

# Addressing Racism in Research Can Transform Public Health

Jacquelynn Y. Orr, DrPH, MHA, Monique S. Shaw, PhD, MPH, Rachel Bland, MPH, George Hobor, PhD, MA, and Alonzo L. Plough, PhD, MPH

## ABOUT THE AUTHORS

All authors are with the Robert Wood Johnson Foundation, Princeton, NJ.

The Centers for Disease Control and Prevention recently issued a declaration reflecting what many already realized: racism is a threat to public health and a fundamental cause of health inequity in the United States. As we continue to grapple with COVID-19, now is the time to move beyond research that shines a light on health disparities and provide evidence of what works to address structural racism and improve health equity.

Racism shapes virtually every aspect of life, opportunity, and well-being. It harms individuals and hurts the health of our nation by unfairly lifting up some and oppressing others. It is also the driving force of social determinants of health, including education, housing, and employment.

Rooted in the belief that everyone should have a fair opportunity to lead a healthy life, philanthropy and research have often teamed up to address health inequities in the United States—inequities that became glaringly clear during the pandemic. COVID-19 epitomizes a complex crisis of infectious disease, food and housing insecurity, and mental distress, conditions already felt by communities and individuals that have been historically excluded.

Research is an essential tool that can ensure that the health and social

policies enacted during the pandemic positively affect communities for decades to come. For example, the COVID-19 US State Policy Database was developed to inform policy decisions that promote health equity and focus on policies that affect marginalized and historically excluded populations.<sup>1</sup> It is a powerful resource for states seeking solutions for an equitable response, recovery, and reopening.

But calling for more research and framing racism as an upstream public health issue cannot alone dismantle racist institutions or support community healing. We must evolve from Public Health 3.0, which emphasizes cross-sector collaboration and improving social determinants of health, to Public Health 4.0, which is community centered and driven by those most affected, to address racism as a public health issue in and outside the context of pandemic response efforts. We must collectively hold accountable the systems allowing racism to continue to be a barrier to health equity.

## REVAMPING DATA

There is a tremendous opportunity to transform public health research, including our nation's data infrastructure and the journals that publish the

findings, to better reveal inequities and their solutions and allow collaboration from all sectors. We have learned that consistent and disaggregated data are critical to understanding the lived experiences and outcomes in a public health crisis. Factors such as immigrant status, gender, sexual orientation, disability, language, socioeconomic status, and experiences with structural and interpersonal racism are intersectional, and all significantly influence health outcomes. That detail is lost once data are aggregated into broad categories of race and ethnicity. If we cannot fully understand the social determinants that affect people's health, it is impossible to respond with adequate action or policies.

In 2020, the Robert Wood Johnson Foundation and the Urban Institute released a series of reports to highlight the lack of data on maternal outcomes disaggregated by race and ethnicity, the link of pandemic-related changes to maternity care and preexisting inequities, and opportunities to improve maternal health equity after the pandemic.<sup>2</sup>

Before COVID-19, the United States was already experiencing a maternal morbidity and mortality crisis, and systemic racism has been a key driver of disparate maternal health outcomes. Women of color with low incomes are more likely to face food insecurity, unstable housing, and mental health challenges such as depression and anxiety, all of which may negatively affect health outcomes. And in recent decades, the maternal death rate has nearly doubled, with Black and Indigenous women two to three times more likely to die of pregnancy-related causes than are White women.

The reports emphasize that our existing data systems cannot support

maternal health equity and offer opportunities to improve it during and beyond the pandemic. As discussed in Huyser et al. (p. S208), the pandemic unveiled particular historical challenges to Indigenous populations and highlights how the current public health infrastructure perpetuates the effects of systemic racism. Hansotte et al. (p. S197) demonstrate how a local public health department used COVID-19 data disaggregated by race and ethnicity to make equitable resource allocation decisions.

As we continue to reimagine data, the Robert Wood Johnson Foundation established the first of its kind (to our knowledge) independent National Commission to Transform Public Health Data Systems.<sup>3</sup> The commission includes some of the nation's leading experts in areas such as health care, community advocacy, government, business, and public health, and it is tasked to identify the improvements in data systems that will better address social determinants and structural factors that result in inequitable health outcomes. The commission's recommendations are expected in fall 2021.

## AMPLIFYING THE MESSAGE

To reduce health inequities, we must use this moment to create a new future—one with strong leadership, commitment, community partnership, and changes in priorities and financing. Awareness of the need for the public health field to address racism is growing, but it will require deeper commitments from those who amplify the message and the data.

Work must continue that ensures that the public health community is explicitly naming racism. A 2018

literature review of peer-reviewed public health literature found that although institutionalized racism is recognized as a fundamental cause of health inequities, it was not often explicitly named in the titles or abstracts of articles published.<sup>4</sup> Naming institutionalized racism refers to explicitly and publicly using language and analyses that describe an issue as a matter of racial justice. By naming institutionalized racism in peer-reviewed literature and being explicit about how systems and institutions are designed to isolate or oppress people of color, we can analyze how these factors influence population health patterns. Researchers and the publications that promote their research have a critical opportunity to highlight how injustice and discrimination have been codified and reinforced in our health systems. Words have power to shift hearts and minds, generate knowledge, share solutions, and shape narratives. Being explicit about naming this critical construct may move the field forward in important ways.

## TAPPING COMMUNITY POWER

Community power is the ability of people most affected by inequity to create change through a shared agenda of achieving a larger vision. As Kline and Quiroga (p. S201) showcase, collaboration among researchers, public health practitioners, and community leaders can advance efforts to address social inequalities that inform poor health. A health equity lens must include the power and knowledge of communities who know best what they need to lead full and healthy lives.

The Robert Wood Johnson Foundation is committed to supporting research that provides evidence of

what works to advance health equity and addresses racism. For example, supporting the Asian & Pacific Islander American Health Forum to implement the Data Equity Project created an opportunity to engage community leaders across the country, including community public health organizations and social justice advocates, to address health challenges and provide local and regional community organizations with the tools, training, and organizational capacity building needed to advance health equity.<sup>5</sup>

Beyond the research itself, we must think critically about who interprets the results. Expanding the Bench offers a network and pipeline for diverse evaluators and builds demand among funders for those practicing culturally responsive and equitable evaluation.<sup>6</sup> These evaluations must comprehensively assess the research, including whether the research methods or approaches started with culturally appropriate planning and design, set a goal to advance equity, developed cocreated questions with the community meant to benefit from the research, amplified the voice of the community in data collection and disaggregated the data for various populations in the community, and validated the findings with the community.

## COMMITMENTS AND NEXT STEPS

To achieve health equity, we must name and identify racism where it exists and challenge the structural racism that shapes our governance, social structures, and policies that perpetuate inequities. Research must provide an evidence base for future policies and interventions that must be implemented at individual and community

levels to enhance health equity for all. This could look like the following:

- A deeper examination and commitment from journals, funders, and peer reviewers to explicitly name institutionalized racism in public health literature.
- An investment from funders and the philanthropic community to ensure research is conducted by a diverse body of researchers in partnership with community.
- Centering people who bear the greatest disparities—primarily Black, Indigenous, Asian American and Pacific Islander, Latino, Hispanic, and other communities of color—in research design, implementation, and policy advocacy.
- Practice-based research that shifts the paradigm to investigate the joint effects of multiple domains of racism (structural, interpersonal, cultural) so we can better measure racism and not just its effects.

There is no one-size-fits-all solution to combating racism. It will take real commitment, difficult conversations, sincere reflection, and humility from all of us. The time is now for researchers—and all those who apply research in their practice—to examine the mechanisms through which we continue to perpetuate racism and the methods critical to addressing it to lead us to a future of health equity. **AJPH**

## CORRESPONDENCE

Correspondence should be sent to Jacquelyn Y. Orr, DrPH, FACHE, Robert Wood Johnson Foundation, 50 College Rd East, Princeton, NJ 08540-6614 (e-mail: jorr@rwjf.org). Reprints can be ordered at <http://www.ajph.org> by clicking the “Reprints” link.

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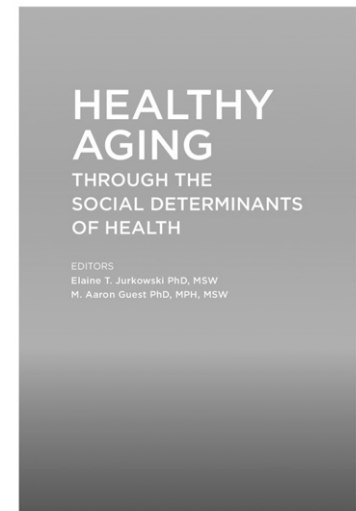
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We have no conflicts of interest from funding or affiliation-related activities.

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Edited by Elaine T. Jurkowski, PhD, MSW and M. Aaron Guest, PhD, MPH, MSW

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