PUBLIC HEALTH CRITICAL RACE PRAXIS: AN INTRODUCTION, AN INTERVENTION, AND THREE POINTS FOR CONSIDERATION

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The field of Public Health has a progressive history of working with vulnerable communities to promote the health of all their residents, but it also has a complicated and problematic relationship to race. Its roles in racializing populations and disease as well as promoting scientific racism are well documented. At the same time, anti-racism resistance has always operated within the field, challenging it and influencing the contributions Public Health makes to society.

The field appears ready for a new anti-racism movement. Researchers increasingly draw on the tools available to them within this multidisciplinary field to conduct studies that might explain and challenge the fundamental ways in which racial stratification contributes to health inequities. Some health interventionists focus their efforts on helping communities raise racial consciousness or build community capacity to challenge racialized power differentials. All of these efforts occur within a context where the need for an anti-racism movement is palpable within and beyond the field.

In this essay, I explore ongoing anti-racism efforts within the field of Public Health. I briefly introduce the Public Health Critical Race Praxis (PHCRP), which is an iterative, empirical approach that while grounded in Critical Race Theory (CRT) is designed for Public Health research, and I discuss its potential to help advance an anti-racism health equity movement. I conclude with three key points for consideration, which are relevant both to the expansion of critical race empiricism within Public Health and to the potential of PHCRP to inform CRT more broadly. The first consideration reflects my concern that expanded uptake of PHCRP maintain fidelity to CRT, even though it must adapt to the needs of Public Health. The second consideration is a simple question: is the purpose of critical race empiricism merely to document? If so, what are the implications of this? The third consideration, which pertains to the critical race concept of voice as it is relevant to Public Health, highlights the need for those of us in Public Health to engage in dynamic de-centering within and outside the academy to reduce the possibility of privileging our perspectives over those of the communities within which and for which we work.

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INTRODUCTION

This essay was written as a contribution to a symposium entitled "Rethinking Public Health Law: Race, Science and Health Disparities." My training is in Public Health, not Law, and I offered the following remarks to provide an insider's analysis of anti-racism efforts ongoing within Public Health. In what follows, I briefly define Public Health and describe the state of the field with respect to empirical applications of Critical Race Theory (CRT). Next, I introduce the Public Health Critical Race Praxis (PHCRP), which is, to my knowledge, the only structured empirical protocol within the biomedical sciences that explicitly draws on CRT to guide health equity research. I conclude by posing three sets of questions. I do not have answers to these questions, but my experience thus far working with others to advance a critical race movement within Public Health suggests that a successful marriage between CRT and empiricism necessitates attention to these issues.

A. What is Public Health?

Public Health can be defined as "the collective efforts of a society [to] create the environmental conditions in which people can be

healthy."[1] The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] As further explained by the WHO, the field's overarching goal is to promote "health security *for all*."[3] Public Health is a multidisciplinary field. Its key disciplines are epidemiology (often considered the cornerstone of Public Health), the socio-behavioral sciences, environmental science, health policy and management, and biostatistics. Two characteristics distinguish Public Health from the other health sciences and, in particular, from Medicine. Public Health (1) focuses on the distributions of disease and the causes of those distributions for entire populations (not just the causes of an individual's occurrence of disease) and (2) it aims to prevent disease from occurring and, if possible, to prevent even the risk factors for disease from occurring. In short, Public Health attempts to prevent disease before it occurs for entire populations, rather than treat people after their exposure to risk factors or diagnosis of disease. People of higher socioeconomic status already have access to many health-promoting resources; therefore, Public Health efforts focus largely on communities that do not.

B. *Characterizing Ongoing General Anti-racism Efforts Within the Field of Public Health*

Currently, the field is generally supportive of research on the "social determinants of health,"[4] and social movements such as Black Lives Matter are pressing the field to target racism as a social determinant of health. Social determinants of health are the environmental and social conditions, such as poverty, that lead to high rates of preventable disease and disparities.[5] The number of studies examining one or more forms of racism and estimating how exposures to racism affect health has grown rapidly over the last two decades. Much of the work is data driven rather than theory driven. In other

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1.   David Satcher, *The Importance of Diversity to Public Health*, 123 PUB. HEALTH REP. 263, 263 (2008).

2.   *Constitution of the World Health Organization*, WORLD HEALTH ORG. (Apr. 7, 1948), http://www.who.int/about/mission/en/.

3.   *Global Health Declarations*, WORLD HEALTH ORG. http://www.who.int/trade/glossary/story039/en/ (last visited Feb. 27, 2016) (emphasis added).

4.   COMM'N ON SOC. DETERMINANTS OF HEALTH, ACHIEVING HEALTH EQUITY: FROM ROOT CAUSES TO FAIR OUTCOMES 16 (2007); Jennifer Jee-Lyn García & Mienah Zulfacar Sharif, *Black Lives Matter: A Commentary on Racism and Public Health*, 105 AM. J. PUB. HEALTH e27 (2015).

5.   COMM'N ON SOC. DETERMINANTS OF HEALTH, *supra* note 4, at 2, 11.

words, the work privileges the authority of data gained through empirical studies rather than the production of concepts that would help to understand the connections between racism and health. There is not a cohesive structure to this body of work. Instead, racism is the topic of inquiry for individual researchers, each employing her or his own definition of racism and strategies to study it.

A socio-ecologic framework, which is a heuristic that explains how factors operate at various levels of social life—the individual level, interpersonal level, familial, community, etc.—guides the study of the social determinants of health. The overwhelming majority of studies on racism and health examines forms of racism that operate on the interpersonal level, such as whether one has recently been treated unfairly by another person because of racial discrimination. Conceptual papers have outlined the actions needed to advance a research agenda on structural forms of racism. They seek to understand how institutional and structural mechanisms, including residential and social segregation, help to reinforce health disparities.[6] Methodological and practical challenges have made it difficult to translate these agendas into empirical projects, however. For instance, it is difficult to identify datasets that contain not only socioeconomic factors and the relevant health-related data but also measures of structural racism. Public Health primarily uses conventional research approaches, such as those that set randomized controlled trials as the gold standard, even though it is neither feasible nor appropriate to use them to answer many research questions. The widespread reliance on conventional approaches to empirical research likely constrains the possibility of developing social interventions that can undo factors such as structural racism. Fortunately, however, innovative work by scholars such as Louis Graham, Derek Griffith, LeConté Dill, and others combines empirical methods and community capacity building.[7]

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6.   *See, e.g.*, Gilbert C. Gee & Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112 ENVTL. HEALTH PERSP. 1645, 1645 (2004); Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8 DU BOIS REV. 115, 116–17 (2011); Edna A. Viruell-Fuentes, *Beyond Acculturation: Immigration, Discrimination, and Health Research Among Mexicans in the United States*, 65 SOC. SCI. & MED. 1524, 1525 (2007); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 404 (2001).

7.   *See, e.g.*, Robert E. Aronson et al., *Brothers Leading Healthy Lives: Outcomes from the Pilot Testing of a Culturally and Contextually Congruent HIV Prevention Intervention for Black Male College Students*, 25 AIDS EDUC. & PREVENTION 376 (2013); LeConté J. Dill, *Poetic Justice: Engaging in Participatory Narrative Analysis to Find Solace in the "Killer Corridor,"* 55 AM. J. COMMUNITY

The field's level of support for research on racism and health is evidenced by at least three factors. First, the National Institutes of Health (NIH), which is the primary funder of biomedical research, solicits proposals targeting racism. Secondly, the Institute of Medicine has published a seminal volume on the contribution of racism to health inequities. Finally, the field's major professional organization, the American Public Health Association (APHA), is led by Dr. Camara Jones, an African American woman whose anti-racism work includes establishing the Measures of Racism Working Group at the U.S. Centers for Disease Control and Prevention (CDC) and publishing racial equity allegories in the scientific literature.[8]

These and other ongoing efforts help us generate new models for conceptualizing racialization and related constructs, document the prevalence of various forms of racism, identify specific mechanisms by which racism contributes to unjust burdens of risk and disease, and develop interventions that target the mechanisms identified through the research. Each of these efforts has its limitations and none is a panacea for racism in the field or in society. Although I am encouraged by the anti-racism efforts ongoing in Public Health, several concerns warrant further consideration. Because a full discussion of these points is beyond the scope of the present essay, I will consider only one of them here. Specifically, the field errs in its tendency to treat racism as, for example, an easily identifiable and treatable hazard that individuals can be taught to avoid. It is more appropriate to consider racism an integral element of the social context in which all populations exist and within which all studies of health disparities are conducted. This one concern has many implications for research methods, knowledge production, and public health practice.

I. CRITICAL RACE THEORY WITHIN PUBLIC HEALTH

In a 2010 paper published in the *American Journal of Public Health*, which is APHA's flagship journal, Collins Airhihenbuwa and I formally introduced CRT to the field, presenting our arguments for expanding its uptake to improve the capacity of researchers and

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PSYCHOL. 128 (2015); Derek M. Griffith et al., *Dismantling Institutional Racism: Theory and Action*, 39 AM. J. COMMUNITY PSYCHOL. 381 (2007).

     8.   UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003). Dr. Jones' most cited allegory is Camara P. Jones, *Levels of Racism: A Theoretic Framework and a Gardener's Tale*, 90 AM. J. PUB. HEALTH 1212 (2000).

practitioners to understand and address health inequities.[9] Since then, the number of researchers explicitly using critical race approaches has grown rapidly, though it remains relatively small. Papers published by Tony Brown, Louis Graham, Stephen Thomas, Sandra Quinn, James Butler, Craig Fryer, Rashawn Ray, Keon Gilbert, and others either built on our call or offered original, detailed examples of their application of CRT to the empirical study of population health inequities.[10] As briefly outlined below, there are at least three trends in the use of CRT *per se* within Public Health: (1) borrowing one or more CRT concepts; (2) drawing on CRT to advance health equity theory or research methods; and (3) reliance on Public Health Critical Race Praxis (PHCRP) to guide the research process.

The first trend reflects the interest in but limited familiarity with CRT that many health equity researchers have. Researchers may, for instance, only draw on one or more elements of CRT to inform the development of a study's conceptual model. Alternatively, they may cite works from the legal CRT literature to frame a study's research questions or to buttress support for the alternative explanations they provide about the reasons for any racial and/or ethnic patterns observed in their study results. Among those who have some familiarity with CRT, enthusiasm is high for integrating it into research. Among other researchers as well as some Public Health practitioners and community-based organizations, however, enthusiasm is dampened by CRT's academic orientation, which they believe renders it exclusive and, therefore, contradictory to the models of community-based

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9.   Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30 (2010). We published the paper in the field's flagship journal, the *American Journal of Public Health*, both to reach a large swath of the mainstream of the field and to underscore the centrality of racism to Public Health research and practice. Others, most notably Vernellia Randall and Dorothy Roberts, had explicitly drawn on CRT in their work, especially conceptual work, prior to our formal charge to the field, though neither provides a guide for conducting empirical research. Healthcrits such as Jennifer Garcia had delivered excellent presentations about CRT and Public Health, but they have yet to be published.

10.   *E.g.*, James Butler III et al., *Characterizing Researchers by Strategies Used for Retaining Minority Participants: Results of a National Survey*, 36 CONTEMP. CLINICAL TRIALS 61 (2013); Louis Graham et al., *Critical Race Theory as Theoretical Framework and Analysis Tool for Population Health Research*, 21 CRITICAL PUB. HEALTH 81, 84–85 (2011); Stephen B. Thomas et al., *Toward a Fourth Generation of Disparities Research to Achieve Health Equity*, 32 ANN. REV. PUB. HEALTH 399, 407 (2011).

participatory research so highly valued within the health equity community.[11]

The second trend is that CRT informs the development of conceptual and methodological interventions into conventional scientific knowledge production processes. A recent example of this is the volume *Mapping "Race": Critical Approaches to Health Disparities Research*, edited by Laura Gómez and Nancy López, which presents thoughtful social science perspectives regarding the study of race in science.[12] Nina Harawa and I do this within the context of epidemiology and with a specific focus on ethnicity. We propose a two-dimensional ethnicity concept to help social epidemiologists conceptualize and, importantly, measure the social meanings of ethnicity in the U.S. where race, not ethnicity, is the dominant axis of social stratification.[13] The literature routinely attributes high rates of disease to characteristics presumed to stem from one's identity. As we view it, however, framing the relationships in terms of ethnicity may mask the true causes of many disparities. Ethnic disparities may signal the presence of some form of social inequality that operates along one or another axis of ethnicity. One of the challenges the use of our concept attempts to address relates to how social epidemiologists might capture the underlying causes for which an ethnicity measure is a proxy. We are particularly concerned with understanding how to do so in nations such as the U.S., where race, which remains a dominant social force, intersects with ethnicity. Our concept exploits the social constructedness of ethnicity (and its intersection with race) to help researchers identify and quantify the contributions that specific social inequalities make to observed patterns of disease.[14] The concept comprises two dimensions: an attributional dimension, which like most

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    11.   The centrality of community based participatory approaches to health equity research, especially anti-racism research, is the focus of a growing body of work, including the works listed here. COMMUNITY-BASED PARTICIPATORY RESEARCH FOR HEALTH: FROM PROCESS TO OUTCOMES (Meredith Minkler & Nina Wallerstein eds., 2d ed. 2008); Derek M. Griffith et al., *Community-Based Organizational Capacity Building as a Strategy to Reduce Racial Health Disparities*, 31 J. PRIMARY PREVENTION 31 (2010).

    12.   MAPPING "RACE": CRITICAL APPROACHES TO HEALTH DISPARITIES RESEARCH (Laura E. Gómez & Nancy López eds., 2013).

    13.   Chandra L. Ford & Nina T. Harawa, *A New Conceptualization of Ethnicity for Social Epidemiologic and Health Equity Research*, 71 SOC. SCI. & MED. 251 (2010).

    14.   *See id.*; Nina T. Harawa & Chandra L. Ford, *The Foundation of Modern Racial Categories and Implications for Research on Black/White Disparities in Health*, 19 ETHNICITY & DISEASE 209 (2009); *see also* AUDREY SMEDLEY, RACE IN NORTH AMERICA: ORIGIN AND EVOLUTION OF A WORLDVIEW 109 (1993).

definitions of ethnicity reflects a group's cultural characteristics (e.g., religion), and a relational dimension that indexes specific ways a group is distinguished from other groups. Our novel contribution is the relational dimension, which emphasizes identification of the social hierarchies that differentially affect ethnically defined groups. Studies that use the relational dimension of ethnicity to examine health disparities can help to illuminate a group's social location relative to a specified social hierarchy.[15] This approach may be particularly useful for social epidemiology, which seeks to identify the causal mechanisms by which social determinants of health such as residential segregation help to generate ethnic variations in rates of disease.

The third trend in the use of CRT in Public Health is that healthcrits conduct research by applying the *Public Health Critical Race Praxis* (PHCRP), which is a four-phase, racial equity empirical process derived in part from CRT. Noted health educator Collins Airhihenbuwa and I developed PHCRP to promote the following within the field: enhance the rigor with which racial equity research is conducted (with respect to both anti-racism and scientific integrity); standardize the tools and lexicon healthcrits use; and promote the collective advancement of a racial health equity movement. PHCRP helps researchers conduct, explain, and address racial phenomena influencing health, while continuously attending to process factors, such as power differentials in the relationship between those being studied and those conducting the research. In 2011, Thomas and colleagues proposed that PHCRP serve as the foundation on which the next generation of health disparities research is based.[16] I discuss PHCRP in detail below.

II. THE PUBLIC HEALTH CRITICAL RACE PRAXIS (PHCRP)

PHCRP is an iterative, semi-structured research methodology that guides investigators through a systematic process to conduct self-reflexive, race-conscious research into the root cause of health inequities. It comprises (1) a semi-structured research process, (2) a lexicon that helps standardize the theory and method used to assess racism's contributions to health inequities, and (3) a set of principles and concepts that together guide anti-racism approaches to Public Health research and practice. Most PHCRP research uses empirical methods to examine associations between racism-related factors and the higher rates of risk factors and/or disease in communities of color.

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15.   Social hierarchies exist with respect to, for instance, skin color.
16.   Thomas et al., *supra* note 10, at 399–400.

PHCRP seeks to generate empirical evidence that communities can use as part of their ongoing health equity and social justice efforts. It responsibly challenges methods and results that uncritically reinforce or racialize inequities. It also employs counter-storytelling and other strategies to help explain research findings.[17]

A race-conscious orientation frames each phase of the PHCRP research process. To take a race-conscious orientation is to bring awareness of the ways in which racialization (not race) functions in society and may be relevant to the questions at hand. Expertise in racism is important to avoid inappropriate or problematic uses of race. At the beginning of a study, researchers establish how and why they believe racialization is salient to the project, and they document their own subjectivities, explaining how those may influence the project. For instance, they ask themselves, "how do I understand my relationship to the group(s) I am studying?" Next, the research process moves sequentially from Phase 1 to Phase 4. The four phases are Contemporary Patterns of Racial Relations (Phase 1), Knowledge Production (Phase 2), Conceptualization & Measurement (Phase 3), and Action (Phase 4).

During Phase 1, researchers explore how racism has changed over time in order to elucidate its relevance with respect to the time period of interest to the immediate study. In Phase 2, they strive to understand and account for social constructions of the knowledge on the health disparities being examined. In Phase 3, researchers develop strategies for measuring the study constructs and health outcomes while attending to the potential for racialized knowledge production and power differentials between researchers and communities. Publishing the findings in the scientific literature is important. In addition, however, healthcrits draw on the findings to address racial equity issues identified through the research. In Phase 4, researchers share knowledge gained from their research with those involved with ongoing efforts to change the social conditions and racialized power differentials contributing to health inequities.

PHCRP is becoming a realistic option for critical race empiricism among health equity researchers as evidenced by the small but growing number of studies based on this model. PHCRP claims a relationship to CRT; therefore, it must adhere to key CRT principles and engage the

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17.   As discussed elsewhere, PHCRP's key research process involves establishing a race-conscious lens through which the investigator details personal relationships to the research question and plans the study; proceeding via a four-phase research process; and applying ten principles, which are the basic tools of the model, as appropriate throughout the research process.

CRT literature. How best to maintain that connection while addressing the unique needs of our field is not yet clear.

III. THREE KEY POINTS REGARDING CRITICAL RACE EMPIRICISM, INCLUDING PHCRP, WITHIN PUBLIC HEALTH

Given the considerations raised thus far, the remainder of this essay explores three questions with which healthcrits are grappling in order to advance PHCRP. Although the questions are particularly relevant for those of us working within Public Health and the biomedical sciences, they can also inform both Law and the disciplinary intersection represented by critical race empiricism (eCRT).

A. In Advancing PHCRP, How Do We Strike a Balance Between Maintaining Fidelity to CRT and Using Approaches That Meet the Specific Needs of Our Field?

A fundamental concern of PHCRP is how to strike an appropriate balance between maintaining fidelity to CRT and granting ourselves permission to diverge from it in order to address the specific needs of our field. How much fidelity, how to assess fidelity, and fidelity with respect to what have yet to be clarified. CRT's relationship to other disciplines has been raised previously in Law. As I understand them, the arguments presented by Kimberlé Crenshaw at the April 2009 conference "Honoring Our Past, Charting Our Future,"[18] which celebrated the twentieth anniversary of the founding of CRT, and elsewhere, by Devon Carbado in his paper "Critical What What?"[19] and by other scholars, establish the origins of CRT proper within Law. Their work also attempts to define the boundaries between CRT and other racial projects, and it begins to explore claims to CRT made from disciplines outside of Law such as Sociology. Questions about CRT's relationship to non-Legal disciplines have also been raised from the standpoint of "the outside disciplines," for instance, as articulated by Gloria Ladson-Billings (Education) and Charles Mills (Philosophy).[20]

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18. *CRT 20: Honoring Our Past, Charting Our Future*, UNIV. DENVER STURM C.L., https://www.law.du.edu/index.php/crt-20/critical-race-theory-speaker-series (last visited Jan. 25, 2016).

19. Devon W. Carbado, *Critical What What?*, 43 CONN. L. REV. 1593 (2011).

20. *See, e.g.*, CHARLES W. MILLS, BLACKNESS VISIBLE: ESSAYS ON PHILOSOPHY AND RACE (1998); Gloria Ladson-Billings, *Just What Is Critical Race Theory and What's It Doing in a Nice Field Like Education?*, 11 INT'L J. QUALITIATIVE STUD. EDUC. 7 (1998).

The tensions intimated by these discussions point to a familiar set of challenges that emerge in any interdisciplinary endeavor.

Relevant challenges to Public Health include the need to clarify whether PHCRP should seek to erase disciplinary bounds versus define and embrace the unique contributions each discipline makes to a collective endeavor. The mainstream Public Health literature routinely publishes studies that document the prevalence of racism exposures (for example, experiences of discrimination) or that estimate associations between such factors and health outcomes. I would not necessarily characterize these studies as examples of eCRT; however, the findings do add to the evidence linking racism to population health.

What distinguishes these types of studies from PHCRP or eCRT research? One distinction is that they rarely involve PHCRP or CRT concepts explicitly, which may limit the possibility that the findings can help to advance critical race scholarship. Healthcrits continue to ask, "To what extent and in what ways must a project adhere to conventional CRT concepts or principles in order to "count" as a critical race endeavor within Public Health?"

B. What Is the Purpose of Critical Race Empiricism? Is It Merely to Document the Existence of Racism and Its Effects, for Example, on Health? If so, What Are the Implications of this?

ECRT offers health equity researchers opportunities as well as challenges.[21] To advance eCRT in Public Health, we must first establish how doing so will help us achieve the objectives we set. In his foreword to the *UC Irvine Law Review* Symposium Issue on Critical Race Theory and Empirical Methods, Professor Osagie Obasogie eloquently explains,

> The goal of this and future efforts is not simply to "improve" critical race theory by incorporating empirical methods, nor is it to simply "improve" social science research through integrating critical race perspectives. Instead, we seek to rethink and change the premise of race scholarship in general by eschewing theoretical and methodological silos in pursuit

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21. Some of these challenges and opportunities reflect what Kimani Paul-Emile has highlighted regarding CRT and the social sciences. *See* Kimani Paul-Emile, *Foreword: Critical Race Theory and Empirical Methods Conference*, 83 FORDHAM L. REV. 2953, 2954, 2956 (2015). Public Health intersects the social sciences; however, it may be more appropriate to consider it a discipline within the life sciences or health sciences.

of deepening our understanding of race and racism to advance racial justice.[22]

This articulation of the goals of critical race empiricism is compelling in part because it privileges neither discipline but situates itself on the bridge between disciplines. The opportunity to pursue eCRT as articulated here is exciting, in part, because its goals are similar to those of PHCRP.

As I reflect on both this articulation of the broad goals of eCRT and the question I pose here about the purpose of eCRT, I am aware that my location within Public Health is the basis for several questions I have about implementing eCRT. I am interested in exploring ways in which the adoption of *conventional* vs. other types (e.g., PHCRP) of empiricism as a strategy can further versus hamper achievement of our goals. How can we build momentum on eCRT while remaining cautious about the potential limitations or threats a shift toward empiricism may pose to CRT movements? The processes by which empirical knowledge production occur are inherently conservative and incremental. What are the implications of incorporating conservative and incremental methods into a movement for radical transformation? If, consistent with CRT's early writings, the goals of PHCRP and of critical race empiricism are to radically alter existing racialized power structures, to what extent must our empirical methods differ from other types of empiricism? On the other hand, to what extent and in what ways can our methods diverge from conventional methods yet be perceived as legitimate within the fields from which the respective methods are drawn?

Evaluation is critical to the success of Public Health programs; it enables researchers and practitioners to identify challenges or unintended consequences that arise during implementation of a planned intervention. Likewise, it is important to evaluate the implementation of eCRT. Doing so will help us build on its strengths and know whether it is achieving its objectives.

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22.   Osagie K. Obasogie, *Foreword: Critical Race Theory and Empirical Methods*, 3 UC IRVINE L. REV. 183, 186 (2013).

C. About Voice, How Can We Engage in Dynamic De-Centering Within and Outside of the Academy to Reduce the Possibility of Privileging Our Individual Perspectives over Those of the Communities Within Which and for Which We Labor?

This question is a flag signaling the need for us (healthcrits) to continuously reflect upon the privilege we hold vis-à-vis our identification with the margins. Questioning our privilege is rooted in the methods of community-based participatory research (CBPR). Community members are integral to Public Health efforts; they ensure the relevance of research and the sustainability of interventions. Critical race theorists working in academia call for scholars and activists to "center our work in the margins"; however, the applied nature of Public Health and PHCRP's adaptation of voice as articulated by Ford and Airhihenbuwa raise several questions about the tenuous nature of academic healthcrits' claims to residence in the margins.[23] Populations surviving in the margins of society are the very populations with which Public Health is most concerned. How is it, then, that after more than a century of Public Health investments the racialized margins persist? Moreover, in what ways might our actions as outsiders within our profession help to reinforce the marginalization of our communities?

Healthcrits continuously navigate social locations that change as we move within and across diverse institutional and social boundaries. We can experience marginalization and privilege simultaneously. Despite the marginalization we may experience within our disciplines, our credentials, academic appointments, and other assets represent forms of privilege that distinguish us from others living in the margins with which we identify. While this type of seamless navigation across cultural and other boundaries is not new, it takes on specific valences within Public Health. Consider an example based on the HIV/AIDS epidemic, which is my primary area of expertise. Racial/ethnic and sexual minority researchers often serve as bridges linking the research industrial complex to the communities in which HIV risk and prevalence are highest. The epidemic has supported myriad pharmaceutical and scientific endeavors and bolstered the careers of many scientists, yet racial/ethnic disparities have persisted since the beginning of the epidemic.[24]

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23.   Ford & Airhihenbuwa, *supra* note 9. For a thoughtful and timely black feminist perspective on similar questions, see PATRICIA HILL COLLINS, ON INTELLECTUAL ACTIVISM (2012).

24.   I include myself and other health equity researchers here. Professor Derrick Bell raised similar concerns more than thirty years ago about "serving two

Those of us interested in changing this dynamic through eCRT must ask ourselves difficult questions. What compromises do we make as we navigate our dynamic social locations? How do these negotiations affect the residents of the deepest margins? What ethical issues arise when healthcrits engage in work that diverges from CBPR's models of equity and community engagement? To answer these questions requires clarity about what centering in the margins offers for each endeavor. Are the goals simply to (1) hear from people residing in the margins as they describe their adverse experiences and (2) increase the professional stature or institutional presence of racial/ethnic minority outsiders within who can serve as proxies for those residing in persistent margins? To answer these questions also requires a willingness to address the power differentials that exist between those of us who are outsiders within our institutions and those of us who are outsiders only.

Public Health is unlikely to undo these power differentials unless we continuously reflect upon at least three questions, "which margins are we talking about?," "who resides in them?," and "who occupies them?" Academic institutions and the public health sector may occupy margins if they maintain a presence in communities primarily to serve their own interests. A special responsibility rests with those of us who reside in institutional margins even as we walk in the "deepest margins" of our communities. We are mediators linking institutional or societal mainstreams to the deepest margins. Those linkages do not necessarily prioritize communities' interests, however. Indeed, they often exploit communities in order to achieve research objectives.[25] Therefore, to be aware of and attentive to the substantial amount of power we hold as facilitators of the linkages requires constant vigilance. I use the term *dynamic de-centering* to describe a self-critical process in which healthcrits reflect on these three questions and allow their responses to inform each aspect of their research process. In Public Health, outsiders within are often the ones who provide spaces in which residents of the deepest margins share their stories with the mainstream. We also hold the key to the portals through which institutions venture in search of human subjects. The idea that such power enables us to exploit the deepest margins for self-interest is not new; whether reflexivity is sufficient to address the implications of these power differentials remains to be determined.

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masters." Derrick A. Bell, Jr., *Serving Two Masters: Integration Ideals and Client Interests in School Desegregation Litigation*, 85 YALE L.J. 470 (1976).

25.   See Chandra L. Ford et al., Key Components of A Theory-Guided HIV Prevention Outreach Model: Pre-Outreach Preparation, Community Assessment, and a Network of Key Informants, 19 AIDS EDUC. & PREVENTION 173, 184 (2007).

CONCLUSIONS

In conclusion, there have been unforeseen challenges in our work to connect health equity research to Critical Race Theory *per se*; however, the Public Health movement is continuing to expand rapidly. Our PHCRP-based work, which represents only one most recent addition to anti-racism efforts within the field, resonates with many health equity researchers and advocates. Whether PHCRP and eCRT survive over the long term to substantively advance racial equity may hinge upon our ability to grapple across the disciplines with the kinds of questions being raised by this Symposium.