several bills are pending in Congress. In July 2020, Ohio Senator Sherrod Brown, Connecticut Representative Jahana Hayes, and several of their colleagues introduced a bicameral resolution to declare racism a public health crisis, require the United States to recognize its racist history, and establish a nationwide strategy to address racial health disparities.

Senator Elizabeth Warren and Representative Ayanna Pressley are sponsoring the Anti-Racism and Public Health Act of 2020, which will create a National Center on Anti-Racism and Health at the CDC and a law enforcement violence prevention program. Among other things, the center would declare racism a public health crisis, research the impact of racism on health and wellbeing, and develop interventions to dismantle structural racism. It would also direct funds to state and local governments for research and anti-racism efforts. Crucially, the bill defines key concepts necessary to understanding and addressing the problem including "structural racism," "anti-racism," and "anti-racist." These definitions are imperative for a shared understanding of what these words mean to us as a society and how we plan to fix the problem.

RECOMMENDATIONS

By declaring racism a public health crisis, governments acknowledge they have a responsibility to put an end to the system of racism. Some of the current and proposed laws have gone further than acknowledgement, providing funding to research racism specifically through a public health lens, for example, and collaborating with impacted communities. Yet, there are still gaps in the laws and policies. Below are recommendations for governments interested in enacting laws declaring racism a public health crisis, including examples of measures that have already passed.

First, the laws and policies must identify racism as a system that causes racial inequalities in housing, healthcare, education, employment, and law enforcement, resulting in physical and physiological harm. Defining racism as a system not only moves beyond the current limited conceptions of racism in the SDOH framework and law, it also ensures that solutions crafted to end racism change the system.

Although no law or policy has defined racism as a system, 22 of the localities listed in **Appendix A** have policies that include definitions of racism that go beyond institutional and interpersonal racism. For example, the resolution passed in Manchester, Connecticut, notes that "race has no biological basis" and that racism is defined as "a social construct" covering individual racism, interpersonal racism, internalized racism, systemic racism, and institutional racism and "affords opportunity and assigns a person's value based on the social interpretation of how one looks." And Durham County, North Carolina, defines both racism and white supremacy. Its resolution references the American Association of Pediatrics' definition of racism as "a socially transmitted disease passed down through generations, leading to the inequities observed in our population today," and defines white supremacy from the socioeconomic context, which "refers to a system in which white people enjoy a structural advantage (privilege) over other ethnic groups, on both a collective and individual level."

Second, research in 2016 showed that if economic trends continued, it would take 228 years on average for a Black family and 84 years for a Latinx family to accumulate the same wealth as a white family. During the COVID-19 pandemic, economic conditions have worsened disproportionately for Black and Latinx people compared to white people. Thus, because racism limits equal opportunities for wealth, education, employment, and housing over multiple generations, the harms from this racism cannot be justly and fully rectified without providing material, institutional, and social support.

In Asheville, North Carolina, for example, the city council in July unanimously approved a reparations policy for its Black residents. Instead of focusing on the traditional meaning behind reparations, Asheville created a Community Reparations Commission to draft a report on "increasing minority homeownership and access to other affordable housing, increasing minority business ownership and career opportunities, strategies to grow equity and generational wealth, closing the gaps in healthcare, education, employment and pay, neighborhood safety and fairness within criminal justice." City leaders said, "the goal is to help create generational wealth for Black people, who have been hurt by income, educational, and healthcare disparities."

In Boston, Mayor Marty Walsh said he would reallocate $3 million (1%) of the police department's overtime budget to addressing racism and public health because "racism [negatively] shapes lives and hurts communities." Walsh also proposed an additional $9 million from the police department's overtime budget be used to fund initiatives around housing, counseling, and supporting minority-owned businesses. This funding ensures that the declaration is more than mere ceremony. In Michigan, Washtenaw County's resolution outlines several ways the county plans to address health disparities, including increasing the budget for the county's health department and racial equity office as well as enacting universal paid leave for employees (including, but not limited to, paid parental leave).

Third, governments must use racial equity tools in their decision-making processes to anticipate and mitigate any racially disproportionate harms. Many local governments, including Asheville, North Carolina; Ann Arbor, Michigan; Seattle; and Alameda County, California, are already using racial equity tools to organize their governmental response to address structural racism.[7] These tools can be used to engage communities and evaluate if and how proposed policies disproportionately affect different racial and ethnic minorities.

Specifically, the Seattle Race and Social Justice Initiative, a city-wide effort to eliminate racial disparities, follows six steps "to guide the development, implementation, and evaluation of policies, initiatives, programs, and budget issues to address the impacts on racial equity." These include: set outcomes for racial equity; involve community stakeholders and analyze the data; determine the benefits and/or burdens on racial equity; develop strategies to create greater racial equity or minimize harms; track impacts on racial equity with the involvement of the community; and share information to resolve any issues. As a result, a majority of city employees have received racial justice training and between 2009 to 2011 the city increased money to minority-owned businesses from $11 million to $34 million.

7. Sidney Watson, Katherine Stamatakis, Ruqaiijah Yearby, Keon Gilbert, and Charysse Gibson, *Cities and Counties Using Racial Equity Tools to Dismantle Structural Racism and Improve Health* (forthcoming 2020).

Fourth, dismantling systemic racism requires collaboration with marginalized communities. The system of racism is about hierarchy and power, and those in power have made decisions that harm those without power, especially racial and ethnic minorities. Consequently, laws and policies to address racism as a public health crisis must engage community members, which includes true collaboration with shared decision making, building alliances, and community involvement throughout the entire process, not merely for completing certain tasks. Additionally, racial and ethnic minorities must be given equal power in crafting laws, policies, and practices that will address their current needs and redress past harms. For instance, the Washtenaw County, Michigan, resolution requires community engagement and dedicates resources to work in solidarity with social movements for racial justice and in partnership with community members.

Fifth, and finally, racism will not be addressed without healing. As the W.K. Kellogg Foundation notes, transformational and sustainable change must include "ways for all of us to heal from the wounds of the past, to build mutually respectful relationships across racial and ethnic lines that honor and value each person's humanity, and to build trusting intergenerational and diverse community relationships that better reflect our common humanity." Providence, Rhode Island, put this into practice with a truth telling and reparations process. The process began with the mayor and a group of advisers meeting to develop "a plan for sharing the state's role throughout history in the institution of slavery, genocide of Indigenous people, forced assimilation and seizure of land," followed by city leaders reviewing laws and policies that resulted in discrimination against Black and Native people. Finally, the city plans to engage the community in a discussion about the "state's history and the ways in which historical injustices and systemic racism continue to affect society today," and then decide what form reparations will take.

CONCLUSION

Some governments have taken the first step in acknowledging that they have a responsibility to put an end to the system of racism. But these problems will not be solved overnight. It will take a concerted long-term effort to achieve racial equity and eradicate the harms caused by 400 years of racism. Governments at all levels (federal, state, and local) must aggressively work to ensure that racial and ethnic minorities are not only treated equally, but also receive the material support they need to overcome harms they have already suffered. Only then can we truly begin to work towards improving the health and wellbeing of racial and ethnic minorities, so that we can achieve racial health equity.

We will continue to track and update the current laws and policies declaring racism as a public health crisis on our website for The Institute for Healing Justice and Equity at Saint Louis University.

COVER PHOTO
Keitravis Squire/UNSPLASH