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Tackling racism as a “wicked” public health problem: Enabling allies in anti-racism praxis

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ABSTRACT

Racism is a “wicked” public health problem that fuels systemic health inequities between population groups in New Zealand, the United States and elsewhere. While literature has examined racism and its effects on health, the work describing how to intervene to address racism in public health is less developed. While the notion of raising awareness of racism through socio-political education is not new, given the way racism has morphed into new narratives in health institutional settings, it has become critical to support allies to make informing efforts to address racism as a fundamental cause of health inequities. In this paper, we make the case for anti-racism praxis as a tool to address inequities in public health, and focus on describing an anti-racism praxis framework to inform the training and support of allies. The limited work on anti-racism rarely articulates the unique challenges or needs of allies or targets of racism, but we seek to help fill that gap. Our anti-racism praxis for allies includes five core elements: reflexive relational praxis, structural power analysis, socio-political education, monitoring and evaluation and systems change approaches. We recognize that racism is a modifiable determinant of health and racial inequities can be eliminated with the necessary political will and a planned system change approach. Anti-racism praxis provides the tools to examine the interconnection and interdependence of cultural and institutional factors as a foundation for examining where and how to intervene to address racism.

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1. Introduction

Racism, is the epitome of what Rittel and Webber (1973) in their landmark text describe as a “wicked” problem. “Wicked” problems are complex problems that are highly resistant to solutions and that are characterized by high difficulty and disagreement about the nature and cause of the problem and their potential solutions. Racism also may be considered a fundamental determinant of health because it is a dynamic process that endures and adapts over time, and because it influences multiple mechanisms, policies, practices and pathways that ultimately affect health (Phelan and Link, 2015; Ramaswamy and Kelly, 2015). There is a long history of research on racism, colonization and white supremacy across the globe describing the scope and depth of the problem (W. M. Byrd and Clayton, 2003; Rodney, 2012). Racism, as a legacy of colonization and slavery, has had profound intergenerational effects on health, social and economic outcomes (Alvarez et al., 2016; Y Paradies, 2016a).

1.1. What is racism?

Racism has been defined as “an organized system, rooted in an ideology of inferiority that categorizes, ranks, and differentially allocates societal resources to human population groups” (D. R. Williams and Rucker, 2000 p. 76). Consequently, racism is an analytic tool to explain systems, patterns and outcomes that vary by population groups that are broader than the explicit decisions and practices of individuals, organizations or institutions. Beyond a series of isolated incidents or acts, racism is a deeply ingrained aspect of life that reflects norms and practices that are often perceived as ordinary, constant and chronic (Ford and Airhihenbuwa, 2010a, 2010b). Racism is a violent system of power that can be active and explicit, passive and implicit, or between this binary (Young and Marion, 1990). Racism pervades national cultures via institutional structures, as well as the ideological

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beliefs and everyday actions of people. While cultural narratives and media coverage often present it as reflecting aberrant views of a minority of people, racism is often aligned with the normative culture of particular eras, geographic contexts and locales (Griffith et al., 2010; Wetherell and Potter, 1992).

1.2. What is anti-racism?

Anti-racism is an educational and organizing framework that seeks to confront, eradicate and/or ameliorate racism and privilege (Bonnett, 2000). While interventions to undo, eliminate or ameliorate the effects of racism have existed as long as people have faced racial oppression (Fredrickson, 2011), how to educate and organize people to achieve health equity in the context of racism is less well developed (Ford and Airhihenbuwa, 2010a; Thomas et al., 2011). Often, anti-racism seeks to heal, organize and empower the oppressed, not those who are advantaged by racism and privilege.

An anti-racism approach often includes a structural analysis that recognises that the world is controlled by systems, with traceable historical roots, that batter some and benefit others. Anti-racism praxis seeks to enable equity, social justice and peace and move toward a world where racism is non-existent or its health effects are negligible. Governments, professional bodies and community-level activists across the globe pursue various anti-racism approaches with variable levels of resourcing and political will. For example, In New Zealand, STIR: Stop Institutional Racism (Came et al., 2016) is a small group of committed people who have for the last three years pursued an anti-racism agenda. STIR is a living partnership between indigenous practitioners and activist scholars and allies who promote decolonisation and engagement with te *Tiriti o Waitangi*. They have mobilised hundreds of supporters to engage in decolonisation, influence government policy and develop policy. They have established a longitudinal study to monitor government racism and undertake other empirical research to isolate sites of racism and possible interventions.

1.3. Overview and objectives of this paper

In this paper, we offer an anti-racism praxis framework as a tool to educate allies of the oppressed. Allies, those who stand in solidarity with people targeted by racism, are essential to the effectiveness of anti-racism efforts yet frameworks to inform strategies to address their unique educational and organizing needs are underdeveloped. Anti-racism praxis is a process not only to educate and conscientise individuals, but also to build coalitions, transform institutions and change population health outcomes. The development of anti-racism praxis that explicitly incorporates the literatures on racism as a societal structure and as a determinant of health inequity to inform public health efforts is limited (Paradies, 2016b).

Because racism manifests differently in particular geographic contexts (Dunn and Geeraert (2003) and racism occurs within particular historical, geographic and political contexts (Lentin, 2016), we draw on learnings from the United States and New Zealand. In both the United States and New Zealand, racism has been a part of key policies and practices that affect many areas of life. Both countries have implemented policies that delineate difference, but more importantly, a hierarchy by race that has implications for health. For at least 50 years in New Zealand (Hunn, 1961; Pōmare, 1980; Pōmare et al., 1995; Robson and Harris, 2007) and more than 100 years in the US (Byrd and Clayton, 2000; U.S. Department of Health and Human Services, 2000, 2010; Heckler, 1985), health disparities have been meticulously documented. Both governments have struggled to devise a strategy to significantly close racial gaps in mortality.

With a focus on enabling allies, this paper introduces an emerging anti-racism framework. The framework is relational, has an analysis of power, a decolonisation component, promotes a planned systems change approach embedded with monitoring and evaluation. We begin by briefly describing the United States and New Zealand contexts. Given the authors shared background in public health we triage getting our own house in order within the discipline of public health, and the development of public health policy and funding decisions. As we turn to framing anti-racism praxis, it is important to remember the context in which these efforts occur and the complexity and dynamism of the issues that these educational and organizing efforts must undo.

2. Anti-racism praxis

Anti-racism praxis is the educational process of training people to apply an anti-racism framework. Paradies (2016b) recent review of the literature found that there is not an agreed upon notion of what is meant by anti-racism. The authors embrace this fluidity of interpretation and reject Labelle's (2016) prescriptive notions of anti-racism and claim that anti-racism is an inclusive term that can encompass explicitly anti-racism media and awareness campaigns, community-led activism, legislative reform, and sovereignty movements and beyond.

Reviews of anti-racism work (Clarke et al., 2013; Rankin, 2014; Shapiro, 2002) show the majority of initiatives are educational interventions targeting individuals. According to Shapiro (2002), many anti-racism programs and initiatives seek to enhance awareness of cultural differences, reduce prejudice, evoke individual growth and transformation and increased activism. A study by Kelaher et al. (2016) has established that anti-racism interventions can also produce positive mental health effects for participants.

Successful institutional interventions, however, need to be targeted, context specific and focus on changing behaviour rather than deeply held attitudes or beliefs (Pederson et al., 2005).

Priest et al.'s (2015) review of the evidence of diversity programmes confirmed diversity training alone is ineffective. Such training needs to be contextualised with skills development, ownership, political will and organizational processes and policies. Spaaij et al. (2016) in their meta study of diversity initiatives in sport found champions were both critical to success but led to vulnerability in programmes as they were built around particular charismatic individuals. They emphasised the importance of organizational commitment.

A key limitation of anti-racism programs is the failure to evaluate their effectiveness (Clarke et al., 2013; Shapiro, 2002). Rankin (2014) noted much anti-racism work is informal, unevaluated and vague in terms of target audiences and goals; consequently, she advocated for detailed planning including pre-testing, concept-testing and embedding evaluation. Rankin (2014) noted that some work has led to substantive changes in practice, while others have been counterproductive and increased prejudice.

We suggest that "wicked" problems require those interested in addressing and eliminating racism to utilize both the science and art of relationship building, reviewing evidence, planning, implementing and evaluating. The past cannot be changed, but reconciliation can occur through sincere apologies, the payment of reparations, affirmative action initiatives, the reorientation of policies, practices and budgets and the realignment of recruitment and retention practices. Tika (correct) relationships can be established and maintained between those experiencing racism and allies. It is from this foundation that we offer five key elements of anti-racism praxis: reflexive relational practice, structural power analysis, systems change theory, socio-political education and monitoring

progress.

2.1. Reflexive relational practice

From a positional standpoint, this paper is the collaboration of a black man from the USA with roots in the Caribbean working in men's health and health equity, and a Pākehā woman from New Zealand working in Māori health. Collectively we have a background in social justice activism, particularly around racism, spanning nearly 60 years and have lived-experiences of systemic discrimination. This emerging collaboration has generated unexpected questions, insights and learnings.

In both contexts, anti-racism work is relational and involves an active process of whanaungatanga (relationship building) (Came and da Silva, 2011). It is based on community organizing principles (Griffith et al., 2007) and the goal is to help people hold those in power accountable to principles of justice and equity (Jones, 2003). Anti-racism praxis is about listening, respecting, understanding, building relationships, and nurturing trust. A fundamental goal of anti-racism organizing is to bring people together who are targeted by racism and allies who are committed to addressing racism to increase their collective agency to promote change in power relations and address the root cause of social and health inequities. For allies, anti-racism praxis is about clarifying the aspirations of those targeted by racism and removing obstacles to these aims being achieved (Land, 2015). Decolonisation and anti-racism work needs to be localised with negotiated co-intentional relationships, and ongoing dialogue between allies and those targeted by racism is essential to robust anti-racism praxis (Margaret, 2013; Nairn, 1990).

In the New Zealand context, these conversations and relationships need to occur between the descendants of the colonised and the colonisers. In the US context, these conversations and relationships need to occur between the various groups who have been the targets of racism and those who have benefitted from white privilege, and these groups need to have conversations and relationships with members of other racial and ethnic groups who are often made to feel invisible in this conversation. When speaking up, sometimes it needs to be those experiencing racism; other times, allies' voices are critical to translate and challenge privilege. These choices must be informed by an understanding of the audience and how power is operating in the setting and context. This understanding comes through socio-political education.

2.2. Socio-political education

Akbar (1998) outlines several phases of political education applicable to the health sector in relation to equity and racism. This framework is congruent with principles of critical consciousness (Freire, 1973), political socialization (Martín-Baró, Aron and Corne, 1994), socio-political development (Watts et al., 1999) and critical self-education (Akbar, 1998). The first phase *unlearning and relearning* is characterized by equipping people to critique research, utilize public health ethics, and engage in cultural and structural critique. This phase highlights an analysis of power, intersectionality and whiteness (Grosfoguel et al., 2015). These frames are utilized to critically analyze how health issues are defined, who defines the issues, what type of research and policy is valued, and how to build respect, trust and the relationships. Foundational knowledge helps allies probe their own privileged standpoint (Came & da Silva, 2011; Margaret, 2013).

Central to this initial phase is decolonisation. Māori leader, Jackson (1989) advocated that decolonising one's mind from colonial subjugation and to reengage with traditional knowledge should be an important goal for those targeted by racism. Freire (2000) called this process of unlearning and relearning conscientization. Such training has been successfully and widely implemented across the world to strengthen the voices of indigenous and marginalized populations and build their capacity to empower themselves. Decolonisation is an educational process but also a global movement shaped by the writings of Fanon (2004), Said (1978) and Freire (2000) that has led to self-government for some and strengthened recognition for other indigenous and oppressed peoples. More than a stroke of a pen, Smith (2012, p. 98) argued that decolonisation is "a long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power". Similarly, allies must pursue a systematic process of unlearning and relearning. The same colonial forces that shape the perspectives of those targeted by racism shape allies' knowledge and perspectives. It is critical for allies to look beyond the sources of information and resources provided by colonial educational systems and scholars and expose themselves to the work of indigenous and other diverse scholars.

The second phase of sociopolitical education involves nurturing the ability to *critically analyze structural inequities and racism* rather than adapt to it (Watts et al., 1999). Practically this involves interrogating a problem in a way that honors the social, cultural, and historical realities of groups targeted by racism. It is important for allies to not only see the world through their own eyes but to try and understand why the perspectives of their colleagues who are targets of racism may be different. There are inherently diverse perspectives on the way a problem can be conceptualized, examined, addressed and explored. It is critical for both targets of racism and allies to recognize that their perspectives and lenses can be biased; however, through education and communication with others, each can get closer to identifying accurate history. Metzl and Hansen (2014) described a similar process for health providers as structural competency: the ability to understand how racism and other structural forces shape and determine what is defined as symptoms, illnesses and diseases in health settings.

The final phase is the *integration of new knowledge and skills* into one's professional practice and institutional setting. It is essential for allies and others to understand that increased knowledge and awareness are necessary but insufficient intermediate goals (Griffith et al., 2012). If the only change that occurs during an anti-racism intervention is increased knowledge the intervention has failed. Knowledge also is not for knowledge's sake; it is to inform and spur collective action. Particularly in the US, for targets of racism and allies, the goal is not to acquire knowledge for its own sake but to learn new knowledge that can help public health professionals become more effective in advancing health equity and an anti-racist agenda through engaging in institutional change and collective action (Griffith et al., 2012).

For example, it is essential for the information learned through anti-racism praxis to affect how public health practitioners make decisions in their daily tasks and jobs. In the US, initiatives for local public health professionals who are charged with developing and implementing programs to change behaviors, remove barriers and promote health have to determine how racism affects the specific behaviors and stressors that may be driving the poor outcomes of interest. Alternatively, state public health professionals whose roles are to identify where resources need to be concentrated, where local public health professionals need technical assistance and support, and where there are gaps in services and programs left by local public health professionals have to discern how best to apply an anti-racism lens to solving these problems as they devise sustainable interventions that can be institutionalized.

In New Zealand, indigenous leaders and allies have been working towards constitutional transformation (Matike Mai Aotearoa, 2016; Peace Movement Aotearoa, Quaker Treaty

Relationships Group and Rowan Partnership, 2012). STIR (Came et al., 2016) a health activist network with indigenous and ally members has been pursuing collective action to end racism. In the US, Black Lives Matter may be the most visible recent organization with a similar agenda. In the end, this phase is congruent with a key aspect of decolonisation: transferring of resources, power and ultimately sovereignty. Moreover, it is critical for allies to maintain their relationships with targets of racism and other allies as it is unlikely that the most successful change will come with the efforts of any one individual. Being open to the knowledge and perspectives of trusted others also could offer new insights into how to apply an anti-racist perspective to their work. With this foundation, the next component to add to an ally's toolbox is a structural power analysis.

2.3. Structural power analysis

It is important to understand the different sources of power, the way power is exercised, and where power lies to create institutional system change (Griffith et al., 2007). Foucault (1977) argues that power is inherent in any relationship in which one person can potentially shape or influence the thoughts or behaviors of another. It is critical to note, however, that where there is power there will be resistance (Foucault, 1977; Lavoie, 2014). In these contexts, it also is important to understand the distinction between formal and informal power. The former is associated with the position one holds in a formal organizational hierarchy, including one's reporting relationships and the ability to issue rewards and punishments, and the latter is derived from the assumptions made about one's possession of and ability to mobilize desirable resources. Because formal and informal power is often concentrated within a few people in an organization, understanding the values and behavior of the people who can most effectively get things done and who are gatekeepers for others are critical to explicating the problems and solutions in a given system (Griffith et al., 2007; Griffith et al., 2010). Allies can be especially important in understanding informal power through their privileged access to people in positions of formal power.

Not all of the power that can influence an organization and create institutional change resides within the organization. Key people and organizations external to the organization can have an important impact on institutional policies and practices (Griffith et al., 2007). Helping staff within an organization to build relationships with people in other organizations, in and outside of health, and to strengthen the organization's relationship with their constituencies can be a key way to mobilize power (Griffith et al., 2007). These relationships utilize social power and informal relationships to exercise various forms of power. These relationships can be particularly helpful in framing the discussion and setting the agenda around these issues, in the community, professional circles, and in the organization. By strategically illustrating how addressing racism or creating equitable systems is congruent with the organization's mission and goals, it is possible to build support from those who might otherwise have not been interested in such an initiative. This requires knowledge and information.

Information is a key source of power, making the ability to access information critical, and the ability to utilize information essential. Some people can limit the choices of others by not allowing certain ideas or approaches to be considered; while others can ensure the social and professional costs and consequences of presenting specific data are too high. The professional and personal ideologies and worldviews that serve as the context for decisions also are critical factors for people to recognize (Griffith et al., 2007). Lukes (1974, 2005) argues power has three faces that demonstrate how power is exercised: i) overt decision-making, ii) agenda setting and prioritization, and iii) shaping meaning and value. It is important that people understand how and what decisions are made, which is the most obvious face of power. What is less obvious, however, is the power inherent in deciding what should be on an agenda for discussion, and how the issues on the agenda are prioritized. This is akin to what Foucault (1977) describes as normalizing judgment, or efforts to make a particular position seem to be common sense or just *what we do* (Lavoie, 2014). Still less obvious, but no less important, is how determinants of health and health inequities are shaped and framed for discussion and action (Diez-Rouz, 2012).

Thus, in order to create institutional change, it is critical to understand the steps necessary to help people become more sophisticated in understanding racism and the potential strategies that may undo it. This may involve asking questions such as - how is racism operating here? Who sets the agenda? Who is benefitting? Who is being disadvantaged? How are indigenous and other minority voices incorporated into this system? Next, we use the three faces of power to illustrate how a power analysis can be utilized in anti-racism praxis.

The first face of power in a new anti-racism praxis could focus on decision-making regarding macro issues such as *policies and investments*. For more than 20 years, research on the relationships between race, racism and health has demonstrated the importance of considering racism and other social determinants of health in strategies to eliminate health inequities, yet the primary strategies to reduce disparities funded by the US and New Zealand government agencies focus on biomedical and behavioral strategies (Shaw-Ridley and Ridley, 2010).

The second face of power is *agenda setting*: the ability to define or determine what is considered a relevant issue to be discussed or addressed through establishing the agenda or prioritizing ideas. Governments have enacted policies of colonization, assimilation, slavery and segregation that have enabled genocide and the mass alienation of indigenous land was institutionally racist (Gracey and King, 2009; Greenwood et al., 2015). For example, New Zealand health policy often rely on northern hemisphere studies that have no indigenous analysis, yet those policies are assumed to work for Māori (Came, 2014). In the US context, the federal research agenda has focused more attention on unlocking the human genome and precision medicine than achieving health equity through addressing social determinants of health or utilizing community-based approaches to improving health.

The third face of racism is the process of shaping or *framing an issue* so that certain ideas are considered and discussed and others are not considered. Jones (1997) argues that culture is a blueprint for living in a society and defining races and the importance of race in society. Racism comprises the cumulative effects of a racialized worldview, based on belief in essential, biological racial differences that privilege white people. These effects permeate dominant white culture in US and New Zealand through institutional structures, ideological beliefs, and personal everyday actions of lay people, health professionals and policymakers (Jones, 1997; Smedley and Smedley, 2005) and shape what are considered determinants of health that should be considered points of intervention.

Ramsden (1994) and Fanon (2004) warn indigenous anti-racism and decolonisation efforts are often met with active resistance as settlers are reluctant to share power and resources. Brooks (2014) study in Canada across three sites found multiple strategies used to resist anti-racism interventions. These included attacking the messenger, inaction or sabotage, dismantling change initiatives, limiting or providing insufficient resources and invoking structural rigidity. It is particularly important for allies to be prepared to be attacked and isolated if they engage in anti-racist efforts (Griffith

et al., 2015). For example, Lavoie (2014) highlights how making and articulating particular observations and led to suspicion and even confrontation in her anti-racist work. She also described how a staff member was encouraged to think about the importance of loyalty to the organization and away from actions that challenged power relations within her organization. In sum, understanding power and all of its faces is essential for doing this work, particularly for allies. After learning to see all of these dimensions of power, the next step is to utilize this power analysis as the foundation of systems change models and approaches to creating organizational and structural change.

2.4. Systems change

When facing a "wicked" problem, it is critical to have a framework to guide an intervention that can inform systematic, multilevel change (Midgley, 2006). An important foundation of a systems change approach is considering how racism operates at multiple levels of an organization: the *extraorganizational*, the *intraorganizational*, and the *individual* (Griffith et al., 2007). At the *extraorganizational* level, institutional racism explains the reciprocal relationship between organizations and their external environment. This external environment includes societal ideals (e.g., individualism, the American Dream, the American Creed) (Geronimus and Thompson, 2004; Kwate and Meyer, 2010), the biomedical lens of medical and healthcare institutions and the intrapersonal and behavioral explanations for health disparities often offered by public health departmental initiatives. At the *intraorganizational* level, institutional racism operates through an organization's internal climate, policies, and procedures (e.g., the relationships among staff). The beliefs about the determinants of social and health inequity and views on where and how to intervene to improve health and reduce inequity are not absent the previous policies and programs, or the fiscal and political climate and policies of the institution or larger national culture (Griffith et al., 2010). As a result, it is essential to demonstrate how organizational policies and procedures, even when not intended, may be contributing to health disparities through health impact assessment and other monitoring and evaluation tools. At the *individual* level, racism operates through employees' attitudes, beliefs, and behaviours. Allies have to understand that the levers for change may occur at any one of these levels and they may be different for each key actor they seek to affect.

Systems change interventions are flexible frameworks that assume that everything in the universe is directly or indirectly connected to everything else, making knowledge of all of the possible permutations of a solution impossible. The goal of employing a systems change approach is to provide a foundation for defining boundaries and making value judgments to determine how to intervene (Griffith et al., 2007). The boundaries are set so that the anti-racist change agents can capture the values, perspectives and concerns of targets of racism and allies who are in key roles in the institution and outside of it. They would use a systems change approach to account for and consider each of these points of view without compromising comprehension of the overall problem.

It is critical for allies to recognize how ethics, morality, politics and cultural values intersect and often come in conflict when seeking to work through the seven stages of a systems change (Soft Systems Methodology) approach: (1) defining the problem; (2) expressing the problem; (3) defining the root definitions of the problem, including the different perspectives on the problem of interest; (4) developing a conceptual model of the systems named in the root definitions; (5) comparing the model to the real world; (6) examining possible interventions, assessing their desirability and feasibility given the system dynamics and contextual culture; and (7) implementing an intervention (action) to address the problem of interest. At each of these points, targets of racism and allies may have different perspectives and may view the political and ethical boundaries of the problem and solutions differently. Nonetheless, the goal of a systems change approach is to examine the situation in new ways that allow them to consider perspectives and solutions they previously had not considered.

A key aspect of this intervention strategy is critically examining five elements of a system: 1) core values and assumptions; 2) social and organizational context and consequences; 3) the relationship among monitoring and evaluation methods; 4) the relationship among explanations of the problem; and 5) actions to achieve health and social equity. The strength of this systems change approach is that it can be used when there are multiple assumptions and logics about the root causes of the issue. This systems change approach is particularly useful in creating an intervention strategy when there are a number of stakeholders with different goals and whose values, assumptions, and perspectives need to be disentangled (Williams, 2005). The goal of designing and implementing a strategy to change the system can be achieved by acknowledging and developing different perspectives about the problem and the intervention, and then constructing models that articulate these perspectives and that compare the viewpoints with real life (Griffith et al., 2007). Learning systems change strategies can be particularly empowering for allies as these frameworks and approaches provide an important tool for moving from knowledge to action. The prior steps help to prepare allies emotionally and intellectually but systems change models provide processes and tools for strategizing and intervening. The final step is developing strategies for monitoring and evaluating anti-racism interventions.

2.5. Monitoring and evaluation

Assessment and monitoring frameworks are invaluable in assessing where an organization is at in relation to equity and racism. In New Zealand a plethora of cultural and treaty audit tools (Cunningham, 1995; Durie et al., 2003; Health Promotion Forum, 2000) have been developed in recent decades, many informed by the work of Māori leaders Ramsden (2002) and Durie (1998). Marrie and Marrie (2014) and Trenerry and Paradies (2012) working in the context of Australia have developed interesting frameworks for assessing racism within organizations.

Similarly, in the US, efforts to promote health equity in state and local public health departments have to be anchored in high quality data that can help inform where and how to intervene (Griffith et al., 2012; Griffith et al., 2015). Data should be used to document inequities, evaluate the effectiveness of interventions and policies, and help guide where and how to intervene (Griffith et al., 2015). This takes a combination of the conceptual skills necessary to operationalize the often-abstract elements of racism and the technical skill to build logic models and other strategies to determine what and how to measure to assess progress (Griffith et al., 2015).

It is critical for allies to understand the importance of data in documenting progress and challenges are occurring in the processes of organizational change. While not unique to the role of allies, it is critical for anti-racism organizational change efforts to be able to document how addressing racism ultimately advances institutional goals, objectives and outcomes. Though often in this work we like to develop moral and ethical arguments for addressing racism, developing the *business case* for anti-racism, quality improvement, and health equity interventions (Griffith et al., 2015) or mental health costs (Elias and Paradies, 2016) may be a much stronger argument for some audiences.

Health impact assessment tools have been adopted around the

world to assess the impact of existing or planned policy and investment decisions (Public Health Advisory Committee, 2005; World Health Organization, 1999). Over time some of these have been tailored to address equity issues (Povall et al., 2014; Prasad et al., 2015). New Zealand has developed a unique indigenous impact assessment tool which examines the potential holistic health effects of a policy on Māori whānau (family). It also examines Māori involvement in policy development and addresses wider cultural, historical and social determinants of health. Widely used in New Zealand, the *Health Equity Assessment Tool* (Signal et al., 2008) is a key part of the Ministry's policy process and district health boards reporting requirements. It was commissioned by the Ministry of Health to build the capacity of the health sector to contribute to heath equity. It consists of a series of questions to enable the assessment of current or future policies programmes and services. Health impact assessment is critical to help allies and others educate policy makers and administrators on the value of anti-racism initiatives. In the US, these tools have been used to help health department staff educate elected officials about the ways that non-health policies (e.g., pay equity for women; investment in head start or early education) can have long-term health benefits.

Perhaps the most challenging aspect of monitoring and evaluating anti-racism interventions is how to measure racism. There remains ongoing debate about how to measure racism (Pieterse et al., 2016; Williams, 2016), and it is particularly challenging to measure it in organizational and institutional settings (Griffith et al., 2007; Griffith et al., 2007). Because definitions of racism are diverse and operational definitions of discrimination and racism are political and contentious, it is important to decide what and how to monitor and evaluate anti-racism interventions using both qualitative and quantitative tools (Griffith et al., 2006). The notion of racism being a fundamental determinant highlights how racism operates through multiple complex mechanisms and pathways (Link and Phelan, 1995; Phelan and Link, 2015), making monitoring and evaluation especially challenging. Qualitative tools that can capture various perspectives are critical in capturing the effects of anti-racism efforts as the implications are not always anticipated or easily measured. This does not diminish the importance of evaluating anti-racism work, but highlights the skills and sensibilities that allies and targets of racism need to have to be successful in this work.

3. Implications and conclusions

Systems are complex; but because they are people-made and people-run, they can be transformed. A review commissioned by the Australian Public Service Commission (2007) found tackling "wicked" problem requires holistic systems thinking, flexible and inter-sectoral approaches, informed debate, engaged stakeholders and a long-term focus. In short, they require bespoke collaborative and innovative solutions to address institutional racism. To address institutional racism, it is important to begin addressing the complex and multiple causes and faces of oppression, and the many ways it is affecting individuals, organizations, institutions, and communities. Because of differing histories of specific nations and population groups, it is critical to recognize the common and unique elements of racism and the different factors that may need to be considered to reduce or eliminate institutional racism.

Anti-racism praxis to inform the work of allies is guided by several key foundations. Social and health inequities are rooted in a history of systems of racism that cut across institutions and levels within institutions. Inequities in various forms of power are key to understanding this history and addressing inequities within institutions and organizations (i.e., health inequities). The cognitive and skill development of targets of racism and allies is necessary but insufficient for addressing racism's effects on health inequities. Monitoring and evaluating anti-racism interventions is essential for their sustainability, viability and refinement. It is critical to ensure that there are tangible and measurable effects for anti-racism efforts to be sustained and institutionalized.

While it can be utilized to create institutional change across every societal sector, this paper focuses on how anti-racism praxis can be applied to public health practice. Lessons learned in addressing racism within this niche can then be usefully applied to address institutional racism in other domains such as housing, education, local government. Despite the challenges and complexity inherent in addressing the fundamental cause of racial inequities, anti-racism praxis provides a blueprint and tools for moving this work forward. It is essential to recognize the common elements of racism across sovereign nations, yet the unique cultural roots and institutional manifestations present in each country. While from one perspective these goals seem impossible to achieve, yet from another they are remarkably simple: people have to come together to create a shared understanding of the problem and develop multi-level and institutionally specific solutions to eliminate inequities.

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