Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism

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Setting the Agenda for Anti-racism

As president of the American Public Health Association (APHA) from 2015-2016, I launched a National Campaign Against Racism as a key agenda of my APHA presidency.[1,2] I set this agenda for the nation's flagship professional society for public health practitioners and researchers because I identified racism as the root cause of "race"-associated differences in health outcomes.[3] We must now set this agenda for our nation. Although some in this country will acknowledge that racism is foundational in our nation's history, many in this country are in denial about the continued existence of racism and its profound impacts on the health and well-being of the nation. Indeed, it is because of this widespread denial of racism that we must launch a National Campaign Against Racism with three tasks: 1) naming racism; 2) asking "how is racism operating here?" and 3) organizing and strategizing to act. Following are brief descriptions of each of these tasks, including a framework for an Anti-Racism Collaborative as a platform for organizing our work going forward.

Naming Racism

Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.[4,5] This definition of racism as a system (rather than an individual character flaw, personal moral failing, or psychiatric illness) helps start conversations because we are no longer trying to divide the room into who is racist and who is not. By acknowledging that racism saps the strength of the whole society, we recognize that we all have "skin" in the game to dismantle this system and put in its place a system in which all people can know and develop to their full potentials.

My use of allegory to illustrate different aspects of "race" and racism has been effective in naming racism to people who have been raised in denial and taught not to see. My Gardener's Tale[6,7] illustrates three levels of racism (institutionalized, personally mediated, and internalized) and strongly suggests that we must address institutionalized/structural racism if we are to set things right in our garden. The story also illustrates the importance of

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addressing both how racism structures opportunity and how it assigns value. Even if we could compel the gardener in that allegory to enrich the poor, rocky soil until it was as rich as the rich, fertile soil, if she continues to prefer the red flowers over the pink flowers, she will continue to privilege red over pink going forward. This story highlights that we must address both the opportunity structures (differential access to the goods, services, and opportunities of society by "race") and the value assignment (White supremacist ideology) in our anti-racism work.

Among my other published allegories, my Cliff Analogy[8,9] illustrates that to eliminate health disparities and achieve social justice, health interventions must address racism and other systems of structured inequity. My Japanese Lanterns[10] allegory illustrates how easy it is to be beguiled by the illusion of "race" as a fixed biological trait. My Dual Reality Restaurant Saga[10,11] illustrates how easy it is for those who are privileged by systems of structured inequity to be blind to the existence of those systems. My Conveyor Belt[10,12] allegory illustrates the three tasks of becoming actively anti-racist against the backdrop of societal indifference and complicity in racism.

Asking "How Is Racism Operating Here?"

The mechanisms of racism are in our structures, policies, practices, norms, and values, which are different elements of decision-making.[4] Structures are the "who?", "what?", "when?", and "where?" of decision-making; policies are the written "how?" of decision-making; practices and norms are the unwritten "how?" of decision-making; and values are the "why?" In evaluating these mechanisms of racism, we need to be especially attentive to the "absence of." Who is at the table, and who is not? What is on the agenda, and what is not? And when we note the "absence of," we need to take action to fill in the gaps. We need to become vigilant in identifying and addressing inaction in the face of need.

Answering the question, "How is racism operating here?" can be a powerful approach to identifying levers for potential intervention. Following is a thought exercise asking, "How is racism operating here?" with regard to police killings of unarmed Black and Brown men and women. Structures: the presence or absence of Citizen Review Boards to hold police departments accountable. Policies: reliance on the Grand Jury system to bring indictments against police officers. Practices: the over-policing of communities of color, which causes more "accidental" interaction. Norms: the Blue Code of Silence, which constrains reporting of and punishment for police misconduct by other police officers. Values: the widely held societal view of Black men as inherently threatening, which leads to justifying the excessive use of force. Any one of these mechanisms could be a fruitful focus for action. Better yet, we could organize to address several of these mechanisms at the same time.

Organizing and Strategizing to Act

During my term as president of APHA, I proposed an Anti-Racism Collaborative with eight Collective Action Teams as a structure for harnessing the wisdom and energy of anti-racism activists across the country and around the world. I envisioned much of the early work of the Anti-Racism Collaborative happening within social networking spaces, with later work extending into local geographies. I imagined the Anti-Racism Collaborative as the structure that would survive my presidency as APHA members and many other partners in communities across the country engaged in a sustained National Campaign against Racism.

Because the APHA social networking infrastructure was insufficient for hosting the Anti-Racism Collaborative, it was never launched by APHA. However, both the Center for the Study of Racism, Social Justice, and Health at UCLA[13] and the Social Medicine Consortium[14] have since embraced the National Campaign Against Racism as part of their work and are using the Anti-Racism Collaborative as a framework. Following are the initial guiding questions for each of the eight proposed Collective Action Teams:

1) Communication and Dissemination: How can we support the naming of racism in all public and private spaces? What tools and strategies are needed to start community conversations on racism?

2) Education and Development: How can we support the training of public health professionals and researchers around issues of "race," racism, and anti-racism at educational institutions of all levels? How does an effective anti-racism curriculum look?

3) Global Matters: How can we use the International Convention on the Elimination of all forms

of Racial Discrimination[15] to support anti-racism work in the United States? What can we learn from anti-racism work in other nations?

4) History: What is the history of successful anti-racism struggle in the United States and around the world? How can this history guide our anti-racism work today? How can we institutionalize attention to history in all decision-making processes?

5) Liaison and Partnership: What anti-racism work is happening at the community level? What anti-racism work is happening in other sectors? How can we create linkages?

6) Organizational Excellence: How do we answer the question "How is racism operating here?" in each of our settings? How do we examine structures, policies, practices, norms, and values?

7) Policy and Legislation: What are current policy and legislative strategies to address and dismantle racism? What new strategies should we propose?

8) Science and Publications: What research has been done to examine the impacts of racism on the health and well-being of the nation and world? What intervention strategies have been evaluated? What are next steps?

Through this Anti-Racism Collaborative, we aim to develop the science and practice of anti-racism, a science and practice complementary to, but quite distinct from, the efforts to document the adverse impacts of racism on the health and well-being of the nation and world. The science and practice of anti-racism will equip us to anticipate and respond to resistance and roadblocks that are thrown up as progress toward social equity is being made.

Barriers to Achieving Health Equity

Health equity has been defined as assurance of the conditions for optimal health for all people.[15] Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need.[15] Health disparities will be eliminated when health equity is achieved.[15]

In addition to economic and political barriers, there are at least three major cultural barriers to achieving health equity in the United States. The first cultural barrier is our narrow focus on the individual, which makes the systems and structures that drive inequities either invisible or irrelevant.[4,16] Self-interest becomes narrowly defined, sometimes not even encompassing extended family. There is a limited sense of inter-dependence and a limited sense of collective efficacy.

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The second cultural barrier is our a-historical stance. The present is viewed as disconnected from the past, and the current distribution of advantage and disadvantage is routinely viewed as happenstance despite the legacy of racism and its current manifestations.[17] Systems and structures are accepted as givens and treated as immutable.[18]

The third cultural barrier is our endorsement of the myth of meritocracy. This is the story-line that if you work hard in this country, you will make it. Certainly many (perhaps most) of the people who have made it in this country have worked hard. But there are many, many other people who are working just as hard or harder who will never make it in this country because, as research[19] has shown, an uneven playing field exists—one created and perpetuated by racism and other systems of structured inequity. Therefore, when we deny racism, we support the myth of meritocracy. And we can deny racism in at least two ways. We can say "I don't believe that racism exists." Or we can simply never say the word "racism." When we refuse to say the word "racism" in the context of its widespread denial, we are complicit with that denial.

One Last Thing: Treaty Obligations

The *International Convention on the Elimination of all Forms of Racial Discrimination*[20] is an international anti-racism treaty that was adopted by the United Nations General Assembly in 1965. It was signed by the United States in 1966. The US Senate ratified the treaty 28 years later in 1994. We have international treaty obligations to "do right" under this nine-page treaty.

One of our obligations is to sub-

mit periodic reports to the United Nations Committee on the Elimination of Racial Discrimination (UN CERD). The US Department of State submits reports roughly every six years, with the most recent report having been submitted in 2013.[21] The UN CERD reviewed this official US report, along with 82 parallel reports submitted by non-governmental organizations, and returned to the US government its Concluding Observations[21] in 2014. Among the Concerns and Recommendations expressed by the UN CERD were racial profiling (paras 8 and 18), residential segregation (para 13), the achievement gap in education (para 14), differential access to health care (para 15), and disproportionate incarceration (para 20).[21] In addition to recommendations in those areas, the UN CERD also "recommends that the State party adopt a national action plan to combat structural racial discrimination" (para 25).[21]

Conclusion

So here we are, recognizing the importance of launching a National Campaign Against Racism, and now also recognizing the international mandate for our government to do so. But a successful struggle against racism will require strong efforts and effective organization outside of the government. I hope that the nascent efforts to launch a National Campaign Against Racism that I made during my APHA presidency will bloom with the continued support and involvement of the Center for the Study of Racism, Social Justice, and Health at UCLA,[13] the Social Medicine Consortium,[14] and others. I hope that you, the reader, will get involved by naming racism, asking "How is racism operating here?", and organizing and strategizing to act. We need all of us, with our wisdom, energy, passion, questions, and gifts. I am convinced that together, we can dismantle this system that structures opportunity and assigns value based on "race",[4,5] and put in its place a system in which all people can know and develop to their full potentials. Let's go!

References

1. Jones CP. Launching an APHA presidential initiative on racism and health. *Nations Health*. 2016;45:3.
2. American Public Health Association. Racism and Health. Last accessed July 3, 2018 from https://www.apha.org/racism..
3. Jones CP. Invited commentary: "race," racism, and the practice of epidemiology. *Am J Epidemiol*. 2001;154(4):299-304. https://doi.org/10.1093/aje/154.4.299 PMID:11495851
4. Jones CP. Confronting institutionalized racism. *Phylon*. 2003;50(1-2):7-22.
5. Jones CP, Truman BI, Elam-Evans LD, et al. Using "socially assigned race" to probe white advantages in health status. *Ethn Dis*. 2008;18(4):496-504. PMID:19157256
6. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. https://doi.org/10.2105/AJPH.90.8.1212 PMID:10936998
7. CityMatCH Annual Urban MCH Leadership Conference, 2002. *A Discussion with Camara P. Jones, MD, MPH, PhD*. Last accessed July 3, 2018 from: https://www.youtube.com/watch?v=1QFCcChCSMU.
8. Jones CP, Jones CY, Perry GS, Barclay G, Jones CA. Addressing the social determinants of children's health: a cliff analogy. *J Health Care Poor Underserved*. 2009;20(4)(suppl):1-12. https://doi.org/10.1353/hpu.0.0228 PMID:20168027
9. The Urban Institute, 2018. *Dr. Camara Jones Explains the Cliff of Good Health*. Last accessed July 3, 2018 from https://www.youtube.com/watch?v=to7Yrl50iHI.
10. TEDx Emory, 2014. Allegories on "Race" and Racism. Last accessed July 3, from https://www.youtube.com/watch?v=GNhcY6fTyBM.
11. Jones CP. How understanding of racism can move public health to action: allegory highlights dual reality of privilege. *Nations Health*. 2016;46(1):3.
12. Jones CP. Life on a conveyor belt: making a choice to take action on racism. *Nations Health*. 2016;46(8):3.
13. Center for the Study of Racism, Social Justice, and Health. National Anti-Racism Collaborative. Last accessed July 3, 2018 from https://www.racialhealthequity.org/projects/.
14. Social Medicine Consortium. Campaign Against Racism. Last accessed July 3, 2018 from http://www.socialmedicineconsortium.org/campaign-against-racism/.
15. Jones CP. Systems of power, axes of inequity: parallels, intersections, braiding the strands. *Med Care*. 2014;52(10)(suppl 3):S71-S75. https://doi.org/10.1097/MLR.0000000000000216 PMID:25215922
16. Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. *Du Bois Rev*. 2011;8(1):115-132. https://doi.org/10.1017/S1742058X11000130 PMID:25632292
17. Gamble VN. A legacy of distrust: African Americans and medical research. *Am J Prev Med*. 1993;9(6 Suppl):35-38. PMID:8123285
18. Bonilla-Silva E. Rethinking racism: toward a structural interpretation. *Am Sociol Rev*. 1997;62(3):465-480. https://doi.org/10.2307/2657316
19. Bertrand M, Mullainathan S. Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination. *Am Econ Rev*. 2004;94(4):991-1013. https://doi.org/10.1257/0002828042002561
20. United Nations, Office of the High Commissioner for Human Rights. International Convention on the Elimination of All Forms of Racial Discrimination. Last accessed July 3, 2018 from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx.
21. United Nations, Office of the High Commissioner for Human Rights. Reports submitted by States parties under Article 9 of the Convention: Seventh to ninth periodic reports of States parties due in 2011. United States of America. CERD/C/USA/7-9, 3 October 2013. Last accessed July 3, 2018 from http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f7-9&Lang=en.
22. United Nations, Office of the High Commissioner for Human Rights. Concluding observations on the combined seventh to ninth periodic reports of the United States of America. Committee on the Elimination of Racial Discrimination. CERD/C/USA/CO/7-9, 25 September 2014. Last accessed July 3, 2018 from https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2fCO%2f7-9&Lang=en.