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The public health critical race methodology: Praxis for antiracism research☆

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ABSTRACT

The number of studies targeting racial health inequities and the capabilities for measuring racism effects have grown substantially in recent years. Still, the need remains for a public health framework that moves beyond merely documenting disparities toward eliminating them. Critical Race Theory (CRT) has been the dominant influence on racial scholarship since the 1980s; however, its jurisprudential origins have, until now, limited its application to public health research. To improve the ease and fidelity with which health equity research applies CRT, this paper introduces the Public Health Critical Race praxis (PHCR). PHCR aids the study of contemporary racial phenomena, illuminates disciplinary conventions that may inadvertently reinforce social hierarchies and offers tools for racial equity approaches to knowledge production.

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Introduction

A growing body of research applies conventional scientific methods to the study of racialized risk factors and populations. The aim of this research is to explain relationships between racism and health disparities. Although it advances understandings of racism as a social determinant of health, this work is largely disconnected from Critical Race Theory (CRT), the most dominant influence on racial scholarship since the 1980s. Reasons for the disconnect include CRT's methodological complexity and jurisprudential orientation, both of which contrast with public health's scientific approach and emphasis on practical application.

To improve the ease and fidelity with which public health researchers can use CRT to conduct health equity research, we developed the Public Health Critical Race praxis (PHCR). PHCR maintains public health's high standards for scientific rigor while drawing on the robust body of antiracism work that exists outside public health.

As detailed elsewhere (Crenshaw et al., 1995; Delgado & Stefancic, 2001) (Ford & Airhihenbuwa, 2010), CRT is a decentralized movement among scholars, researchers and activists that coheres around a set of tenets regarding racialization, marginalization and the role of critical race theorists (i.e., 'crits') in producing knowledge about societal inequities (Delgado & Stefancic, 2001). That a study involves racialized exposures, populations or outcomes does not automatically make it a CRT endeavor. In fact, most such studies are not based on CRT. Studies are critical race endeavors if they adhere to CRT's core tenets. PHCR is grounded in CRT. Both CRT and PHCR attempt to move beyond merely documenting health inequities toward understanding and challenging the power hierarchies that undergird them. PHCR helps public health researchers to carry out health equity research with fidelity to CRT.

The purpose of this paper is to describe our Public Health Critical Race praxis (PHCR). PHCR tailors CRT to the field of public health, thus facilitating the use of CRT for health equity research. An example of empirical research conducted using CRT has been published elsewhere (Ford & Airhihenbuwa, 2010). Here, we continue to build the capacity for CRT-based, health equity research. We summarize key characteristics of CRT and describe PHCR's schematic, process, four focuses and ten principles. Finally, we discuss recommendations for and cautions regarding widespread uptake of PHCR within the field of public health.

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Key characteristics of critical race theory (CRT)

CRT has at least four distinguishing characteristics. First, issues of racialization (i.e., racial phenomena, race, ethnicity and racism) are at its core. Racialization describes how socially constructed racial and ethnic categories are used to order groups in society. All critical race endeavors begin with the question, "How does racialization contribute to the problem at hand?" Accordingly, race consciousness is fundamental to CRT. As we discuss later, race consciousness connotes the acknowledgement and explicit study of racial dynamics both in society and within one's personal life. Race consciousness is particularly important in the early 21st century as racial inequities generally are attributed to non-racial (e.g., socio-economic) factors while potentially relevant racial factors (e.g., discrimination) remain largely unexamined. Accounting for non-racial factors is important; however, doing so should not preclude consideration of the integral, often antecedent ways that racialization may condition disease distributions (Brown et al., 2003).

Issues of social location are also important to CRT. Social location refers to an individual's or a group's position within a social hierarchy (e.g., privileged vs. marginalized, minority vs. majority) and informs the perspectives from which one views a problem. For instance, disciplinary discourses generally are rooted in the perspectives of the mainstream, even when the discourse aims to understand issues disproportionately affecting marginalized groups. This orientation can subtly reinforce the marginalization of viable, non-mainstream perspectives, however. CRT therefore emphasizes the perspectives of marginalized groups. This process, known as "centering in the margins", can enrich mainstream understandings of problems and reduce the possibility of developing perspective imbalances (Schulz & Mullings, 2006).

A final characteristic of CRT is that it aims not only to understand inequities, but to eliminate them. Thus, researchers rely heavily on the findings to develop strategies for addressing inequities.

Crits (short for critical race theorists) are often described as "a collection of activists and scholars interested in studying and transforming the relationship among race, racism, and power"(-Delgado & Stefancic, 2001) (p. 3). Considered 'outsiders within' their respective disciplines, they integrate expertise regarding their discipline's theories, methods and conventions with expertise derived from critical personal analyses, experiential knowledge and scholarship on marginalization. The integration of these knowledges yields a double consciousness (Du Bois, 1903) that enables them to draw on multiple or integrated perspectives when examining problems.

Since its emergence in jurisprudence, scholars in gender studies (Collins, 2004; Wing, 2003), education (Ladson-Billings, 1998), social science (Bonilla-Silva, 2006; Krysan & Lewis, 2004), philosophy (Mills, 1998), American studies (Kelley, 1994) and other disciplines have used terms such as Latcrits or femcrits to signal the primary focus (e.g., Latinos or women, respectively) of their CRT work. In that spirit, we coin the term 'healthcrits' to name persons who use PHCR or CRT more broadly to conduct health equity research or practice.

Public health critical race praxis (PHCR): the model and process

There are many ways to draw on CRT. What PHCR offers is a semi-structured process for conducting research that remains attentive to issues of both racial equity and methodologic rigor. As praxis (i.e., an iterative methodology), it combines theory, experiential knowledge, science and action to actively counter inequities. PHCR may be used either alone as a broad framework or in conjunction with other theories or methods. It informs research on the causes of health disparities. It also guides efforts to understand how racialization may influence disciplinary conventions (e.g., academic promotion standards that place little value on building

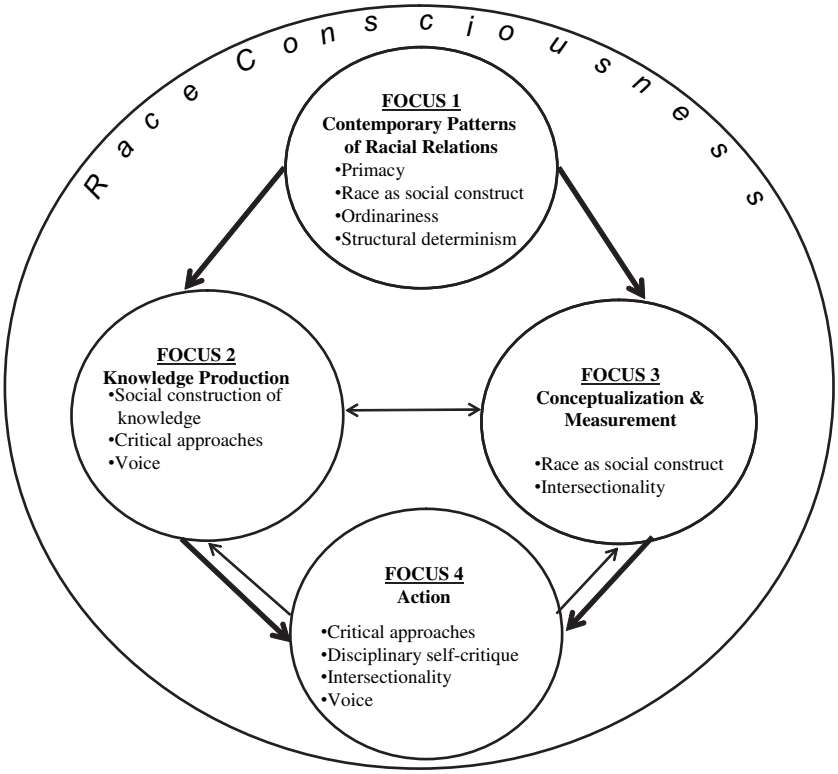


Fig. 1. Race consciousness, the four focuses and ten affiliated principles.

community capacity), including modes of knowledge production (e.g., the tendency to perceive minority populations from a deficits perspective) that may inadvertently reinforce inequities. In the following section, we describe the PHCR schematic and process.

The schematic

The PHCR schematic (Fig. 1) is like a roadmap; it guides researchers in carrying out PHCR research. In contrast to behavioral and epidemiologic schematics in which the lines and shapes indicate hypothesized causal associations, PHCR's lines and shapes indicate the order in which to proceed during the research process, the main areas of focus at each of four phases in the process, and the principles on which to draw. Although research generally moves sequentially from Focus 1 through Focus 4 as indicated by the thick arrows in Fig. 1, some movement in the opposite direction also occurs as indicated by the thin arrows. PHCR proceeds through four phases, called focuses. Healthcrits systematically work through each focus by drawing on the affiliated principles. To 'work within a focus' means to devote one's energies to addressing that focus's purpose. For instance, to work within Focus 3: Conceptualization and Measurement means to draw on the affiliated principles of *race as social construct* and *intersectionality* to operationalize study variables.

The process

This section explains how to conduct PHCR research. First, establish a personally race conscious orientation to a proposed endeavor, clarifying how and why the race conscious orientation is taken. To understand the causes of racial health inequities requires solid understandings of the salience of racialization in society and in one's personal life; therefore, race consciousness frames the entire process (Fig. 1).

While working in *Focus 1: Contemporary Patterns of Racial Relations*, describe key characteristics of societal racialization for the study's time period. For instance, where do the groups being studied fall on the prevailing racial hierarchy? In *Focus 2: Knowledge Production*, identify disciplinary norms or other considerations that, if unaccounted for, may inadvertently bias the understandings derived from the research. For instance, does the prior literature rely (explicitly or implicitly) on assumptions that the proposed research fundamentally contests? If so, describe the implications for the present study or explicate how study design preferences within a field might limit the scope of the equity-oriented research question. In *Focus 3: Conceptualization and Measurement*, decide how best to operationalize key concepts while accounting for the implications raised in Focus 2: Knowledge Production. For instance, compare conventional and novel measures to determine the adequacy with which each captures the study's racial equity concepts. In *Focus 4: Action*, use the knowledge gained from the research to determine whether any action(s) can be taken to help counter the inequities. For instance, share study results, including its limitations and strengths, with the affected communities.

Throughout the process, draw on empirical data as well as other kinds of information as needed to address each focus's purpose. Qualitative data, theory and personal reflection are important information sources. When used appropriately, they provide rich insights that are unobtainable from quantitative data. For instance, while critical self-reflection is invaluable in helping investigators identity their personal biases relative to a project, quantitative data is not helpful for this purpose.

Key concepts

PHCR's key concepts include four *focuses*, which represent the main phases of the PHCR process, and ten basic *principles*. Although some PHCR concepts may initially seem familiar to new healthcrits, their meanings within CRT should not be confused with those used elsewhere. In this section, we describe each focus's purpose and indicate its affiliated principles. In the next section, we describe the PHCR principles.

Four focuses (i.e., phases) of PHCR

There are four main phases to the PHCR research process (Fig. 1); we call them the four focuses. They include Contemporary Patterns of Racial Relations (Focus 1), Knowledge Production (Focus 2), Conceptualization & Measurement (Focus 3), and Action (Focus 4).

Focus 1: contemporary racial relations

Although racism is permanent within racialized societies, the ways in which it operates change over time.

> "The defeat of Jim Crow racism and the victories of the civil rights era did not eradicate…gargantuan disparities in accumulated wealth; …they did not reallocate political power and other elements of American political culture…that feed and sustain racism.
>
> These victories did, however, fundamentally restructure the terrain on which racism is now enacted, understood, and reproduced."(Bobo, 2004) (p. 34)

To study racism's effect on health, healthcrits must conceptualize racism based on how it operates in the period of interest to the study. Efforts to understand inequities in the 1950s should reflect how racialization operated then, while research on inequities in the 2000s should be based on contemporary characteristics. Key characteristics of US racialization in the post-civil rights era include that it is structural in nature, but subtler than the overt racism of earlier periods (Bobo, 2004; Bonilla-Silva, 2006; Winant, 2004). Studies on inequities in 2050 should capture key characteristics of racialization in 2050. If the conceptualization does not capture contemporary ways that racism operates, the study will generate misunderstandings and invalid estimates.

Within the focus of contemporary racial relations, healthcrits describe salient characteristics of racialization relative to the study's time period. Questions they may pose include, which populations are most marginalized? Or by what mechanisms does racism work? Healthcrits draw on four principles—primacy, race as social construct, ordinariness and structural determinism—to characterize contemporary racialization. By properly characterizing it, they identify factors for which to account either qualitatively or quantitatively in the research (Fig. 1). If quantitative assessments are infeasible or inappropriate, healthcrits can qualitatively describe relevant characteristics in the Introduction or Discussion sections of related publications.

Focus 2: knowledge production

The purpose of this focus is to understand how racialization may shape a project or, conversely, how the project may reinforce existing beliefs about racial groups or phenomena. Crits consider knowledge production an inherently subjective enterprise in which discipline's norms and conventions help to reinforce existing racial (and other) hierarchies (Mills, 1998; Zuberi & Bonilla-Silva, 2008). Scientific knowledge is not excepted; nevertheless, its social construction is rarely acknowledged (Press & Tanur, 2001). Further, many public health researchers continue to believe that the objectivity of the scientific method precludes bias from influencing their research. Overreliance on this belief, however, can blind them

to the inadvertent influence of racial or other biases especially when research targets social phenomena or groups (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007).

While working within this focus, healthcrits explore how personal subjectivities as well as disciplinary conventions may shape the knowledge on a topic. Important considerations include (1) whether racialization already has informed existing knowledge on a topic (e.g., does the literature on a topic reflect historical biases?); (2) how the conventional tools for knowledge production may influence an immediate study (e.g., standard research approaches may stigmatize a community, but journals may be unwilling to publish findings based on other approaches such as those emphasizing positive outcomes); and, (3) whether the research findings advance knowledge on a topic in ways that promote racial equity. As indicated by the two-headed arrow in Fig. 1, a dynamic relationship exists between this focus and that of Conceptualization & Measurement. By working iteratively between the two focuses toward saturation, healthcrits refine the assessment of study concepts and relationships. The principles of social construction of knowledge, critical approaches and voice are used while working within this focus.

Focus 3: conceptualization and measurement

The purpose of this focus is to define a study's race- or racism-related constructs, the hypothesized relations between constructs, and the social contexts in which the constructs and relationships exist. Constructs and measures should be context-specific because racism functions differently depending on the place, population, time and context. For example, studies that use fixed racial categories to examine social determinants of health across diverse geographic regions can acknowledge the possibility of overestimating racial effects while underestimating regional ones (Ford & Harawa, 2010).

While working within this focus, healthcrits use qualitative and other information, including theory, to operationalize constructs and describe hypothesized relationships. They develop measures to capture the constructs' characteristics. Two principles, social construction and intersectionality, are central to the focus of Conceptualization & Measurement (Fig. 1).

Focus 4: action

> "There is no distinction between theorization and intervention. We regard all theorization as political intervention and all intervention as theoretically motivated."(Airhihenbuwa, 2007a) (p. 34)

As praxis, the critical race process comes full circle when researchers use the knowledge obtained through their studies to help disrupt one or more causes of the inequities. Action steps may include: (1) expanding the vocabulary with which to discuss poorly understood racial and power relations; (2) using storytelling that is centered in the margins to describe a problem; and, (3) directly challenging identified injustices (e.g., direct action, lawsuits). Although the problem may be due to racism, the responses are not necessarily racial in nature as cultural or other tools may be more effective in addressing the problems (Airhihenbuwa & Liburd, 2006). Efforts to improve understandings of racism are hampered by the inadequate vocabulary for discussing it and the pervasive but contestable belief in the declining significance of racism. Therefore, crits target these challenges by expanding the lexicon for studying abstract racial concepts and relations (for example see (Robinson, 2008)).

Critical storytelling is one of the ways that crits take action based on study findings. The use of allegory, metaphor and other storytelling tools helps researchers translate complex ideas into simple tales. Storytelling is non-threatening; therefore, healthcrits can use it to promote understandings of controversial topics. In addition, storytelling personalizes the experiences of minorities, reducing the social distance between majority researchers and minority communities. Whatever actions a project takes, it draws on the principles of critical approaches, disciplinary self-critique, intersectionality and voice (Fig. 1).

Ten principles

In the previous section, we described the four areas on which the PHCR process focuses. Each focus is affiliated with one or more principle(s). While working within a focus, healthcrits draw on the affiliated principles to guide them in achieving the focus's purpose. Table 1 lists the 10 principles—(1) race consciousness; (2) primacy of racialization; (3) race as social construct; (4) ordinariness of racism; (5) structural determinism; (6) social construction of knowledge; (7) critical approaches; (8) intersectionality; (9) disciplinary self-critique; and, (10) voice—and the focus(es) with which each is affiliated.

Race consciousness

Race consciousness is the backbone of PHCR because it is difficult to investigate racism's contribution to health inequities without first acknowledging and understanding racialization. As Derek Bell, the father of CRT put it,

> The racial philosophy we must seek is a hard-eyed view of racism as it is and our subordinate role in it (Bell, 1991) (pp. 89–90).

As previously indicated, race consciousness is the lens through which all aspects of PHCR research occur. Race consciousness connotes explicit attention to racial dynamics in the social world and in one's personal world (e.g., clarifying one's relationship to a racial project). Race consciousness is important whenever, as is the case in the early 21st century, colorblind ideologies pervade racially stratified societies (Bobo, 2004). According to colorblindness, non-racial factors such as poverty fully explain ostensibly racial disparities. Colorblindness further posits that to acknowledge race is in and of itself racist. This conflation (of race with racism) is problematic because it fails to distinguish between naming race and naming the differential allocations of power that occur by race. King (1997) examined how race and racism are conflated and misused in research on smoking among African Americans. He described flawed approaches in which racially classified social groups (i.e., blacks) are treated as independent biologic and genetic variables. Conclusions about "racial" differences in smoking behaviors that are drawn from the flawed approaches typically are based on categories of 'social convenience' and 'convention', rather than scientifically acceptable distributions of population genes (King, 1997). Even when differences are explained sociologically (e.g., low socioeconomic status), they often are attributed to group characteristics with little attention paid to systemic and institutional racism.

According to CRT, however, racialization is integral to society. CRT refutes colorblind ideologies that ignore the role of racialization in generating racially differential risks for otherwise non-racial, social exposures (e.g., poverty, incarceration).

Colorblindness undermines efforts to redress racial causes of inequities by restricting the vocabulary for describing problems, limiting the availability of data for studying racial problems and discarding the tools with which to remedy them (Bonilla-Silva, 2006). For instance, several years ago, social conservatives attempted to end the routine collection of data on race and ethnicity in state databases (Krieger, 2004). Had this effort been successful, it would have become illegal to collect the data on

Table 1
PHCR principles and affiliated focuses.

Principle	Affiliated Focus(es)	Definition	Conventional Approach	PHCR Approach
1. Race consciousness	All	Deep awareness of one's racial position; awareness of racial stratification processes operating in colorblind contexts	Colorblindness-belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors (e.g., SES)	A researcher clarifies her racial biases before beginning research within a diverse community
2. Primacy of racialization	Contemporary Racialization	The fundamental contribution of racial stratification to societal problems; the central focus of CRT scholarship on explaining racial phenomena	Tendency to attribute effects to race rather than to racialization or racism	A study on neighborhood characteristics includes factors hypothesized to reflect structural racism
3. Race as social construct	Contemporary Racialization Conceptualization & Measurement	Significance that derives from social, political and historical forces	Biological determinism – the belief that race is meaningful because it provides insights about one's biology and propensities	A study assesses race not as a risk factor but to identify a population at risk for specific racism exposures
4. Ordinariness of racism	Contemporary Racialization	Racism is embedded in the social fabric of society	Racial exceptionalism-defines racism as rare, discrete and overtly egregious incidents	A study on racism and health operationalizes racism as routine exposures (e.g., being followed while shopping)
5. Structural determinism	Contemporary Racialization	The fundamental role of macro-level forces in driving and sustaining inequities across time and contexts; the tendency of dominant group members and institutions to make decisions or take actions that preserve existing power hierarchies	Emphasizing individual or interpersonal factors	A multilevel study considers policy factors that may promote residential segregation
6. Social construction of knowledge	Knowledge Production	The claim that established knowledge within a discipline can be re-evaluated using antiracism modes of analysis	The belief that empirical research carried out properly is impermeable to social influences	A disparities-related literature review compares articles published in minority vs. majority journals
7. Critical approaches	Knowledge Production Action	To dig beneath the surface; to develop a comprehensive understanding of one's biases	To accept phenomena or explanations at face value	A researcher considers alternative explanations for findings than those previously posited
8. Intersectionality	Conceptualization & Measurement Action	The interlocking nature of co-occurring social categories (e.g., race and gender) and the forms of social stratification that maintain them	Additive model of co-occurring social categories (e.g., race and gender)	Efforts to reduce HIV risk behaviors among diverse men who have sex with men address racial stereotypes
9. Disciplinary self-critique	Action	The systematic examination by members of a discipline of its conventions and impacts on the broader society	Limited critical examination of how a discipline's norms might influence the knowledge on a topic	Researchers examine implications for research of using 'health inequities' vs. 'health disparities' vs. 'health inequalities'
10. Voice	Knowledge Production Action	Prioritizing the perspectives of marginalized persons; Privileging the experiential knowledge of outsiders within	Routine privileging of majority perspectives	Responses of skepticism or anger when outsiders within speak truth to power

ethnicity and race needed to determine whether minorities are systematically excluded from opportunities (Krieger, 2004).

Through formal and informal training, critical race scholars develop expertise not only in their traditional areas of study, but also in racialization. This is necessary to ensure that race conscious critical analyses are rigorous and anchored in the existing knowledge on racialization. Healthcrits draw on race consciousness in every focus of PHCR.

Primacy of racialization

Racialization describes social stratification in which socially constructed racial categories are the bases for ordering society. The primacy of racialization has two connotations within PHCR. It connotes racialization's foundational contribution to inequities. It also names critical race scholarship's central focus: understanding how racialization influences (1) observed outcomes, (2) knowledge production, and (3) the field's impact on the broader society. Racialization is not the only cause of disparities. For critical race theorists, however, it is the point of scholarly departure in defining US social problems. This principle is affiliated with Focus 1: Contemporary Patterns of Racial Relations.

Race as social construct

Social construction is a "process of endowing a group or concept with a delineation, name or reality" (Delgado & Stefancic, 2001) (p. 155). The statement, 'race is a social construct' has both oppositional and affirmative connotations. Its oppositional connotation, the one typically invoked by health equity researchers, challenges the notion that health disparities result from biology or genetic race, or that observed disparities reflect differences with which racially-defined groups are endowed by nature. Biological determinism suggests population-based interventions have limited value because biology does not respond to behavioral changes, institutional changes or social arrangements. While the oppositional connotation describes what race is not, the affirmative connotation explains what race is:

> "the ways in which "race" orders and constrains us …have reconstitutive effects and ensure that race becomes in social fact what it is supposed to be in naturalist theory: a differentiating trait that orders us in hierarchical terms as members of inferior or superior races."(Hayman & Levit, 2002) (p. 160)

That race is not fundamentally biological does not mean that it is not real. Race is very real in our social worlds. Socially, race incurs unearned disadvantages for those low on the racial hierarchy (e.g., blacks) and unearned advantages (see Airhihenbuwa, 2007a) for those high on the racial hierarchy (e.g., whites) (Feagin, 2003). In countries where race is an important mechanism for categorizing populations (e.g., in Department of Labor and US Census Bureau statistics), understanding how race functions socially improves the accuracy with which research measures the societal mechanisms that create and sustain racial hierarchies in health.

Although race is considered a proxy for racism, research should not just treat measures of race as indicators of racism because the race proxies do not necessarily explain the mechanisms by which racism effects occur. To identify the specific pathways linking racism and health requires explicit focus on racism (Krieger, 2008). This principle is affiliated with Focus 1: Contemporary Patterns of Racial Relations.

Ordinariness of racism

According to ordinariness of racism, the ubiquity of racism, not its absence, characterizes society's normal state. Ordinariness challenges the erroneous but widely held assumption that exposures to racism are perceptible because they are infrequent, intentional occurrences that stand out against an otherwise racism-free, societal context (Delgado & Stefancic, 2001). By definition, racialization permeates all facets of society, making it impossible to fully disentangle its effects from, say, socioeconomic ones (Kaufman, Cooper, & Mcgee, 1997). Chronic exposure to the microaggressions of everyday racism (e.g., being followed while shopping or targeted by police based on race) may be a source of unrelenting stress for minorities (Clark, Anderson, Clark, & Williams, 1999; James, 1994). Majority group members are less susceptible to these exposures, however, and they tend to underestimate their pervasiveness (Bonilla-Silva, 2006; Muntaner, Nagoshi, & Diala, 2005). As discussed later, one way to improve understandings of the ordinariness of racism is through the concept of voice. Ordinariness of racism is affiliated with Focus 1: Contemporary Patterns of Racial Relations and Focus 3: Conceptualization & Measurement.

Structural determinism

Structural determinism posits that macro-level factors and systemic forces are what fundamentally drive population level inequities. Research and interventions, therefore, should target these factors operating at the macro levels of the socioecologic framework. The structural nature of racialization is what enables it to persist across time and place. One school of thought further posits that without conspiring to do so dominant institutions and group members tend to make decisions in ways that preserve their collective interests. Actions taken based on this interest convergence help to reinforce existing power hierarchies (American Public Health Association, 2001). This principle is affiliated with Focus 1: Contemporary Patterns of Racial Relations.

Social construction of knowledge

> "[D]ata never speak for themselves. It is the questions we pose (and those we fail to ask) as well as our theories, concepts and ideas that bring a narrative and meaning to marginal distributions, correlations, regression coefficients, and statistics of all kinds."(Bobo, 2004) (p. 30–31)

According to CRT, scientific knowledge, like other types of knowledge, is socially constructed. To advance the knowledge on a topic researchers should therefore understand the implications of social construction for any given project. Culture and power shape knowledge production by establishing the processes by which understandings are generated and disseminated, the perspectives informing research aims and interpretations of findings, the types of information deemed important, and whose contributions count (Airhihenbuwa, 2007a,b; Hayman & Levit, 2002; Wing, 1998).

The principle of knowledge production guides healthcrits in illuminating specific ways that a discipline's conventions (e.g., a discipline's tools for knowledge production) may constrain efforts to study health inequities. The premise underlying this principle is not new to public health: critiquing methods, theory, or other aspects of prior research is fundamental to the scientific method (Press & Tanur, 2001). PHCR considers research inherently subjective and tied to the social context in which it is conducted. When knowledge production is presumed to be value-free, a majority group's cultural norms, assumptions and methods are likely to dominate research while viable, non-mainstream approaches and understandings remain marginalized.

According to this principle, the rigor of empirical research is enhanced when investigators explicate their subjectivities relative to the work. Because disciplines (and researchers) are endogenous to the racially stratified social contexts in which research occurs, neither the "objectivity" of research nor the systematic way in which it is conducted automatically de-racializes it. Structural (e.g., funding priorities) and interpersonal factors may drive study aims, the assumptions guiding research, the tendency to set whiteness or whites as the norm (defining other groups based on their deviation from that norm), and the interpretations of findings (Airhihenbuwa, 2007b; Arthur & Katkin, 2006; King, 1997). This principle is affiliated with Focus 2: Knowledge Production.

Critical approaches

> "Question the question."(Airhihenbuwa, 2007b) (p. 33)

The principle of critical approaches calls for healthcrits to interrogate dominant cultural norms and assumptions as well as their own social positions (e.g., educational attainment) to understand "the assumptions inscribed in the theories and models" they use (Airhihenbuwa, 2007b). Critical methodologies "dig beneath the surface of social life to uncover the assumptions and masks that keep us from a full and true understanding of how the world works" (Johnson, 2000) (p. 67). A primary objective of critical theory is to evaluate and advocate for justice and fairness in society. This kind of evaluation seeks a balance between the descriptive methods typified in the utopian reach of socio-political philosophy and the explanatory methods typified in some of the uncritical premises of the social sciences (Ingram, 1992).

Critical processes are deliberative, thoughtful and reflective. They involve both cognition and affect (Johnson, 2000). Through cognition, researchers develop understandings of the relationships under study. Affect is the emotional involvement that occurs as they recognize and process the emergent cognitions. The consequent emotions (i.e., affect) motivate them toward action. Full critical consciousness occurs when corrective actions are taken in response to the cognitions and emotions (Johnson, 2000).

According to this principle, our collective and individual biases, identities, power positions (relative to others) and worldviews shape our personal assumptions and these, in turn, can inadvertently influence our research (Airhihenbuwa, 1995, 2007b; Wing, 1998). To correct this, healthcrits iteratively evaluate their relationship to the project, the study participants and the broader population served by their research. For example, in preparing to examine stigmatized risk behaviors (e.g., illicit substance use) among racial minorities, a non-minority researcher may ask, "What

a priori assumptions do I hold about the population?" An African American researcher hired to facilitate a white research team's entry into a distrustful African American community may consider the intra-racial power dynamics that emerge when minority representatives from majority institutions work on behalf of those institutions to encourage the distrustful communities to participate in research. The researcher may identify ways that racial power hierarchies are relevant to this role, clarify how they may influence interactions with diverse stakeholders and consider potential long-term implications for the community and the study. This principle is affiliated with Focus 2: Knowledge Production and Focus 4: Action.

Intersectionality

Intersectionality posits that social categories (e.g., race, gender) and the forms of social stratification that maintain them (e.g., racism, sexism) are interlocking, not discrete (Crenshaw, 1989) (Collins, 2004). Power undergirds these intersections and interactionally affects people who are multiply oppressed (e.g., racial minorities who are also sexual minorities) (Airhihenbuwa & Liburd, 2006). While a category (e.g., race) or its corresponding structural force (e.g., racism) may influence health, the interactions between categories (e.g., race and gender) or forces (e.g., racism and sexism) further complicate these relations. For instance, the epidemiologic category men who have sex with men (MSM) cannot be fully understood without accounting for its interlocking relationship with race because racism operates via gendered and sexualized proscriptions (Collins, 2004; Ford et al., 2007; Mays, Cochran, & Zamudio, 2004; Roberts, 1997; Wyatt, 1997).

Because social categories and inequities are linked across diverse populations, undoing the inequities affecting the most marginalized groups has the potential to unsettle those affecting multiple groups. Healthcrits draw on intersectionality not only to address the needs of one group, but also to address '-isms' connecting diverse groups. The principle of intersectionality is affiliated with Focus 3: Conceptualization & Measurement and Focus 4: Action.

Disciplinary self-critique

Disciplinary self-critique helps a discipline to shine a light on itself from within in order to understand how its norms may inadvertently buttress disparities either within the discipline or in society at-large. As outsiders within (i.e., persons who are members of a field but often marginalized within it because of their social identities), critical race theorists understand and appreciate their respective disciplines' strengths and visions. At the same time, they recognize many of their racial inadvertences. Addressing the inadvertences can propel a discipline toward more equitable realization of its stated mission. In jurisprudence, for instance, seminal critical race analyses showed that colorblind approaches to law restrict minority plaintiffs' options for redress in cases of institutional racism (Holmes, 2007; Valdes, Culp, & Harris, 2002). They also explained how racialization inadvertently influenced patterns of scholarship citation, which biased the knowledge on affirmative action (Delgado, 1984). Simple network analyses indicated that prominent white scholars tended to cite only other white scholars on affirmative action issues, even though minority scholars had developed a robust body of work in this area (Delgado, 1984). One unfortunate result was that the dominant perspectives on affirmative action, which were authored by white legal scholars and published in the highest tiered journals, diverged from those of minority legal scholars (Delgado, 1992). The identification of this important blind spot gave the discipline an opportunity to integrate the two bodies of knowledge.

That the principle of disciplinary self-critique is instructive to jurisprudence, the field most explicitly committed to doctrines of equality and justice, suggests all disciplines can benefit from it. Within public health, for instance, one might examine whether how journal impact factors are assigned influences the knowledge on health inequities. The current approach systematically relegates outstanding journals such as *Ethnicity and Disease* to the margins even though minority investigators rely heavily on their content (Airhihenbuwa, 2007a). The principle of disciplinary self-critique is affiliated with Focus 4: Action.

Voice

> "The social location of groups situated at the intersections of multiple systems of inequality provides not only a unique but also a privileged position from which to understand those systems" (Schulz & Mullings, 2006) (p. 33)

Voice is the privileging of marginalized persons' contributions to discourses. It responds to an insidious way that institutionalized racism subtly reinforces both the dominance of majority group perspectives and the re-marginalization of minorities' perspectives. Colorblind ideology compounds this dynamic by obscuring the role that racial stratification plays in shaping discourses (Kelley, 1994). Outsiders within often hold perspectives that diverge from those of the mainstream. When these ideas are put forward, however, they may be perceived as extraneous or as lacking merit (Schulz & Mullings, 2006). To avoid perspective imbalance in discourses requires actively "hearing" the voice of the marginalized.

Voice offers disciplines several strengths (Box 1). It helps to illuminate disciplinary blind spots that are otherwise imperceptible from within a discipline's mainstream. It increases understandings of minorities' lived experiences, which improves operationalization of constructs, development of effective interventions and creation of an equitable society. The collective experience of the margins gives birth to resilience and alternative ways of knowing; therefore, voice also promotes the development of creative alternatives for achieving a discipline's mission (Schulz & Mullings, 2006).

Voice posits neither that minority status automatically entitles one to "speak for the race" nor that individual minorities lack unique perspectives. It recognizes that all individuals possess experiential knowledge informed by their social locations. Although racialization divides groups according to their socially assigned race, their experiences of and responses to marginalization are not uniform. Voice is always in tension with tokenism. Tokenism occurs when minority individuals are included merely to present an illusion of equity. Whereas voice privileges marginalized perspectives in order to elucidate power relations, tokenism prefers the nominal presence of minorities to any substantive challenge to the status quo. The principle of voice is affiliated with Focus 2: Knowledge Production and Focus 4: Action.

Box 1. Strengths of Voice

- The potential of outsiders within to notice patterns and relations not apparent to persons socially located in the mainstream.
- A tendency for dominant group members to confide in marginalized group members in ways they do not confide in other dominant group members.
- Creativity and resilience that arise from the experiences of marginalization.
- Potential to draw on strategies of resistance originating within the margins.

Adapted from: Schulz & Mullings, 2006.

Discussion

The time is ripe for racial equity public health praxis. Interest in addressing racial health inequities has grown substantially in recent years. So, too, have the capabilities for measuring racism effects. What until now has been missing is a public health framework that grounds the health equity efforts in the robust body of work outside the field and that moves us beyond merely documenting disparities in order to challenge their root causes. CRT has been informing work in law, education and other fields for years. Tailoring it for health equity research can facilitate widespread uptake within the field of public health.

This paper introduced the Public Health Critical Race praxis (PHCR), which adapts Critical Race Theory for health equity research. Healthcrits (i.e., critical race theorists within public health) use PHCR to examine relationships between racialization, health disparities, disciplinary conventions and the discipline's influence on society. PHCR's schematic (Fig. 1) outlines the race conscious, four-phase framework used to ensure research processes and products reflect methodological rigor while remaining attentive to racial equity.

PHCR advances the goals of public health in several important ways. It improves the conceptualization and measurement of racism effects on health. It promotes disciplinary awareness of ways that the field or its conventions may unintentionally buttress disparities. It also draws on the important contributions that racial/ethnic minorities bring to the study of health disparities.

PHCR contributes to the broader CRT community, too. It helps to extend the reach of CRT into science- and social science-based disciplines; makes health disparities central to issues of racial equity; provides tools for conducting empirical research; and, highlights the need for practical application of critical race analyses (e.g., by developing appropriate interventions).

When, as is the case in the early 21st century, colorblindness is pervasive, PHCR can be useful for educating policymakers about specific ways that racial factors undergird ostensibly socioeconomic problems (e.g., limited access to healthcare).

Cautions and concerns

Despite the potential benefits of PHCR, there are several issues about which we remain cautious and concerned.

First, while it is entirely appropriate to apply most public health theories in a formulaic fashion, similar "application" of Critical Race Theory would constitute a gross violation of its *critical* approach. CRT is praxis, not a standard theory. Its constituent constructs cannot be used merely to quantify relations between raced risk factors and individual-level health outcomes. Researchers interested in widespread uptake of PHCR must ask, "How can we ensure that researchers use PHCR with fidelity to CRT's tenets?"

A second challenge is that many public health researchers seem to believe that understanding racism in the broader society is not necessary, even when studying health disparities. Healthcrits not only investigate how racialization influences disease patterns, they also study its potential influences on the production of knowledge. Important questions for addressing this challenge include, "What methods can be used to study research processes when presumptions of its objectivity are so deeply engrained? How do we begin to incorporate and legitimate experiential knowledge?"

A third concern, based upon trends in other fields and in society, is whether the rhetoric of CRT—but not its substance—might be invoked in ways that actually reinforce the marginalization or displacement of minority contributions (Delgado, 1992). In colorblind society, re-marginalization of minorities occurs when majority groups misappropriate the language and strategies marginalized groups use to fight inequity. For instance, social conservatives have invoked affirmative action's rhetoric of equal access in order to implement policies that in effect preferentially select whites. This concern will become more salient as people increasingly describe the US as entering a "post-racial era". The persistence of racial health inequities and mounting evidence of racism effects on various health outcomes suggest this assertion is premature. In public health, power differentials are inherent to, for example, collaborations between majority-run schools of public health and minority-serving institutions. Critical questions include, "Might majority institutions or researchers invoke the rhetoric of equity in ways that do not reallocate power in decision-making? How might this displace or silence minority perspectives? Are there knowledge-related implications?"

A final set of concerns has to do with institutional factors that may exacerbate professional advancement for healthcrits. Evidence from community based participatory research suggests that traditional promotion and tenure standards poorly accommodate faculty whose research entails lengthy, critical processes. Key questions include, "What strategies can healthcrits use to advance their careers while using PHCR?"

Conclusion

This paper presented the Public Health Critical Race praxis (PHCR), a new methodology grounded in Critical Race Theory that guides racial equity approaches to public health research. PHCR offers novel tools for investigating and attempting to eliminate health inequities. It informs all aspects of the research process; from the formulation of research questions to the actions taken based on the findings. Care must be taken to ensure PHCR's use occurs with fidelity to Critical Race Theory.

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