

Critical Race Theory's Antiracism Approaches: Moving From the Ivory Tower to the Front Lines of Public Health

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Learning to conduct applied research (e.g., program planning, implementation, and evaluation) is a basic part of public health training^{1,2}; however, the training typically does not teach students how to address the health implications of racism. Some public health professionals routinely collect data and perform research activities to document and challenge racism. Others observe the health effects of racism in the communities where they work but do not know how to document these problems empirically. We believe there are at least five reasons for public health professionals to target racism when conducting applied research (Box 16-1). In this chapter, we discuss how the antiracism research approach called Public Health Critical Race Praxis (PHCRP) can aid efforts to target racism directly as part of program planning, implementation, evaluation, or other applied research.

Box 16-1. Five Reasons to Involve Practitioners in Racism-Related Research

1. Practitioners work with many populations of color that are impacted by racism. To promote health in these populations, it is important to understand and address their experiences with racism.
2. Practitioners working on the front lines of public health have *experiential* knowledge about communities, public health problems, and solutions that academic researchers often lack.
3. Practitioners can improve the quality of data on race, ethnicity, and agency/program indicators routinely collected by their organizations. This can help them identify and monitor the underlying causes of any racial/ethnic disparities in their programs. It may also make the data more useful for health equity research (e.g., in collaborations with academic partners).
4. The settings where practitioners work (e.g., public health clinics) are the subject of a growing number of studies that seek to understand how and why racial inequities occur in the delivery of public health services and programs. Practitioners understand the policies, practices, workflow, etc. of the settings in which they work, making them the natural leaders for conducting this type of applied research and evaluation.
5. Understanding and assessing racism-related indicators can help practitioners identify and address subtle ways racism may be operating within their programs and agencies.

BACKGROUND

Over the last three decades, the antiracism movement called Critical Race Theory (CRT) has been gaining currency in the “ivory tower.”^{3,4} Since originating in the field of law, CRT has spread to disciplines as diverse as education (see Chapter 7),^{5,6} ethnic and American studies, gender studies,⁷ philosophy, and, more recently, public health.⁸ Scholars in these fields have used CRT to identify and address the ways racism reinforces racial and ethnic inequalities. Critical race theorists are known for using direct, sometimes confrontational, strategies to force their disciplines to address the myriad of subtle and overt ways racism operates within the field.

Some of CRT’s core ideas have found their way into the public sphere. Communities and activists deploy these academic ideas alongside their own antiracism strategies to highlight injustices and work toward achieving health equity. For instance, the African American Policy Forum, which was founded by critical race theorist and legal scholar Kimberlé Crenshaw, launched the #SayHerName campaign to raise awareness about how police brutality affects Black women.⁹ The concept undergirding the campaign is intersectionality, which emphasizes the co-occurrence of social statuses (e.g., Black women or gay, Asian men) due to the ways the corresponding social inequalities such as racism and sexism interact. #SayHerName sheds light on the precipitous rise in the rates of police brutality against Black women, which has received little public attention despite the media’s attention to police brutality against Black men. #SayHerName brings forward the interacting experiences of being Black and being women within the context of police violence. CRT has also been a foundation of the reproductive justice movement, emphasizing that the “control, regulation, and stigmatization of female fertility, bodies, and sexuality are connected to the regulation of communities that are themselves based on race, class, gender, sexuality, and nationality.”¹⁰ These brief examples illustrate how the academic ideas of CRT are already being used in community-based movements.

Our goal in writing this chapter is to move PHCRP, which is a health equity offshoot of CRT, from the “ivory tower” to the settings where many public health professionals work. Frontline public health professionals and others not affiliated with an academic institution may not be able to access the information about CRT or PHCRP that is published only in academic journals or available only to those with current subscriptions.¹¹ To help bridge this gulf between academic and frontline antiracism efforts, we explain how researchers are using CRT to study the health effects of racism and describe ways professionals might draw on PHCRP principles—or CRT more broadly—as part of applied research (e.g., program evaluation).

As disciplines take up CRT, they adapt it to meet their unique needs and interests. How best to adapt the information in this chapter for use on the front lines of public health will become clearer over time as it is applied in diverse settings. Here, we provide an overview on the topic and include examples and key considerations, but we do not attempt to dictate the specific approaches all public health professionals should use.

APPLYING CRITICAL RACE THEORY PRINCIPLES TO HEALTH EQUITY RESEARCH

An important shift is taking place in the field of public health; researchers are beginning to target racism directly by applying CRT principles to health equity work.¹² This shift encourages projects to do the following:

- Name racism explicitly and investigate it directly, rather than studying proxies such as socioeconomic status (SES);
- Establish research aims and hypotheses from the perspective of racial/ethnic minority outsiders;
- Acknowledge how research endeavors reflect the racial biases of the broader society; and
- Challenge implicit and explicit racial assumptions in the field.⁸

Several excellent models exist for applying CRT to health equity problems.^{7,13–18} This chapter focuses on just one of them, PHCRP. We explain its main components, describe how to use it to conduct applied antiracism research, offer tips for addressing racism in public health organizations, and conclude with recommendations for addressing challenges that may arise when doing this kind of work.

Public Health Critical Race Praxis: A Research Approach

PHCRP is a semistructured process for applying CRT principles to health equity research.¹⁹ It is useful when researchers want to address the subtle ways racism influences both health inequities and the approaches used to study them. By posing a series of questions at key stages of the research process, PHCRP helps research teams (1) respond to ways racism operates contemporarily, (2) identify biases in the field that may hamper antiracism work, (3) decide how to measure key racial/ethnic concepts, and (4) take action based on the lessons learned from the study.

How Does Public Health Critical Race Praxis Go Beyond Conventional Research?

In general, any study that targets racism explicitly helps to move the field beyond merely documenting racial/ethnic disparities.²⁰ PHCRP attempts to go even farther by anchoring health equity research in the antiracism strategies and ideas advanced primarily by CRT experts and advocates of color.¹⁴ The integration of scholars' and advocates' experiential knowledge into the health equity work helps distinguish PHCRP approaches from mainstream ones. PHCRP's conceptual elements support the development of sophisticated understandings about racial dynamics and help illuminate racism deeply embedded in the research process or the field.

According to PHCRP, racism—not race/ethnicity—is a root cause of racial/ethnic inequities. This distinction between the role of race/ethnicity and that of racism is important. When the description of the problem includes the role of racism, interventions can address the mechanisms by which it contributes to the inequities. Otherwise, however, interventions may conflate the root cause of the problem (e.g., racism) and the people most affected by it (e.g., racial/ethnic minorities). For example, a study may aim to address obesity among Native Americans who live on reservations or Latinos/Latinas who live in cities. Focusing on racism, including racialized forms of imperialism and nativism, as a root cause of obesity in these populations suggests interventions must consider the historical and contemporary stripping of resources from Native American communities and the role of segregation in limiting Latinos'/Latinas' access to healthier options.²¹⁻²⁴ By contrast, focusing on race/ethnicity could lead to the development of interventions that encourage dietary changes but do not address the underlying reasons for the current diet.

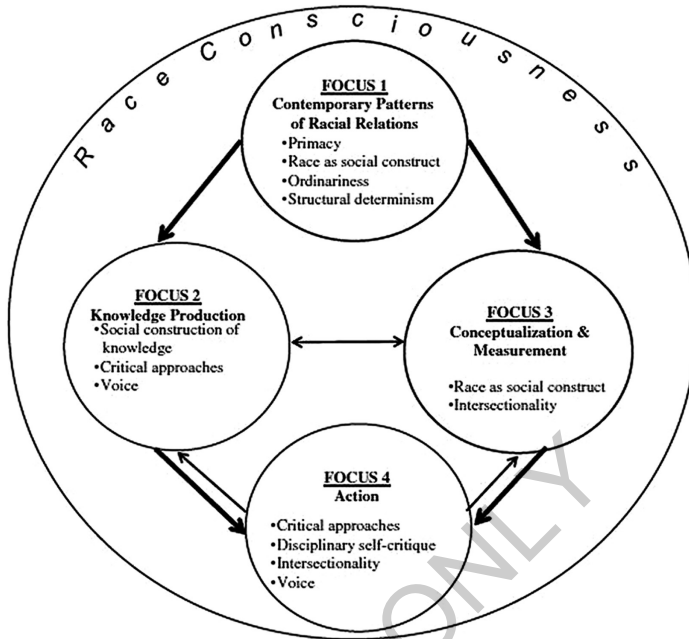
Unfortunately, the norms and conventions of our field can hamper efforts to address racism. One common tendency is to view racial/ethnic minority communities from a deficits perspective (i.e., to define them based on what they lack—such as financial resources, higher educational attainment, or biomedical health knowledge).²⁵ This problematic perspective makes it difficult to identify both the structural factors driving their experiences and the sources of resilience on which interventions could be based. For these reasons, in addition to studying the health inequities, PHCRP projects also attempt to account for racial biases in the field or in a project (e.g., in the assumptions informing research questions) that affect understandings about how to address the inequities.²⁶

In sum, PHCRP differs from standard health disparities research in several ways. Its grounding in CRT is explicit. Its studies on the health effects of racism simultaneously account for ways racism is embedded in the field. And, it attempts to orient the project from the perspectives of socially marginalized people. In the next section, we describe PHCRP's major components and its process, then we explore some tips for conducting this type of work in public health settings.

The Major Components of Public Health Critical Race Praxis: What They Are and How to Use Them

PHCRP's major components include the following:

- A racism-centered orientation: Those conducting PHCRP research establish racial consciousness at the beginning of a project and maintain it until the end of it. To establish racial consciousness means to develop deep awareness of the ways racism operates in society and within oneself and how it might influence the project at hand.



Source: Ford and Airhihenbuwa.²⁷ Reprinted with permission from Elsevier.

Figure 16-1. Race Consciousness, the Four Focuses, and Ten Affiliated Principles

- A set of 10 principles based on CRT, which serves as both the basic tools used to carry out the research and a lexicon to facilitate more sophisticated discussions of and understandings about racism.
- A semistructured process for conducting research (Figure 16-1).

Figure 16-1 outlines the PHCRP process, which involves establishing racial consciousness and then drawing on the PHCRP principles address the four areas of focus systematically. The outer circle of Figure 16-1 represents the race-conscious frame through which members of the research team conduct all aspects of the study.²⁷ After establishing racial consciousness, the study team enumerates the main ways racism is relevant to the project for the period(s) of interest (Focus 1). This is important because most of the ways racism operates in the 21st century are more subtle and more difficult to perceive than are historical forms of racism. Next, the team tries to understand how racial dynamics embedded in their own thinking or in the field could affect the project (Focus 2). They refine the study's conceptual model and operationalize the variables in light of these considerations (Focus 3). Upon completion of the study, the team uses knowledge gained from the findings, the research experience, or both to take action against the problem (Focus 4). This entire process can be integrated into any study design, including those used in applied research (e.g., program evaluation). Table 16-1 highlights the central concerns and strategies of each PHCRP focus.

Table 16-1. Applying Public Health Critical Race Praxis in Evaluations. Other Applied Research, Program Planning, Implementation, and Intervention: Key Issues to Address in Each Focus

Focus	Issues to Address in the Study
<p>Focus 1 Contemporary racialization</p>	<ul style="list-style-type: none"> • List ways racism matters in society today and how it might matter for this study. • Focus on social and political, not biological, explanations for any racial/ethnic differences. • Consider the everyday forms of racism (e.g., being treated with less respect), not just the extreme forms (e.g., hate crimes). • Consider structural and institutional forms of racism (e.g., segregation), which may be difficult for some study participants to perceive.^{28,29}
<p>Focus 2 Knowledge production</p>	<ul style="list-style-type: none"> • List assumptions the field has about the racial/ethnic populations involved in the study. • Researchers' biases can subtly influence study findings, so document your biases in advance. • In literature reviews, consider alternative explanations for racial/ethnic findings. • Seek out and prioritize the perspectives of socially marginalized groups.
<p>Focus 3 Conceptualization and measurement</p>	<ul style="list-style-type: none"> • Develop measures that reflect social and political, not biological, reasons for racial/ethnic differences. • People are affected by multiple social forces (e.g., sexism), not just racism, so clarify how together the various forces might combine to uniquely affect the study population.
<p>Focus 4 Action</p>	<ul style="list-style-type: none"> • Challenge your initial understandings of the study's findings; see if there are alternative explanations for them. • Are there any lessons learned about racial factors influencing the study's assumptions, methods, etc.? If so, share these with the field in scientific papers and presentations. • Prioritize the perspectives of marginalized groups. Share findings with communities.

Source: Based on Ford and Airhihenbuwa.²⁷

HOW CAN I OR MY AGENCY USE PUBLIC HEALTH CRITICAL RACE PRAXIS TO ADDRESS RACISM OCCURRING IN THE PUBLIC HEALTH SETTING WHERE I WORK?

Issues of racism may arise in public health work settings. Therefore, in this section, we offer several tips to help professionals identify and monitor potential racism-related inequities in the organizational culture, in program planning, and in program evaluation or other applied research.

Improving Organizational Culture

- **Become aware of your own biases:** Identifying one's own implicit biases is a logical first step toward achieving health equity. Some organizations have already begun to identify and address the ways that staff members' implicit (i.e., unconscious) racial biases might lead to racial/ethnic differences in the delivery of services. It is important for the organizational leadership to go further, however, by identifying the structures and institutional mechanisms that reinforce a culture in which the biases can exist.³⁰
- **Improve data quality:** To identify racial injustices and monitor progress toward achieving equity requires good quality data on race/ethnicity.¹² Agencies and programs routinely collect demographic (e.g., race, ethnicity) and other information (e.g., recent behaviors, preferences) from the clients and communities they serve; however, poor data quality is a pervasive problem that limits the reliability, validity, and utility of this information.^{31,32} Box 16-2 highlights several data-quality issues in a hypothetical collaboration and describes strategies the research team used to address them. Data are of poorer quality if the following issues are present:

Box 16-2. Hypothetical Case: Addressing the Quality of Race/Ethnicity Data in Medical Records

A researcher received a grant from the National Institutes of Health to study racial/ethnic disparities among patients who have health insurance and a health care provider. In collaboration with a large managed care organization, the research team obtained de-identified (i.e., patients' names, birthdays, etc. were removed) clinical and demographic information from each patient's medical record, then began preparing the data for analysis. Though initially pleased that the sample included millions of patients, they soon realized that a lot of the information on race and/or ethnicity could not be used. Because the focus of the study was racial/ethnic disparities, the issues with the race and ethnicity data would have to be resolved before they could proceed with the analyses. The practitioner collaborators were particularly interested in using the study's findings to improve the organization's protocols for collecting patient information, so they provided detailed information on how the data had been collected.

How did the research team obtain information on race/ethnicity?

On the clinic intake form

Each patient completed an intake form at the first health care visit. It included the item "Please indicate your race/ethnicity: black, white, Hispanic/Latino, Asian Pacific Islander, other, or 'don't know.'"

(Continued)

Box 16-2. (Continued)***From intake form to medical record to research variable***

- All information on the intake form was entered into the medical records exactly as written.
- During the data abstraction process, the collaborating practitioners shared the de-identified medical records with the researcher team.
- The research team noticed issues (e.g., missing information) with the race/ethnicity data and consulted the health care practitioners for more information about how race/ethnicity was collected.

What issues did researchers notice?***Failure to use standard categories***

The race/ethnicity categories on the intake form were not the same standard categories outlined in the US Office of Management and Budget guidelines. Nor did they capture the social construction of race/ethnicity (Table 16-2), making it difficult to compare the findings from this study to those of other studies for certain racial/ethnic groups.

Missing data

When information cannot be used in the analysis, it is called “missing data.” Some medical records had no information on race/ethnicity. Others were marked “don’t know.” Unless the team resolved these issues, the information from these patients would not be included in the study. If certain kinds of patients are more likely than others to have missing data, the study findings may end up being biased.

Data collection protocol

Although the managed care organization’s handbook states that patients should self-report their race/ethnicity, in practice this was not always followed.

Self-report versus staff report. Some intake receptionists completed the intake form on patients’ behalf, but left the question blank or just guessed about a patient’s race/ethnicity. This resulted in missing or potentially invalid data about the patient’s background.

What solutions did practitioners implement going forward?

Although the researchers used statistical techniques to circumvent some of the challenges, they were unable to include all of the patients in the sample. To prevent this from happening in the future, practitioners at the health care organization decided to implement the following:

- Collect all patient race/ethnicity information according to US Office of Management and Budget Directive 15 guidelines.
- Institute an annual staff training that explains the procedures staff should use with the intake forms and medical records.
- Regularly conduct quality control checks of the data via reviews of a random sample of medical records.

- No standard protocol is used to collect the information. This can occur either because no protocol exists or because the staff does not consult it.
- The information is not collected from every client.
- The client information is ambiguous, which may result in the receipt of duplicate information from some clients or no information from others.
- Clients skip certain questions on an intake form because they do not understand or want to answer them.
- Staff completes some or all of the intake form on behalf of clients. As a result, the information may be incorrect or reflect staff perceptions, not those of the clients.

- **Monitor practices and services:** Practitioners can use the results of internal evaluations to identify subtle ways organizational policies and practices may inadvertently perpetuate racism (e.g., in the treatment of employees or the delivery of services) or make it difficult for people to confront it. Documenting these patterns is the first step toward addressing them. It equips the organizations with the information needed to monitor progress toward equity.³³

In Program Planning

- **Build community capacity:** Incorporate and prioritize community input. Train members of the affected communities to serve as advisors and team leaders. Doing so reduces the “perspective imbalance”³⁷ that occurs when services intended for a community are developed without their input. It may also bolster the collective capacity of communities to conduct their own independent research or build the trust needed to establish community–academic partnerships in the future.³⁴ **Acknowledge that diversity exists within racially/ethnically defined populations:** All people are influenced by more than one social force (e.g., racism, sexism, and classism); moreover, it is impossible to separate fully how any one social force affects people with multiple minority social statuses. The concept of intersectionality^{35,36} serves as a reminder that diversity exists within each racial/ethnic group and that both racial and nonracial factors matter. For instance, HIV prevention educators focused narrowly on sexual behaviors and sexuality may miss the role of historical racism (e.g., racial stereotyping) in shaping those behaviors.^{37,38} **Ask relevant questions:** When conducting evaluations, include questions about racial equity and racism-related dynamics that may be particularly relevant to the most vulnerable members of the populations with whom you work. Are the issues affecting those lumped into an “other” racial category (e.g., Asians, Pacific Islanders) obscured by comparing them to more numerous groups (e.g., African Americans, Latinos/Latinas)? If so, how can you better capture the needs of the smaller groups?

In Program Evaluation

- **Consider how bias may influence the results of each assessment or evaluation:** According to sociologist Larry Bobo, “[D]ata never speak for themselves. It is the questions we pose (and those we fail to ask) as well as our theories, concepts and ideas that bring a narrative and meaning to marginal distributions, correlations, regression coefficients, and statistics of all kinds . . .”³⁹ With this in mind, try to explain racism-related biases that may be embedded in the research questions and hypotheses informing any of the evaluations or other applied research. Ideally, this occurs in the planning stages, well before any analysis has been conducted.

- **Use meaningful measures:** The US Office of Management and Budget (OMB) Directive 15⁴⁰ is the regulation that establishes the measures and protocols federal agencies must use to collect data on race/ethnicity; however, these measures are insufficient for studying the social determinants of inequities (Table 16-2).⁴² Race and ethnicity are complex concepts that often serve as proxies for the true underlying causes of health conditions; therefore, it is important not to limit measures of race/ethnicity to the OMB categories.^{42,43} Whenever possible, also include measures that capture population- or region-specific considerations. For instance, in some regions of the country it is important to go beyond a census category such as Asian or Latino/Latina to obtain more detailed information on diverse subpopulations. As shown in Table 16-2, how race or ethnicity is measured in a project (See Appendix B of this book) determines the types of understandings the work can produce.

Various measures of racism exist (Appendix B),⁴⁴ but it is not always clear how well a measure reflects the needs of a particular community. Together, communities, professionals, and researchers can identify, adapt, or develop new measures as needed to capture the ways racism matters in specific communities. It is preferred to convene a group of community members who can offer advice on matters such as these when studies are being designed.⁴⁵ If this is not possible, practitioners may be able to draw upon some of their interactions with community members to voice whether the proposed measures of racism reflect what community members have described as their actual lived experiences. In practice, public health practitioners might improve the relevance of the measures of racism by collecting information from clients about the contexts in which they live (e.g., neighborhood characteristics or interactions with law enforcement). Appendix B includes validated and nonvalidated instruments that can serve this purpose.

- **Share the findings:** Whether producing findings from internal evaluations or collaborations with academic (or corporate) researchers, one way to support equity is to share the findings of the work with the communities. In collaborations, memoranda of understanding can be established that require academic research partners to share the findings with organizations and individuals in the community. As the late social epidemiologist Steve Wing explained eloquently in the seminal paper, “Whose Epidemiology, Whose Health?,” community members stand to benefit most from the findings.⁴⁶

This section highlighted concrete actions frontline public health professionals can take to strengthen their individual or organizational capacity to identify racism-related inequities and monitor progress toward achieving equity in public health settings. Though not prescriptive, these tips can inform the integration of PHCRP’s antiracism principles into health equity work. In the next section, we briefly discuss common challenges to doing this type of work.

Table 16-2. Considerations for Assessing Race and Ethnicity in Health Equity Work

Variable	Variable Categories	When to Use
Office of Management and Budget (Directive 15) Guidelines⁴⁰		
Race	White, Black/African American, American Indian or Alaska Native, Asian, Hawaiian or other Pacific Islander, other race	<ul style="list-style-type: none"> On projects with any federal funding To compare trends across government agencies If other federal data sources (e.g., Census) information are also used (e.g., Census tracts)
Ethnicity	Spanish/Hispanic/Latino or not	<ul style="list-style-type: none"> On projects with any federal funding To compare trends across government agencies If other federal data sources (e.g., Census) information are also used (e.g., Census tracts)
Other Approaches Used in Racism Research		
Self-reported race	Varies. Typically respondents are asked how they identify and given a short list of options from which to choose. Ideally, this indicator should be assessed using one or more open questions, which can subsequently be recoded into several main groups.	<ul style="list-style-type: none"> To study people's personal identity
Perceived race/ethnicity	Varies. For example, "How do other people usually classify you in this country?" ⁴¹ Also, skin tone or other physical characteristics.	<ul style="list-style-type: none"> To study the effects of unfair treatment people experience based on how they look (i.e., discrimination)
Ethnicity	Varies. Shared group characteristics and identity.	<ul style="list-style-type: none"> To study people's personal identity and culture To identify sources of resilience
Socially constructed ethnicity ⁴²	Varies based on specific ways a group is treated differently by the dominant group or other groups in society.	<ul style="list-style-type: none"> To study the effects of racism on <i>ethnic</i> (not necessarily racial) minorities

COMMON CHALLENGES TO STUDYING RACISM

The kinds of challenges that arise when studying and confronting racism can occur whether using a preexisting antiracism model (e.g., CRT or PHCRP) or some other approach to name racism, evaluate its impact on services, and address its health implications. Common challenges include a lack of experience addressing racism explicitly and directly, lack of human or financial resources to conduct racism-related research, and resistance or reluctance to address racism within the organization. Fortunately, strategies exist for dealing with many of these challenges.

First, understand that it is normal for people who are studying racism to feel awkward discussing it. To effect positive change, it is important that the people who lead these discussions first obtain antiracism training. Training is also important for people who conduct research on racism. Training helps people develop the racial self-awareness needed to reduce the risk of accidentally harming the community. Such training is not routinely offered in public health training programs. The resources in Appendix C provide excellent starting points and may help build the organizational support needed to develop a culture of health equity.

Practitioners may lack the resources, including time, funds, and staff, needed to add a research component to their responsibilities.⁴⁷ If the applied research (i.e., evaluation) is done in partnership with academic researchers, some of the financial, staff, and time costs can be covered by the academic partner. Typically, it is the responsibility of academic researchers to budget for the types of expenses practitioners must cover in order to collaborate equitably.

Peers or superiors may resist or reject requests to study or address racism, mistakenly believing the topic is not relevant or is too incendiary for the organization to address.⁴⁸ Public health practice is supposed to be evidence-based, however; therefore, one way to respond to this resistance is to cite the scientific evidence^{49–54} that racism is prevalent among diverse populations, occurs in public health settings, and is negatively associated with a wide range of health outcomes.^{55,56} It may also help to point them to publications that show that health care professionals—like others—hold implicit biases, which, if not addressed, may contribute to racial/ethnic disparities.^{57,58} As the number of studies on racism, health, and health care continues to grow, it may become possible in the future to cite studies about specific ways racism operates in the setting where you work. Another strategy is to use the lexicon of PHCRP to discuss specific ideas more comprehensively.²⁷

Public health professionals conducting applied research on racism may face several predictable challenges. Some of these challenges can be addressed while planning or conducting the work. Addressing the challenges helps align organizations with the goals of fostering health equity. It also improves the validity of the findings from evaluations or other applied research, which makes the work more useful for communities.

CONCLUSIONS

In this chapter, we sought to extend the reach of CRT and PHCRP beyond the academic institutions where reliance on these antiracism resources is growing. We hope that our colleagues working on the front lines of public health can use what we have presented here to support their ongoing work in public health settings, in partnerships with communities fighting for health equity, in collaborations with academic researchers, and in efforts to augment current approaches to program planning, evaluation, and other applied research.

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