

RATIONALE FOR THE DESIGN AND IMPLEMENTATION OF INTERVENTIONS ADDRESSING INSTITUTIONAL RACISM AT A LOCAL PUBLIC HEALTH DEPARTMENT

Ryan Duerme, MPH¹; Alan Dorsinville, MPH¹;
Natasha McIntosh-Beckles, BS²;
Stacey Wright-Woolcock, MPH, MSW²

Purpose: The Bureau of Communicable Disease (BCD) at the New York City Department of Health and Mental Hygiene developed and implemented a multi-level intervention to: 1) establish bureau-wide race consciousness; 2) provide opportunities to examine the contemporary manifestations of racism impacting institutions and communities; 3) develop praxis applying a racial equity and social justice lens to communicable disease surveillance; and 4) center the experiences of Black, Indigenous, People of Color (BIPOC) staff.

Methods: A staff committee designed and implemented a multipronged initiative grounded in Public Health Critical Race (PHCR) praxis. The findings from a qualitative report focused on the experiences of POC staff formed the basis of the initiative.

Results: Three major themes were identified in the report (Microaggressions Report) as factors that resulted in institutional inequities within the workplace: race-based biases in promotion of staff; lack of opportunity sharing for professional growth; and dominant power relations silencing the voices of POC staff. Based on findings from the Microaggressions Report, BCD designed and implemented seven interventions including: 1) Racial Identity Caucusing; 2) Multimedia Learning; 3) All-staff Workshops; 4) Social Breakout Committee; 5) Surveillance and Data Equity; 6) Core Values Development; and 7) Committee for Hiring, Retention and Promotion.

Conclusion: We describe the rationale, design, and implementation of a multipronged intervention at a local health department as a strategy to address institutional racism. The creation of a Microaggressions Report and the PHCR methodology framed our ongoing effort to improve workplace culture

BACKGROUND

Institutional racism in the workplace manifests in explicit and implicit ways.¹⁻³ The most salient examples include inequity in promotion of staff into leadership and managerial positions, disparities in pay, disciplinary action and complaints between White and Black, Indigenous, People of Color (BIPOC) employees. A 2018 report by Service Employees International Union (SEIU) 1021 in San Francisco showed that 36% of employees cited for workplace violations were African American, despite only making up 15% of the city's workforce.^{4,5} Such citations can negatively affect performance evaluations tied to opportunities for advancement within an organization. Another study showed only 3%

of the African American members of the SEIU 1021 union held jobs in the highest tier of a given pay category, and the highest average salary for African American city workers was \$67,816, less than half of White workers' salary of \$150,165.⁶

The federal government is also implicated annually in racial discrimination class-action complaints and in minimally responding to redress the significantly lower proportion of federal Hispanic/Latino employees compared with the Hispanic/Latino proportion in the civilian workforce, 8.6% and 15% respectively.⁷⁻¹¹ While anti-discrimination laws serve to prevent workplace harassment and unequal treatment, persistent racialized outcomes in employment continue to exist.

The implicit expressions in the

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¹ New York City Department of Health and Mental Hygiene, Division of Disease Control, Long Island City, NY

² New York City Department of Health and Mental Hygiene, Bureau of Communicable Disease, Long Island City, NY

Address correspondence to Stacey Wright-Woolcock, City Research Scientist II, NYC Department of Health and Mental Hygiene; swright2@health.nyc.gov

workplace, such as favoritism and racial microaggressions (Table 1), are more difficult to categorize as clear violations of anti-discrimination policies and therefore harder to challenge and address through current channels like Equal Employment Opportunity (EEO) and employee unions.^{3,12-14} The lack of employee training, incident tracking, or policies to mitigate favoritism and racial microaggressions support the continued implicit manifestations of institutional racism. Racial inequity and racism are used interchangeably here.

This article describes the conceptualization, process and immediate outputs of the [NYC] Bureau of Communicable Disease's intervention, Dismantling Racism (DR).

Race-based oppression and White privilege show up across the levels of racism (internalized, interpersonal, institutional, structural). Individual self-perceptions shape interpersonal interactions and when these interactions and racial self-perceptions influence how people are valued and how opportunities are racially distributed in an institution, they become institutional rac-

ism. A multitude of institutions that consistently uphold White privilege and racial oppression shape societal values and racial outcomes. This is referred to as structural racism.

Persistent interpersonal racism experienced at work, such as microaggressions, without clear policies to redress them constitutes as institutional racism. In order to effectively address the four levels of racism, an intervention must be intersectional, critical, and responsive to the needs raised by the people most affected. Past victories establishing anti-discrimination policies often addressed racism only at one level. This can result in unintended outcomes. For example, consider Brown vs Board. This policy is praised for ending de jure segregation of public school students. However, the Supreme Court decision failed to include employment protection for both African American teachers and administrators, which resulted in the loss of stable employment for an estimated 38,000 government employed African American teachers a decade after Brown vs Board.¹⁵⁻¹⁷

Within the context of public health institutions, similar efforts to address racial inequities require a concerted effort from a critically conscious workforce skillfully equipped to interrogate racism and its effects across communities and within institutions.¹⁸ The framework for Critical Race Theory (CRT) aligns well with public health practice as it requires both thoughtful examination and sound action to eliminate institutional and structural inequity.^{19,20} To the best of our knowledge, the marrying of CRT and public health oc-

curred a decade ago with the development of the Public Health Critical Race praxis (PHCR) by Chandra L. Ford and Collins O. Airhihenbuwa.^{20,21} PHCR and, in 2014, the PHCR Institute at the University of Maryland's Center for Health Equity, guide population health researchers and practitioners in applying CRT in project design, methodology, and implementation.^{21,22} PHCR pushes public health practitioners to apply race beyond its typical role as a population variable or client demographic. PHCR, as a research and interventions roadmap that incorporates CRT, focuses on racism (rather than race) as an embedded and intertwined determinant of health and life outcomes. The methodology of PHCR requires disciplinary self-critique of how racism operates within programs, services, and policies, and by individuals. Projects utilizing PHCR are also bound within a contemporary timeframe, understanding that time, locality, and additional intersecting social identities determine how racism operates to structure which groups confront negative outcomes and which groups receive advantages and protections in health and society. Because racism stratifies opportunity and assigns social and institutional value in ways often benefiting Whites at the cost of BIPOC, placing groups and individuals most negatively impacted at the center of decision-making roles within projects is essential to the PHCR framework.

The New York City (NYC) Department of Health and Mental Hygiene (DOHMH) is an agency of more than 6,000 employees and is the oldest public health institu-

tion in the United States. The racial and ethnic demographics of the health department's employees are reflective of the diversity of NYC's 8.5 million residents; however, internal Human Resources data show BIPOC remain underrepresented in leadership positions. In 2016, DOHMH launched an agency-wide internal reform initiative to examine policies, practices, and operations with the goal of advancing racial equity and social justice across the Department.^{23,24} The initiative was grounded in the belief that eliminating health inequities in NYC begins with training staff to recognize and name racism in public health work and its impact in the workplace and across communities.²⁵⁻²⁷

The Bureau of Communicable Disease (BCD) is one of seven bureaus within the DOHMH's Division of Disease Control and includes approximately 100 employees whose key responsibility is to conduct surveillance for more than 70 reportable infectious diseases in NYC. In alignment with the agency-wide racial equity and social justice campaign, BCD developed and implemented a multi-pronged antiracist intervention to: 1) establish bureau-wide race-consciousness; 2) provide opportunities to examine contemporary manifestations of structural racism impacting institutions and communities; 3) develop praxis applying a racial equity and social justice lens to communicable disease surveillance; and 4) center the experiences of BIPOC staff. This article describes the conceptualization, process and immediate outputs of BCD's intervention, Dismantling Racism (DR).

METHODS

Setting

In March 2016, DOHMH conducted an agency-wide baseline survey exploring staff's knowledge, attitudes, and perceptions about race, racism, and racial equity efforts within the agency. Approximately 50% of employees responded to the survey, of which 84% stated they believed it is critical to discuss issues of racism within the Health Department and nearly 60% wanted to be more active in addressing racial inequities.²⁴

BCD Qualitative Assessment

As a follow-up to the agency-wide questionnaire, BCD conducted a qualitative assessment among employees who vocalized reluctance to participating in the baseline survey. The assessment comprised open-ended interviews exploring reasons for nonparticipation and pointed inquiry into staff experiences related to race and racism within the agency. Interviews were 30-60 minutes and conducted over a period of one month. The assessment was led by a female clinical social worker with training in antiracism pedagogy and trauma-informed care and employed by BCD for more than 10 years. The assessment was first initiated by eight employees who openly shared their reluctance about the agency-wide survey with the social worker. Each staff member shared their reactions to the survey independently and their responses were unsolicited. Their feedback included references to the experiences of four other employees who were subsequently interviewed by the social worker. Af-

ter receiving consent to share their narratives, a thematic analysis was performed, and the results were formalized into a deidentified report. In July 2016, the findings, officially known as the Microaggressions Report, was submitted to the assistant commissioner of BCD for review.

In 2016, the killing of two unarmed Black men and five Dallas police officers also prompted BCD to host a one-hour open forum to discuss the tragedies' impact on employees.²⁸⁻³⁰ The forum confirmed the need for ongoing dialogue and action, sentiments expressed and outlined in the results of the agency-wide survey and the themes identified in the Microaggressions Report. The latter formed the rationale and basis of our initiative.

Dismantling Racism Initiative

The inception, formalization, and execution of our initiative was exploratory. The Dismantling Racism (DR) initiative attempted to apply the principles of PHCR into the norms and practices of the culture and operation of BCD through five goals: 1) expand staff understanding of structural racism; 2) allow multiple entry points for staff engagement; 3) re-examine and transform policies and practices to better align with an antiracist organization; 4) share best practices and materials with other programs; and 5) create a more equitable workplace for BIPOC staff. Table 1 provides definitions and key terms related to our work; Table 2 shows the select principles of PHCR grounding DR, its adaptation into the specific context of our project setting, and the prin-

ciples' alignment to the five goals and seven interventions comprising DR. The five goals and seven interventions were developed from the results of the Microaggression Report and the need to address racism at the internal, interpersonal, and institutional levels. Because the initial components of DR were exploratory at its genesis, details of each intervention and outputs are included in our results, along with the themes identified in the Microaggressions Report. Our process outcomes are clear and replicable action steps that can be adapted at other public health programs to begin their own antiracist practice transformation.

The DR coordinating team included 15 employee volunteers from diverse staff titles, varying levels of managerial and non-managerial roles, and different racial backgrounds. The activities related to the coordination and execution of each intervention were completed in addition to the regular duties of each staff member and conducted during normal work hours. The only mandatory event for staff were the all-staff workshops; all the other committees and programs were optional and open to staff and interns. Staff were not required to attend a minimum number of sessions or interventions.

RESULTS

BCD Microaggressions Report

Approximately 12% of staff (10 BIPOC staff and two White) participated in the qualitative interviews. A few of the themes from the Microaggressions Report are highlighted below:

If [BIPOC staff] speak out about racial and social injustices they experience in the workplace, they are accused of being hostile, aggressive, difficult, and/or angry.

BIPOC staff observed that some [managers] in the bureau have expressed progressive, liberal views; however, many of them don't notice the physical and social segregation of certain units in the bureau and how it's much more difficult for BIPOCs to get promoted or salary increases than for others.

Staff members from all racial backgrounds noted preferences given to students and staff who are White, from elite schools and universities, and those who have "favorable network connections."

A staff of color with a graduate degree shared that they were thrilled to get a job in the bureau. However, within a couple of months, they noticed that some White colleagues, regardless of title, would speak condescendingly in meetings, often translating, clarifying, or explaining what was said. Observing that the same behavior didn't happen with White colleagues, they came to the realization that their opinions were probably less valued than [White colleagues].

Unequal treatment seems not exclusively based on color, but social and economic class, which is often associated with color.

The Microaggression Report identified three major thematic areas of concern as factors influencing race-based inequities among staff: 1) race-based inequities in promotion of staff; 2) lack of opportunity sharing for professional growth; and 3) dominant power relations silencing the voices of BIPOC staff. Additionally, BIPOC staff articulated a sense of doubt about the agency's prioritization of internal racial equity reform; their repeated sentiment was that the status quo within BCD and the agency would be maintained despite these efforts. While only 12% of BCD staff contributed to the report, other staff reported that the themes within the Microaggression Report reflected their experience in the workplace.

The Dismantling Racism Initiative

Tables 3 and 4 describe the seven interventions and the results of their implementation from September 2016 to present. Three interventions (Racial Identity Caucusing, Multimedia Learning, and All Staff Workshops) served as methods of learning and developing critical consciousness. Two (Surveillance & Data Equity and Hiring, Retention & Promotion) focused on examining current administrative and surveillance practices then identifying ways to better align policies and operation to CRT. The remaining two (Social Breakout and Core Values Development) attempted to build social cohesion among BCD employees guided by a common call to action for racial equity.

Table 1. Definitions and key terms on dismantling racism**Critical Consciousness**

Paulo Freire's framework of learning and action aimed to dismantle structural inequity. Freire proposed a cycle of critical consciousness development that involved gaining knowledge about the systems and structures that create and sustain inequity (critical analysis), developing a sense of power or capability (sense of agency), and ultimately committing to take action against oppressive conditions (critical action).³¹

Critical Race Theory (CRT)

An approach to studying and transforming the relationship among race, racism, and power. CRT incorporates the four basic features of race consciousness, contemporary orientation, centering in the margins rather than in the mainstream, and praxis (ie, theory-informed action).³²

Public Health Critical Race (PHCR) Praxis

Framework for conducting public health research supporting alignment of research question and methodology to the principles of Critical Race Theory.^{21,22}

Racial Equity

Achieved when race can no longer be used to predict population outcomes, such as health, education, and income.³³

Racial Microaggressions

Instances of subtle, interpersonal racism that negatively affect the physical, emotional, and mental health of Black, Indigenous, People of Color (BIPOC). In workplace settings, microaggressions can lead to loss of productivity and social cohesion.³⁴

Racism

A system of power and oppression that structures opportunities and assigns value based on race and ethnicity, unfairly disadvantaging BIPOC, while unfairly advantaging Whites. Racial prejudice + power = racism.³⁵⁻³⁷

Internalized Racism

The situation that occurs in a racist system when a racial group oppressed by racism supports the supremacy and dominance of the dominating group by maintaining or participating in the set of attitudes, behaviors, social structures, and ideologies that undergird the dominating group's power.³³

Interpersonal Racism

Occurs between individuals. Once one brings their private beliefs into their interaction with others, racism is now in the interpersonal realm.³³

Institutional Racism

Refers to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but their effect is to create advantages for Whites and oppression and disadvantage for people from groups classified as BIPOC.³³

Structural Racism

Characterized as the interaction of two or more institutions, culture, history, ideology, and codified practices that perpetuates inequity among racial and ethnic groups.³³

DISCUSSION

Beginning in 2016 and over a period of the next three years, BCD designed and implemented an internal initiative, Dismantling Racism (DR) composed of seven interventions attempting to address institutional racism within the bureau. The goals and activities of DR comprised multiple entry points for BCD staff

to gain a critical understanding of how racialization operated within the policies, practices, and organizational culture of the bureau. Dismantling Racism was educational, evaluative, and prompted practice change from BCD administration, its disease surveillance protocols, and established a call-to-action to all staff to learn and apply critical consciousness as a mecha-

nism for achieving racial equity.

The Microaggressions Report served as a collection of individual experiences and interpretations of the effects of institutional racism within a bureau at a large public health organization. The insidious nature of microaggressions can often be difficult to categorize as race-based discrimination, and thus difficult to address through current

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Table 2. Adaptation of PHCR principles into BCD Dismantling Racism (DR) Initiative

PHCR principles ²¹	DR adaptation	Aligned DR goals	DR interventions
Race-consciousness. Deep awareness of one's racial position; awareness of racial stratification process operating in colorblind contexts	Establish bureau-wide race-consciousness	Expand staff understanding of structural racism Allow multiple entry points for staff engagement	Racial Identity Caucusing Multimedia Learning All-staff Workshops Social Breakout Committee
Intersectionality. The interlocking nature of co-occurring social categories (eg, race and gender) and the forms of social stratification that maintains them			
Race as a social construct. Significance that derives from social, political, and historical forces	Provide opportunities to examine the contemporary manifestations of racism impacting institutions and communities	Expand staff understanding of structural racism Allow multiple entry points for staff engagement	Multimedia Learning All-staff Workshops
Ordinariness of racism. Racism is embedded in the social fabric of society			
Disciplinary self-critique. Systematic examination by members of a discipline of its conventions and impacts on the broader society	Develop praxis applying a racial equity and social justice lens to communicable disease surveillance, reporting and internal practice	Re-examine and transform policies and practices to better align with an antiracist organization Share best practices and materials with other programs to support overall agency Create a more equitable workplace for BIPOC staff	Surveillance and Data Equity Core Values Development Hiring, Retention, and Promotion
Voice. Prioritizing the perspectives of marginalized persons; privileging the experiential knowledge of outsiders within	Center the experiences of BIPOC	Re-examine and transform policies and practices to better align with an antiracist organization Create a more equitable workplace for BIPOC staff	Racial Identity Caucusing All-staff Workshops Hiring, Retention, and Promotion

BCD, Bureau of Communicable Disease; BIPOC, Black, Indigenous, People of Color.

policies and procedures. When persistent, microaggressions are disruptive in occupational settings and oppressive to employees impacted by these incidences. Moreover, the mitigation of these occurrences is often left up to the individual on the receiving end of the microaggression. Operationalizing the documentation and reporting of racialized microaggressions can serve to galvanize programs and form the basis of a more

sustained initiative aimed to improve workplace culture. An all-staff survey of microaggressions including and extending beyond perceived racial bias disseminated annually can also serve to capture more voices and measure progress over time.

Many experiences included in the Microaggressions Report were sentiments of frustration and powerlessness. The slow (and often lack of) progress on the structural, ad-

ministrative, and policy barriers that lead to racial inequities, coupled with ongoing incidences of racialized microaggressions, likely lead to increased stress and experiences of burnout for BIPOC staff. Many BIPOC staff who coordinated DR expressed similar symptoms. As a result, information on prevention and reduction of stress and burnout techniques were researched and presented as part of DR. Without

Table 3. Interventions and outcomes of the Dismantling Racism Initiative

Interventions	Outcomes
Racial Identity Caucusing: Bi-monthly 90-minute meetings facilitated by at least two staff members. Two separate meeting spaces for staff who identified as White and staff who identified as BIPOC. The BIPOC caucus could be further broken down into racial groups and a multiracial caucus based on the demographics and needs of the office. The last half-hour was a debrief with both groups together.	Between 15-25 staff attended each caucus meeting Explored many topics including racial identity formation, effects of racism on BIPOCs and BIPOC staff, White privilege and White supremacy, self-care and burnout, distancing behaviors, colorism, intersectionality, and the four levels of racism At least three additional bureaus adopted and implemented the caucusing model in their programs
Multimedia Learning: Bi-monthly 90-minute meetings featuring multimedia piece as the basis for a group discussion. Monthly email communication sent to all staff with links to media that related to race, racism, and social justice. Informed staff about institutional and structural racism.	Between 10-25 staff members attended each Multimedia group meeting Explored the following topics: White fragility, school segregation in NYC, policing, racism in the criminal justice system, the weathering hypothesis and maternal health of Black women, Japanese incarceration during WWII, the uprising in Ferguson, voter suppression, microaggressions, and debate over Confederate monuments
All-staff Workshops: Focused on critical learning, facilitating dialogue, and learning about the mechanisms of institutional racism. Brainstormed and strategized as a bureau how to resolve themes identified in the Microaggressions Report. Workshops included leadership development and team-building activities.	Completed four workshops to date. Two led by facilitators from the Center for Social Inclusion (CSI) and two organized and facilitated by BCD staff Summer 2017 Workshop (CSI led): Creating a shared understanding Fall 2017 Workshop: Examining microaggressions and establishing personal commitments Spring 2018 Senior Leadership Workshop (CSI led): Developing leadership for racial equity Fall 2018 Workshop: Staff narratives and core values commitments

BIPOC, Black, Indigenous, People of Color; BCD, Bureau of Communicable Disease.

including self- and community-care techniques, BIPOC staff may disengage from similar activities due to repeated presentations of the negative and triggering effects of racism. Features of DR aimed to build encouragement and staff solidarity by intentionally incorporating trauma-informed approaches, balancing content to emphasize empowerment, and incorporating team-building elements to the interventions.

Centering the voice of BIPOC staff in the design, approach, and envisioning of desired outcomes of DR directed the coordinators to the PHCR praxis. Ford and Airhihenbuwa's framework moves beyond

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conventions of diversity and multiculturalism to include challenging notions for both White and BIPOC staff at BCD.²¹ Introducing the concepts of White privilege, White fragility, intersectionality, and the use of racial identity caucusing required careful planning, clear definitions, and patience. The larger agency effort to adopt a racial and health equity lens reinforced the need to define and apply these concepts as new norms to public health practice.

Breaking conventions on what constitutes an outcome presented an additional challenge for DR coordinators. DR required staff to not only accept a longitudinal time frame to

Table 4. Interventions and outcomes of the Dismantling Racism Initiative (cont.)

Interventions	Outcomes
Social Breakout Committee: Planned and facilitated intentional social events aimed at team-building, staff support, and self-care.	Completed 15 successful bureau-wide events that included: One after-work BCD social hour outing Ongoing afternoon team-building tea breaks
Surveillance and Data Equity: Ongoing committee reviewing data collection protocols and ensuring race and ethnicity were collected in a manner that can effectively inform public health strategies to reduce infectious disease-related health inequities in NYC.	Developed a protocol for staff to guide race and ethnicity data collection during case interviews and chart reviews. Designed, implemented, and deployed electronic tools to accommodate and support the new BCD race/ethnicity data collection procedures Inspired Division-level workgroup to adopt a similar protocol for collecting race and ethnicity data across six additional bureaus
Core Values Development: Formed in response to an activity held at the 2017 all-staff workshop aimed to collectively develop core value statements to guide interpersonal engagement and institutional conduct.	DR Team collected and refined vision statements provided by more than 100 staff members and developed the following value statements based on their response. BCD Core Values: We stand for equity and commit ourselves to confronting racism and oppression in our daily work We strive to build a supportive and inclusive community where all staff have a voice and can be their authentic selves. We commit ourselves to sharing opportunities for growth and extending access to resources equally among all staff. We stand for supportive supervising and relationships to foster mentoring and knowledge sharing We believe in open communication, respect, compassion, and humility in our interactions with each other.
Hiring, Retention, and Promotion: Aim to ensure that new and current BCD staff were given equitable opportunities for professional development, meaningful inclusion and advancement.	Review of hiring and retention practices Implementation of peer mentorship program with 26 members, staff appreciation award and several other retention programs Provided staff with career development resources (eg, webinars, in-person human resources presentation)

BCD, Bureau of Communicable Disease.

measure sustained improvements in workforce equity, but also to view both staff engagement in racial/critical consciousness and the process toward becoming an antiracist institution as outcomes. New knowledge, changes to protocols, and advocating for equitable approaches to project assignments are meaningful ongoing and short-term goals for DR, whereas eliminating discrimination,

improving workplace culture, and pay equity are more distal. BCD administration is planning to review salaries for existing staff, including analyzing the data by race, gender, title and tenure. Investing time and prioritizing pay equity, is imperative to establish trust and assure BIPOC staff of BCD's commitment to equity and fair compensation. Agency and city-level response mirroring

the multi-pronged approach of DR is also needed to sustain advancements to workplace equity, as a single program within a large government agency cannot fully address these issues without clear support from city government leadership.

Generating the Microaggressions Report and utilizing the principles of CRT grounded our initiative. Our team also identified key strategies

and tactics that proved helpful in implementing the seven interventions. These strategies and tactics included:

Leverage organizational commitment to health equity as a prompt to initiate dismantling racism interventions;

Act fast as efforts to curtail the advancement of social justice should be anticipated;

Leadership advocacy and front-line participation can facilitate uptake in employee participation;

Normalize conversations about race and racism with ground rules and group agreements that allow for productive discourse;

Center race and utilize the framework of intersectionality in dialogue and when designing policy changes; and

Disseminate lessons learned and methodologies to dismantle the practice of knowledge silos and hoarding.

CONCLUSION

We describe the rationale, design, and implementation of multi-pronged interventions at a local health department as a strategy to address institutional racism affecting agency staff. In order to sustain capacity and efforts to address structural racism in public health, it is imperative that equal

effort be taken to interrogate how institutional racism within an organization affects the workforce tasked with implementing change, especially for BIPOC staff who often bear a greater burden of discrimination, trauma, and barriers to employment opportunities. Our conceptualization of racism as acting simultaneously on multiple levels incited a response to counter workplace racialized stratification at the internal, interpersonal, and institutional levels. The seven components of our initiative, Dismantling Racism, were grounded in PHCR principles and provided novel approaches for practitioners in health equity to bridge anti-racism methodologies with practice transformation. Uplifting the voices and empowerment of BIPOC staff as well as providing White staff with mechanisms to gain greater understanding of and to challenge systems of White supremacy were integrated throughout the activities of DR.

We invite other public health programs to become active anti-racist practitioners who call out implicit racism and pursue systemic change vs symbolic gestures. In the words of Assata Shakur, “We have nothing to lose but our chains.”

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CONFLICT OF INTEREST

No conflicts of interest to report.

AUTHOR CONTRIBUTIONS

Research concept and design: Duerme, Dorsinville, McIntosh-Beckles, Wright-Woolcock; Acquisition of data: Duerme, McIntosh-Beckles, Wright-Woolcock; Data analysis and interpretation: Duerme, Dorsinville, McIntosh-Beckles; Manuscript draft: Duerme, Dorsinville, McIntosh-Beckles, Wright-Woolcock; Administrative: Duerme, Dorsinville, McIntosh-Beckles, Wright-Woolcock; Supervision: Duerme, Wright-Woolcock

REFERENCES

1. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463. [https://doi.org/10.1016/S0140-6736\(17\)30569-X](https://doi.org/10.1016/S0140-6736(17)30569-X) PMID:28402827
2. Holroyd J. Implicit racial bias and the anatomy of institutional racism. *Crim Justice Matters*. 2015;101(1):30-32. <https://doi.org/10.1080/09627251.2015.1080943>
3. Pager D, Shepherd H. The sociology of discrimination: racial discrimination in employment, housing, Credit, and Consumer Markets. *Annu Rev Sociol*. 2008;34(1):181-209. <https://doi.org/10.1146/annurev.soc.33.040406.131740> PMID:20689680
4. SEIU 1021. San Francisco city workers fight discrimination on the job- hearing planned for July 18. Published July 10, 2018. Last accessed January 4, 2021 from <https://www.seiu1021.org/article/san-francisco-city-workers-fight-discrimination-job-hearing-planned-july-18>.
5. SEIU 1021. Workers take action to stop harassment and discrimination. Published March 11, 2019. Last accessed January 4, 2021 from <https://www.seiu1021.org/article/workers-take-action-stop-harassment-and-discrimination>.
6. Bishari N. Black city workers tackle systemic racism. *SFWeekly*. Published November 28, 2018. Last accessed January 4, 2021 from <https://www.sfweekly.com/news/black-city-workers-tackle-systemic-racism/>.
7. The Federal Hispanic Work Group, U.S.

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- Equal Employment Opportunity Commission. *Report on the Hispanic Employment Challenge in the Federal Government*. Published 2008. Last accessed January 4, 2021 from <https://www.eeoc.gov/federal-sector/reports/report-hispanic-employment-challenge-federal-government-federal-hispanic>
8. Davidson J. Latest federal diversity report from OPM shows little or no progress and some regression. *The Washington Post*. April 2, 2018. Last accessed January 4, 2021 from <https://www.washingtonpost.com/news/powerpost/wp/2018/04/02/latest-federal-diversity-report-from-opm-shows-little-or-no-progress-and-some-regression/>.
 9. Starks GL. Minority representation in senior positions in U.S. federal agencies: A paradox of underrepresentation. *Public Pers Manage*. 2009;38(1):79-90. <https://doi.org/10.1177/009102600903800106>
 10. United States Office of Personnel Management. *Federal Equal Opportunity Recruitment Program (FEORP) Accomplishment Report Fiscal Year 2016*. Published 2016. Last accessed January 4, 2021 from <https://www.dhs.gov/publication/fy16-feorp-report>.
 11. United States Office of Personnel Management. *Executive Branch Employment by Gender and Race/National Origin; September 2006 – September 2017. Data, Analysis & Documentation*. Last accessed January 4, 2021 from www.opm.gov/policy-data-oversight/data-analysis-documentation/federal-employment-reports/reports-publications/executive-branch-employment-by-gender-and-racenaional-origin/.
 12. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271-286. <https://doi.org/10.1037/0003-066X.62.4.271> PMID:17516773
 13. DeCuir-Gunby JT, Gunby NW Jr. Racial microaggressions in the workplace. *Urban Educ*. 2016;51(4):390-414. <https://doi.org/10.1177/0042085916628610>
 14. Galupo MP, Resnick CA. Experiences of LGBT microaggressions in the workplace: implications for policy. In: Kollen T, ed. *Sexual Orientation and Transgender Issues in Organizations: Global Perspectives on LGBT Workforce Diversity*. Switzerland: Springer International; 2016:271-287. https://doi.org/10.1007/978-3-319-29623-4_16
 15. Montalvo A. The rise and fall of Black teachers and principals in U.S. public schools since Brown v. Board. Published May 4, 2018. Last accessed January 4, 2021 from <https://commons.trincoll.edu/edreform/2018/05/the-rise-and-fall-of-black-teachers-and-principals-in-u-s-public-schools-since-brown-v-board/>.
 16. Oakley D, Stowell J, Logan JR. The impact of desegregation on black teachers in the metropolis, 1970-2000. *Ethn Racial Stud*. 2009;39(9):1576-1598. <https://doi.org/10.1080/01419870902780997> PMID:24039318
 17. Rosenthal JO. Negro teachers' attitudes toward desegregation. *J Negro Educ*. 1957;26(1):63. <https://doi.org/10.2307/2293328>
 18. Griffith DM, Childs EL, Eng E, Jeffries V. Racism in organizations: the case of a county public health department. *J Community Psychol*. 2007;35(3):287-302. <https://doi.org/10.1002/jcop.20149> PMID:18852826
 19. Graham L, Brown-Jeffy S, Aronson R, Stephens C. Critical race theory as theoretical framework and analysis tool for population health research. *Crit Public Health*. 2011;21(1):81-93. <https://doi.org/10.1080/09581596.2010.493173>
 20. Ford CL, Airhihenbuwa CO. Commentary: just what is critical race theory and what's it doing in a progressive field like public health? *Ethn Dis*. 2018;28(suppl 1):223-230. <https://doi.org/10.18865/ed.28.S1.223> PMID:30116090
 21. Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. *Soc Sci Med*. 2010;71(8):1390-1398. <https://doi.org/10.1016/j.socscimed.2010.07.030> PMID:20822840
 22. University of Maryland Public Health Critical Race Praxis Institute. *What is Critical Race Theory?* [Webpage] Last accessed January 4, 2021 from <https://sph.umd.edu/center/che/public-health-critical-race-praxis-institute>.
 23. New York City Department of Health and Mental Hygiene. Race to Justice - NYC Health. [Webpage] Last accessed January 4, 2021 from <https://www1.nyc.gov/site/doh/health/neighborhood-health/race-to-justice.page>.
 24. Human Impact Partners. *New York City Races to Justice*. [Webpage] Last accessed January 4, 2021 from <https://healthequityguide.org/case-studies/new-york-city-races-to-justice/>.
 25. Geronimus AT. To mitigate, resist, or undo: addressing structural influences on the health of urban populations. *Am J Public Health*. 2000;90(6):867-872. <https://doi.org/10.2105/AJPH.90.6.867> PMID:10846503
 26. Hagopian A, West KM, Ornelas IJ, Hart AN, Hagedorn J, Spigner C. Adopting an anti-racism public health curriculum competency: the University of Washington experience. *Public Health Rep*. 2018;133(4):507-513. <https://doi.org/10.1177/0033354918774791> PMID:29847749
 27. Aysola J, Barg FK, Martinez AB, et al. Perceptions of factors associated with inclusive work and learning environments in health care organizations: a qualitative narrative analysis. *JAMA Netw Open*. 2018;1(4):e181003. <https://doi.org/10.1001/jamanet-workopen.2018.1003> PMID:30646094
 28. Bassett MT. #BlackLivesMatter—a challenge to the medical and public health communities. *N Engl J Med*. 2015;372(12):1085-1087. <https://doi.org/10.1056/NEJMp1500529> PMID:25692912
 29. National Association of County & City Health Officials (NACCHO). *Statement of Policy: Public Health, Racism, and Police Violence*. Published July 2015. Last accessed January 4, 2021 from <https://www.naccho.org/uploads/downloadable-resources/15-04-Public-Health-Racism-and-Police-Violence.pdf>.
 30. WSJ News Graphics. From Ferguson to Dallas: a recent history of deaths involving police. *Wall Street J*. July 8, 2016. Last accessed January 4, 2021 from <http://graphics.wsj.com/dallas-police-involved-deaths/>.
 31. El-Amin A, Seider S, Graves D, et al. Critical consciousness. *Phi Delta Kappan*. 2017;98(5):18-23. <https://doi.org/10.1177/003172171717690360>
 32. Delgado R, Stefancic J. *Critical Race Theory: An Introduction*. New York, NY: New York University Press; 2001.
 33. Racial Equity Tools [Webpage]. Last accessed January 4, 2021 from <https://www.racialequitytools.org/resources/fundamentals/core-concepts>
 34. Hall JM, Fields B. "It's Killing Us!" Narratives of Black adults about microaggression experiences and related health stress. *Glob Qual Nurs Res*. 2015;2:2333393615591569. <https://doi.org/10.1177/2333393615591569> PMID:28462310
 35. 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
 36. Race Forward. *Race Reporting Guide*. Published June 2015 [Webpage]. Last accessed January 4, 2021 from <https://www.raceforward.org/reporting-guide>
 37. The People's Institute for Survival and Beyond (PISAB). *Our Principles*. Published May 8, 2018 [Webpage]. Last accessed January 4, 2021 from www.pisab.org/our-principles/.